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# **Anthropology, Brokerage and Collaboration in the development of a Tongan Public Psychiatry: Local Lessons for Global Mental Health**

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## **Abstract**

The Global Mental Health (GMH) movement has revitalised questions of the translatability of psychiatric concepts and the challenges of community engagement in countries where knowledge of the biomedical basis for psychiatric diagnosis is limited or challenged by local cultural codes. In Tonga, the local psychiatrist Dr Puloka has successfully established a publicly accessible psychiatry that has raised admission rates for serious mental illness and addressed some of the stigma attached to diagnosis. On the basis of historical analysis and ethnographic fieldwork with healers, doctors and patients since 1998, this article offers an ethnographic contextualization of the development and reception of three key interventions during the 1990s inspired by traditional healing and reliant on the translation of psychiatric terms and diagnosis. Dr Puloka's use of medical anthropological and transcultural psychiatry research informed a community engaged brokerage between the implications of psychiatric nosologies and local needs. As such it reveals deficiencies in current polarised positions on the GMH project and offers suggestions to address current challenges of the Global Mental Health movement.

## **Introduction**

Discussion on the merits of the Global Mental Health (GMH) agenda is often polarized (Bemme & D'souza, 2014 ). Supporters emphasize the laudable goal of mental health care for all and argue GMH is driven by local needs and knowledge (Horton, 2007; Collins, et al., 2011). Critics draw attention to the imperialistic undertones underlying the 'Global' tag and the detrimental impacts of imposing western illness categories on local experience (Fernando, 2012; Summerfield, 2008; Mills 2014). Fassin reiterates in a critical analysis of 'the obscure object of global health' that in spite of globalization and the contemporary shift to framing health in global terms most health issues require policy interventions that are 'national, even local' (Fassin, 2012, p. 96). Medical anthropology has long valued research on local modalities and strategies of addressing mental illness in advance of establishing psychiatric services (Desjarlais, et. al., 1995). The challenges and politics of translating global policies and initiatives into local interventions are most clearly played out at the meeting point between health care providers and communities (see Sridhar, 2008; Adams, 1998). Ethnographic studies of psychiatry have illuminated the politically and epistemologically loaded communication at this nexus (Estroff, 1985; Gaines, 1992; Littlewood and Lipsedge, 1992; Luhrmann, 2000). More recent research has encouraged more attention to the adaptations of psychiatry in new populations, and psychiatry's need to "recreate and redefine concepts to fit with local cultural codes" (Behague, 2008, p. 143).

Tonga, a sovereign South Pacific nation of 176 islands with a population of approximately 103,000 people, provides a propitious case study of a local psychiatry that drew productively on medical anthropology and transcultural psychiatry research. Never formally colonized, the influence of British protectorate status from 1900-1971 was largely

restricted to external affairs. A constitutional monarchy since 1875, Tonga transitioned in 2010 to a more democratic form through legislative reforms prompted by the public protests of a longstanding pro-democracy movement (Besnier, 2011). Research on colonial psychiatries is challenging and nuancing the standard 'imperialistic' critique of the reductionism and depoliticisation of suffering by colonial psychiatric practice that resonates strongly with critics of GMH.<sup>1</sup> For the most part, colonial psychiatrists were not engaged in projects of direct social control, and most usefully offered a scientific language to understand local behaviour (Mahone & Vaughan, 2007). This in turn facilitated a brokering across the boundaries between psychiatric and indigenous knowledge, that the 'decolonizing' psychiatrist Thomas Lambo famously demonstrated in the 1950s in Nigeria. The Aro Village Scheme provided 'a holistic, community-based experience' where families lived with their mentally ill relatives in a village where traditional medical practitioners were incorporated (Heaton, 2013, p. 57). By comparison the initiatives in the 1990s of Tonga's psychiatrist, Dr Mapa Puloka, did not pursue an intermediary space for treatment between the mental hospital and a previous home. Rather, he strove for a more publically accessible hospital based psychiatry emergent of dialogue with healers' conceptualisations. He was integrative in conceptualizing and communicating psychiatric knowledge, but not in psychiatric practice.<sup>2</sup> Dr Puloka recognized that a successful and publicly accessible Tongan psychiatry needed to broker local knowledge with global nosologies, and offer ideas of

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<sup>1</sup> As Sadowsky outlines, these include the expectation of psychiatry's dual 'hegemonizing' effects of persuading the "colonized of the rightness of imperial rule" and undermining the indigenous belief system facilitating the "development of colonial, capitalist social forms" (Sadowsky 1999, p. 116).

<sup>2</sup> By 1981 the Aro Village Scheme had severed its links with traditional healers reflecting a wider ambivalence in the transcultural psychiatry literature on the possibility of synthesis in Nigeria influenced, in part, by 'culturally relativistic identity politics' (Heaton, 2013, p.160).

citizenship and improved patient communication to a nation edging towards democratic reform (Puloka, 2011, per com). Critical of biomedicine's tendency to misunderstand local healing practice he argued for an approach 'in harmony with people's current state of belief' that took account of the 'special meaning' attributed to the efficacy of local healing (Puloka, 1998, p. 89). With the aim to encourage early diagnosis and address the stigma attached to attributions of mental illness, he attempted to transform psychiatric practice and revolutionize public knowledge of mental illness using radio, television and newspaper media.

The way that Dr Puloka addressed the 'treatment gap'<sup>3</sup>, in the 1990s was distinct from the typical modality of current GMH initiatives, that of packages of care predominately focused on recognition and management (Mari, et. al, 2009). His initiatives were grounded in an ethnographic appreciation of mental illness, and were founded on collaboration and public engagement. To appreciate the context for, and contribution of, his initiatives I introduce Tonga and then Tongan psychiatry in terms of the important role of Christianity. I frame a dramatic increase in admissions in the late 1990s in relation to literature on the reception of media in Tonga, analyze it through the pragmatics of Tongan health seeking and draw attention to the culturally loaded meeting point between religious ideas and Dr Puloka's initiatives. The central part of this paper focuses on the reasons and inspirations for, and the reception of, Dr Puloka's triple strategy: (1) Collaboration and workshops with traditional healers; (2) The translation of psychiatric diagnoses;(3) Encouraging freedom of movement and legal appeal to involuntary admission. While each is introduced in relation to key general challenges or critiques of GMH initiatives I analyse the reception and response

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<sup>3</sup> The GMH movement use this term to refer to the proportion of people who need mental health care but do not receive it. In this conceptualisation, non biomedical treatment is not counted as mental health care.

to Puloka's 'recreation and redefinition of concepts', in relation to particular professionals, patients, carers and others. Most Tongans I spoke to, when explaining the behaviour of family and friends do not generalize, preferring to focus on people's personalities and life histories whilst acknowledging the limits of their knowledge. Attention to diversity of reception nuances the general argument of the value of anthropology, brokerage and collaboration to reframing how GMH might approach a rapprochement between local concepts and psychiatric knowledge not overdetermined by the biomedical imperialism vs cultural adaptation dialectic.

## **Methodology**

The following analysis is grounded in an initial eighteen months of ethnographic fieldwork from 1998 to 2000 on biomedical and local treatment for mental illness and spirit possession.<sup>4</sup> Six months of ethnographic research in the psychiatric unit on the main island of Tongatapu preceded an extensive survey of healers in Vava'u, the second most populated island group. Over one year I assisted two of the most active 'spirit' healers in their healing practice. With the assistance of Dr Puloka and public health nurses in Vava'u I also traced past patients' movements between psychiatric and traditional treatment. In subsequent research visits in 2005, 2007, 2009 and 2011 I have continued to shadow Dr Puloka in his work and teaching, interview more psychiatric unit staff and follow up on cases. The analysis of the reception of Dr Puloka's public psychiatry is grounded in extensive ethnographic knowledge of specific individuals' resort to traditional and hospital treatment and the attribution of efficacy and value to treatment more broadly.

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<sup>4</sup> Ethical approval was granted by University College London and by the Tongan Ministry of Health. Tongan guidelines on patient consent were met and informed consent was gained with all participants.

## **The Establishment of Psychiatry in Tonga**

Tonga has been a Christian nation since King Tāufa‘āhau Tupou I used missionisation to unite Tonga under his rule at the beginning of the 19<sup>th</sup> Century. Now the vast majority of the population are members of Free Wesleyan, Catholic, Church of Tonga, Evangelical and Mormon congregations. King Tupou’s highly political and symbolic act in 1845 of giving Tonga to God in a ceremony in Pouono, Neiafu, followed the first written law of Tonga-the Vava’u code in 1839- and anticipated the declaration of a Constitutional Monarchy in 1875. The idea of nature under divine control affirms the most stigmatizing cause of mental illness : divine punishment or nemesis (*mala’ia*) for a crime against the church. It also explains the divine efficacy of plant based remedies used by healers-often prominent members of church congregations- who explain the same behaviour in the non-stigmatising terms of interaction with spirits. These explanations still have great appeal despite the development of modern health services, which as ‘careful and purposeful selections of certain forms of ‘modernity’’ (Young Leslie, 2005), continued the strategy of ensuring self-governance that Tonga had managed through establishing credibility as a nation and evading colonization, the only Polynesian Kingdom to do so (Besnier, 2011).<sup>5</sup> The first training of Tongan medical students in Fiji in 1928 heralded more large scale migration in the 1960s to New Zealand, Australia and the United States for work and study. Public Health Nurses, by contrast, are trained in Tonga and carry out prevention and outreach in family planning and nutrition, sanitation and hygiene, immunization, infection control, school health and reproductive health. Tongan born health workers who work overseas remit proportionally more than

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<sup>5</sup> The establishment of the Department of Health in 1919, the provision of free health care, the building of the first major Vaiola hospital in 1923 in the capital Nuku’alofa were strongly supported by the monarchy.

fellow migrants, and contribute to Tonga's remittance and aid based economy (Connell & Brown, 2004).<sup>6</sup> Agriculture, fisheries, tourism and commodity exports constitute the remainder (World Bank, 2005).

Dr Puloka publicly compared the challenge of shifting public knowledge of mental illness caused by 'evil spirits' or divine punishment to the scientifically validated knowledge of mental illness as a 'brain disease' to the European enlightenment in the 18<sup>th</sup> century (Puloka, 2004, p.2). Privately he was more modest and recognized that his aim was more rhetoric than realistic. The psychiatric unit in Tonga was established to address a longstanding deficiency in health provision that became both political and public in 1976 during the court case of a murder of a Peace Corps volunteer by a fellow volunteer (Weiss, 2004). Without a Tongan psychiatrist to contest the diagnosis of a psychiatrist from Hawaii employed by the Peace Corps to repatriate him at all cost to avoid a death penalty, the accused was sent back to the United States. There was considerable consternation in government at the revelation that the accused had escaped justice and forcible treatment because the agreement for him to be detained in the US was voluntary. The need for a psychiatric unit was also supported by HBM Murphy, one of the key proponents of transcultural psychiatry at McGill, who argued that many people suffering from chronic psychosis had never presented at the hospital. In extreme cases families would keep their disturbed relatives chained up in outhouses when symptomatic (Murphy & Taumoepeau, 1980). His co-writer, New Zealand doctor Bridget Taumoepeau, was one of the founders of the Psychiatric unit.

A brief comparison of mental health policy transfer of Tonga's westerly neighbour,

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<sup>6</sup> Historically the Tongan Ministry of Health has relied heavily on New Zealand, Australia, Japan and WHO for funding, fluctuating between 30-40% of the total health budget - USD\$1.2 million in 2009/10 (Fadgen 2013; MOH(Tonga) 2012).



Fiji and northerly neighbour, Samoa, confirms how institutional and governmental politics strongly influence local refractions of allied national policies. Colonial control does not entirely predict earlier development of mental health services. Fiji's dedicated asylum was built in 1884, 'as a sign of imparting civilization to colonies' under British colonial power, but was driven in the first instance by a recognized expatriate need (Leckie, 2011, p. 31). Tonga's asylum was established in the 1940s and was attached to the prison. In Samoa, patients continued to be housed in Tafaigata prison until the mid-1990s. Neither Germany, as colonial power from 1889 to 1914, nor New Zealand from 1914 to 1946, established a dedicated asylum. Fadgen's exhaustive comparative study of mental health policy transfer to Tonga and Samoa credits greater political stability in Samoa to their success in implementing both mental health law and policy by contrast to Tonga's minor legislative reform. For Tonga he details long term support from countries (Australia, New Zealand, the United Kingdom, Japan, China, the United States) the WHO and ADB (Asian Development Bank), in passing before focusing on key health sector reforms starting in January 1997 funded by AusAID. Despite WHO assistance in the drafting on the Mental Health Act (2001), this had little impact on creating a mental health policy in Tonga as a result of prioritizing NCDS, civil society organization's predominant focus on domestic violence, drug abuse and deportees, and the lack of a supportive political insider during key stages in policy change (Fadgen, 2013).<sup>7</sup>

Despite the lack of a Tongan mental health policy Fadgen attributes most change to

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<sup>7</sup> The WHO's influence on the development of psychiatry in Tonga has been limited to drafting the mental health act (2001) funding workshops with traditional healers and on law and mental illness (1997), informal advice and providing visit reports formalizing the scale of mental health problems (see Williams, 1993). Fadgen states "The sense was that mental health was neither being vigorously pursued by the MoH nor insisted upon by Geneva as a matter requiring sustained attention beyond the particular agenda of any particular ministry of health' (Fadgen, 2013, p.178)

two decades of 'practice-level policy innovations' including community education that would be missed by focusing on hard policy transfer. He credits Dr Puloka with the transformation of Tongan psychiatry through a reconciliation of Tongan cultural conceptions with his understanding of international best practice (2013, p. 164 ).

Dr Puloka's frequent referral to witnessing the abuse of a mental patient in 1975 as the origin of his interest in psychiatry affirmed a cultural mandate for psychiatry that referenced personal involvement and conscience (Puloka, 2005, per com). At the age of 17, and as Dux of the Methodist Tupou College, he went to a church service at the prison as part of voluntary work. A female patient from the asylum swore at one of the officers. Several prison officers then dragged her out of the church by the hair, while punching her repeatedly. Physical disciplining was still common fifteen years later when he stepped into the position of Medical Officer in Charge of the Psychiatric Unit. One of his first aims to remove patients from the prison asylum and prison discipline, was realized with the building of a new security extension in the psychiatric unit in 1993.

### **Admission, Reception and Criticism**

Admissions statistics suggest a dramatic shift in the accessibility and acceptability of the Psychiatric unit at the end of the 1990s. In 1996, six years after Dr Puloka took over, six people were admitted with a diagnosis for schizophrenia-in 1997, twenty seven, and in 1998, thirty five. Admission for Bipolar mood disorder rose from 11 in 1996 to 17 in 1997 to 42 in 1998 (Minister of Health, 1998, p. 64). After demonstrating the relevance of literature on Tongan reception of Hollywood films to appreciating the reception of Dr Puloka's TV broadcasts, I consider a number of possible explanations for the increase and why they are contradicted by the ethnographic evidence. This frames the following analysis oriented to

the reception of improved communications between the psychiatric unit and potential patients and their care givers. Before Dr Puloka's media initiatives there was no media coverage of medical understandings of mental illness.<sup>8</sup> He focused on translating psychiatric diagnoses and explaining them in relation to contemporary social challenges. TV presentations drew on the same content from Dr Puloka's writings. Publication in both the main newspapers meant that his articles were accessible and could be discussed.<sup>9</sup> Tonga has an almost 100% literacy rate with easy access to media. Despite considerable increase in consultation following broadcasts and publications, Puloka was cautious in explaining the dramatically raised admission rates only in terms of increased public awareness of signs and symptoms (Psychiatry Unit, 2004, p. 14). A useful parallel can be made between Tongans' reception of Hollywood films and their reception and action in response to Dr Puloka's radio and television broadcasts. Hahn dismantled some of the assumptions of 'media imperialism' in her exploration of 'how Tongan audiences use cinema to reference and reinforce being Tongan' (Hahn, 1990, p. 104). Rather than focusing on how the Tongan cinema experience is explained by 'poor viewing conditions and poor comprehension' she argued for a focus on 'what aspects of Tongan culture they bring to the theatre' (Hahn, 1994, p. 109). Of most relevance to understanding increased admissions following public mental health broadcasts is Hahn's argument that the cinema experience was subordinated to Tongan churchgoing practices. The key question then is how enduring Christian ideas of mental illness as punishment for past wrongdoing are contradicted or served by psychiatric ideas or medications? The shame associated with mental illness and admission to the asylum had

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<sup>8</sup> The format of Dr Puloka's TV appearances were formal in form (he sat behind a table) like other public health promotion campaigns using expert doctors. His delivery and content, however, stood out as being accessible and interesting.

<sup>9</sup> In 1998 the MHWO found TVs in almost all the home she visited.

always extended beyond the family neglect or 'unseemly behaviour' that led them to be incarcerated (Murphy & Taumoepeau, 1980, p. 474). Gossip might allude to incest, illegal acts or deliberate damage of church property. In one famous case mental illness was explained by the individual smoking tobacco wrapped in the page of a Bible (Poltorak, 2007). Families with suffering family members would find it challenging, though not impossible, to address the implied slur and impact on the social confidence of the family.

Prior to the mid 1990s families rarely brought their relatives voluntarily to the hospital unless there was a personal or familial connection to the psychiatrist, a factor that similarly facilitates consultation with healers through the typical health seeking process of *kole tokoni* (asking for help) from someone identified through kin and church links (McGrath, 1999; Poltorak, 2010, 2013). In the process of seeking treatment, diagnostic considerations were secondary to establishing the entitlement and confidence to request help (Poltorak, 2013, p. 278). Potential stigma could be mitigated through healers' communication and confirmation of spirit involvement. My focus in the following section, therefore, draws on the continuity of health seeking and its value as a 'public relations' strategy to demonstrate how attributed public perceptions of the reason for an increase of admissions do not explain why patients would approach the psychiatric unit.

#### Explanations for the increase in admissions

Some examples of use and understandings of psychotropic medications counter the argument that the increase in admissions can be attributed to public perceptions of psychiatry's superior efficacy. One traditional healer added haldol secretly to his traditional remedy (Puloka, 2005, per com). The increased efficacy of his treatment strengthened his

non-stigmatising diagnosis of spirit involvement. Even patients who have benefitted from psychotropic medications are likely to attribute their change of behaviour to the benefits of forgiveness and reconciliation. In Vava'u, the only case of mental illness that public health nurses actively encouraged me to interview was a woman cured of schizophrenia by a new evangelical church. The nurses emphasized the part of the cure that involved her husband seeking forgiveness for beating her when she was ill. In person she denied she was completely better but attributed her improvement, to the laying on of hands of the charismatic minister, the casting out of evil spirits and taking control of the dialogue with voices in her head. Another longstanding patient with bipolar disorder insisted that she gained more benefit from sleeping with the Bible under her pillow than from medications that gave her terrible side effects. Many patients saw healers concurrently or received help from relatives at the same time as taking psychotropics. They preferred to attribute efficacy to forms of healing that did not imply a shameful diagnosis of mental illness.

The increase in admissions also cannot be attributed to an actual or perceived increase in mental illness in the population. Explanations for a societal increase in mental illness reference cultural malaise reflected in increased un-Christian behaviour and increased visibility of some patients more than any scientifically validated survey. I recall hints of this morally loaded explanation when I first met the Mental Health Welfare Officer (MHWO) in 1998.<sup>10</sup>

She described how some of her youngest teenage patients had personality disorders caused or made worse by glue and pen sniffing. She then detailed how much more access

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<sup>10</sup> Her responsibilities included recording incoming and outgoing patients, reviewing medication advice, keeping records of forensic cases, participating in the weekly ward round, Mental Health awareness talks and budgeting of the unit. Subject to availability of transport she would also assess and adjust doses of antipsychotic injection and oral medications during community visits.

teenagers now had to beer, marijuana, glue and petrol to sniff and how TVs were in nearly every home (Lolohea, 1998, per com).

A number of researchers, historians and commentators have concurred on the significance of the 1990s as a period of significant transition in Tonga, one describing it as the “most profound turning point in its 3000 year history” (Campbell, 1992, p. 228). A growing wage earning middle class with increasing overseas experience are key to understanding changing values reflected in a decline of some traditional Tongan practices and a concomitant desire for more representative government (Besnier, 2011). The first convention for democracy was held in 1992. The first national strike in Tongan history was by nurses in 1979-80, the second, a civil servants’ strike in 2005, galvanised unprecedented protest (Benguigui, 2011). A concern with moral decline was common in this ‘transition culture’ (Van der Grijp, 1993). Traditional brother/sister avoidance and respect for the nobles declined as freedom of movement increased. A deteriorating economy and raised public debt contributed to increased internal (rural to urban) and overseas migration, and heavier reliance on remittances. Adjustment processes of migration have been suggested to be contributory to proportionally higher rates of mental illness of Tongans in New Zealand (Vaka, 2014). Increased psychosocial stress in adapting family structures coupled with physical discipline and violence have been argued to be precipitating factors to mental illness in Tonga (Puloka, 1999).

However, the MHWO’s account of what patients liked most about the psychiatric unit- ‘The most, volleyball. Then the once monthly bus trips. Singing and dancing. Eating. Barbecues. Mango Drink. Pretty much everything’ –strongly suggested that morally loaded macro-social explanations for increased incidence were not central to appreciating why particular people approached, resisted or even wished to remain in the psychiatric unit.

### **Criticism, Communications and Psychiatric Distinction**

An ethnographically sensitive and sufficiently general explanation for increased admissions to frame the analysis of Dr Puloka's particular interventions is best revealed through the absence in the 1990s of a valued public or political discourse critical of medical practice. Public criticism of medical treatment was devalued in Tonga due to the achieved chiefly status that doctors occupied in relation to patients. Nevertheless, dissatisfaction was manifest in low expectation of successful medical treatment, an acceptance of death as the natural consequence of sickness and desire for treatment overseas. The extent of community collaboration, aim for accessibility and increased dialogue with patients underlying all of Dr Puloka's strategies meant that the Psychiatric Unit was distinguished by comparison with a general dissatisfaction with hospital services. Only people occupying the position of critical outsider such as patients who had been treated overseas and visiting psychiatrists, were overtly critical of the psychiatric unit. Rarely, however, did their frustrations approach or justify a position of anti-psychiatry.<sup>11</sup> The limited public criticism of psychiatry was not only the result of Dr Puloka's respect for families' mental illness treatment strategies, the absence of state or government use of psychiatry to silence or address dissent and the very low financial support by comparison to other countries that

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<sup>11</sup> Within the Western Pacific region, there has been little organized or formal resistance to psychiatry. This reflects a shorter history and less overt use of psychiatry to silence dissent that in countries where anti-psychiatry movements have support. Nor are there 'service user' or 'survivor' movements. Established in 2010, the first NGO dedicated to mental health (Tonga Mental Health and Disabilities Association) was largely organised by family members of those with mental illness. Despite a connection to a New Zealand organization that focused on Pacific Islander Mental Health Concerns, their first concern was supporting treatment by 'providing supplemental food and clothing to the patients' (Fadgen, 2013, p. 181).

had limited its reach.<sup>12</sup> There were simply no vocal former patients or practitioners extolling alternatives or criticizing psychiatric practice in the public domain. Dr Puloka's first strategy acknowledged that healers were usually the first port of call not only for most behaviour resembling mental illness but also illness more broadly (Parsons, 1983).

### **(1) Collaboration and Workshops with Traditional Healers**

The need for expanded engagement with local communities and 'respectful global-local alliances' contradicts the GMH movement's aim of 'scaling up mental health services' and mental health advocacy according to one critique of GMH (Campbell & Burgess, 2012). The assumption of passive communities waiting for external experts to solve their problems undervalues communities' ability to assess and integrate into their daily lives what biomedicine has to offer (Ibid, 2012, p. 388). In Tonga healers present the most vocal and accessible sources of community perceptions of health and illness. Their popularity reflect their understandings of public perceptions.

Potential integration in Tonga was challenged by healers' lack of confidence in biomedical notions of disease and suspicion of the motives of the Ministry of Health. Healers typically treat symptoms, affirming linguists' arguments that Polynesian languages do not reference 'disease' (Capstick et al., 2004). There is an implied impermanence in descriptions of illness suggested by the distinction between the most commonly used word for sickness (*puke*) and the rarely used combination of terms used to describe a long sickness (*puke ma'u pe*). Tongan and Polynesian models of health are better refracted through ideas of identity and relationship (McMullin, 2005). Tongan spirit healers treat

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<sup>12</sup> Funding has rarely exceeded 0.5% of the total health budget (Puloka, 2004).



inappropriate interaction between spirits (*tēvolo*) and humans that are typically short-term (Jilek, 1988).

In Tonga the challenge of community engagement could best be met by researching and valuing healers' knowledge (Parsons, 1983). There were, however, few precedents of psychiatrist and traditional healer collaborations in the Pacific or in the literature to draw on. Wolfgang Jilek's encouragement followed the 1978 Alma Ata declaration for greater recognition of, and integration with, traditional healers (WHO 2002).<sup>13</sup> After a consultancy to the Tongan Ministry of Health in 1987 he argued that patients "suffering from what appears to be schizophrenic process psychosis, can show significant improvement with culture-congenial psycho-phyto-physiotherapy" (Jilek, 1988, p.173).

WHO-sponsored workshops in 1996 and 1998 with traditional healers revealed a diversity of approaches and remedies, some of which implied syncretism with the form and occasionally content of biomedical treatment (Williams, 1999; Poltorak, 2010). The MHWO was instrumental in using the workshops to build links with the community. Moved by pity she had joined the Psychiatric Unit in 1989 from the general ward with a desire to practice long term care,. As the longest serving member of staff, who had also benefitted from training overseas, she was well qualified to comment on the transformation of the Psychiatric Unit: 'Previously a placement in the Psychiatric ward was considered as a punishment. However, nurses are now taking more of an interest thanks to Mapa's presentations' (Lolohea, 1998, per com).

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<sup>13</sup> He also argued strongly against using etic terms for Tongan conditions "Tongan emic disease classification cannot be simply translated into medical nomenclature" (Jilek, 1988, p.173). Jilek's research in Tonga fed into WHO policy through his contribution of a section 'Traditional Medicine Relevant to Psychiatry' in a WHO book edited by Sartorius on 'Treatment of Mental Disorders: A Review of Effectiveness' (Jilek, 1993). Coincidentally, Incayawar (2009) identifies Jilek's later work in North America as a prime example of psychiatrist and traditional healer collaborations.

The importance of her involvement is well captured in the six year professional friendship she developed with a very active local healer. Their mutual trust meant the healer attended two workshops and referred patients to the unit. In the late 1990s the MHWO dedicated two days a week to visiting on average 8-10 patients a day. She always took the opportunity to visit healers to encourage them to refer patients with more enduring or serious conditions. Her engagement with patients was distinct from the typical instructional mode of communication in the hospital:

'I treat them as an individual person. I take precautions, I take a person with me. I don't feel threatened and feel at ease with most patients. Eventually most patients will open up. Talking with locals about mental illness is very negative, people are more positive about Tongan medicine. Only when Tongan medicine fails do they bring them to the hospital. Most cases have gone from one traditional healer to another before they finally come to the hospital'. (Lolohea, 1998, per com)

In 1997 she made 894 home visits, an increase by comparison to 1996 (759) and 1995 (537) (Psychiatry Unit, 2004).<sup>14</sup> Described by Dr Puloka as 'multi purpose' because of her ability to take over other responsibilities when needed, she developed the knowledge and sensitivity to be the ideal broker between healers, families and the psychiatric unit. She split patients into two groups: a majority of commoners, often unemployed with a low standard of living and a minority of students and more educated people who recognized their symptoms from reading Dr Puloka's newspaper articles. Her insights into family dynamics gained from meeting patients at home meant that treatment could proceed from an understanding of the family circumstances of patients, often difficult to obtain in mental health evaluations. Her community involvement strongly contributed to the confidence patients and families had in their ability to ask the unit for help, confirmed when funding constraints led to the decrease in

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<sup>14</sup> To attenuate the stigma implied from a visit from the psychiatric unit she chose not to wear a uniform.

availability of transport. As a result of less frequent village visits the number of patients recommended by healers dropped, and the severity of symptoms of patients at first admission increased. According to Dr Puloka, the funding constraints followed senior doctors disapproval of his support of traditional healers. Dr Puloka had no choice but to replace effective care in the community with a cheaper media strategy that addressed a wider public.

## **(2) The Translation of Psychiatric Diagnoses**

The translation of psychiatric diagnoses into terms that have cultural salience to local populations is a key challenge of GMH initiatives. Dr Puloka's aims in the 1990s are well encapsulated by the two (of a total of twenty-five) challenges that the GMH movement more recently identified as cultural: "Reduce the duration of untreated illness by developing culturally sensitive early interventions across settings" and "Develop culturally informed methods to eliminate the stigma, discrimination and social exclusion of patients and families across cultural settings" (Collins, et al., 2011 p. 8-9). Anthropological research informed, and fellow Tongan scholars supported, Dr Puloka's transformation of the term *'āvanga* that described relationship with spirits or infatuation to a basis for psychiatric diagnostic translations. Churchward's dictionary confirmed healers' non-pathologising use of the term while defining the possibility of biological causality: '(1) sickness caused (or believed to be caused) by a *fa'ahikehe* or *tēvolo*' (Churchward, 1959, p.555).

The most strident argument for making a term for symptoms stand for a medical condition came from Professor Futa Helu, a Tongan scholar and founder of 'Atenisi (Athens), the first privately funded university in the South Pacific autonomous of government and church. In a 1984 article entitled 'Thinking of a Psychotic', he argued that spirit caused behaviours were in fact "mental illnesses" and "manifestations of emotional conflict between

basic drives and urges and a rigid social environment” (1999, p. 37). Helu’s argument intended to politicize distress as part of a much wider project of critical education in Tonga. He presented new terms and arguments for the nascent pro-democracy movement (‘Atenisi, 1989; Janman, 2011). Helu’s explanation of spirit-caused sickness resonated with anthropological research arguing that Samoans reference to ghosts constituted a covert institution (Shore, 1978). As a surrogate form of regulatory conflict resolution it provided psychological and symbolic relief while maintaining the status quo. Health professionals’ observations of healers using the ‘metaphor’ of spirits to cover up embarrassing events of abuse and inappropriate or illicit relationships supported this argument. Anthropologists of Tonga agreed and disagreed with Helu’s (1999) position that traditional treatment served to depoliticise distress. Gordon, for example, argued ‘that *avanga*’s potent marginality provides a tool for social critique on a potentially wide scale.” (1996, p. 73). McGrath’s accommodation to both positions- ‘talk of *tēvolo*’ simultaneously sustained and resisted the existing unequal social order’- suggested that more ethnographic exploration of particular cases was necessary (McGrath, 2003, p. 44). Of most use to Dr Puloka was Cowling’s translation of *āvanga motu’a* as ‘chronic mental illness’ and her suggestion that although it typically described long established relationship with spirits it could signify schizophrenia (Cowling, 1990, p. 73).

Inspired by traditional healers’ distinctions between different kinds of *āvanga*, Dr Puloka took *āvanga* as a base term and a second term, gleaned from dictionaries to define schizophrenia as *Avanga-Motu’a* and Bipolar Mood Disorder as *Avanga-Femaleleaki* (Puloka, 1998). Used singly *motu’a* can refer to an old or elderly person. Following *āvanga* it describes a condition that is old or full developed. *Femaleleaki* evokes a leaning or swaying from side to side (Churchward, 1959). In 1997, schizophrenia and bipolar mood disorder made up 32% and 20% of all formal admissions to the psychiatric unit. Contra Jilek, Puloka had treated enough

patients with schizophrenia and bipolar disorder to recognize that traditional treatment offered management and reduction of potential stigma but little chance of remission (Puloka, 2011, per com). Dr Puloka's explanations of the symptoms and origins of, and treatments and prognosis for different mental illnesses appeared in the newspaper Taimi 'o Tonga (Tonga Times) from May 1997 till May 1998. After a period of frequent radio broadcasts he appeared on TV from 1998 to 2003. He explicitly engaged with Tongan perceptions of mental illness:

Some Tongans describe *'āvanga motua* as a form of lunacy (or *faha, sesele, vale*) in which the ailment is not caused by a spirit, but is a curse (*mala* or *talatuki*) or divine punishment upon a particular family and its descendants for ancestral wrongdoing. Thus the ailment is considered to be hereditary and not responsive to traditional treatment: it may need 'higher heavenly intervention' for its cure ....*Avanga motua* has been conceptualised within the framework of Western psychiatry as schizophrenia (Puloka, 1997, p. 91).

Printed in New Zealand and critical of government Taimi 'o Tonga supported the pro-democracy movement, through an affirmation of peoples' perspectives on current Tongan affairs (see Moala, 2002). Publishing in Taimi 'o Tonga associated psychiatric diagnosis with a pro-active position on citizen rights. It distinguished psychiatry from other medical practice, in terms of a more dialogic relationship between doctor and patient, more akin to healers' practice.

### **Accessibility, Humour and Novelty**

Puloka's translations became familiar to people because of media attention and because most were based on terms in popular use. In 2004 I asked Dr Puloka if people were already familiar with some of his ideas? He responded: 'Yes, for the last five years, yes. They start talking about a politician and they ask me what kind of *'āvanga* is that politician' (Puloka, 2004). A employee

of the Supreme Court, with experience of caring for mentally ill relatives, argued that the possibility of misuse weakened the credibility of Dr Puloka's translations:

'Some people are laughing at his translations. He should have discussed the names in a group, like we do in court. Terms that are ridiculous don't stick. An example of this is Banke loupati for bankrupt, it just didn't stick. There is much to recommend in discussion. People say as a joke go to Mapa, to imply you are a little crazy in a similar way they would joke about going to Viliami Talo , the surgeon for elephantiasis' (1999).

Some doctors felt that humour weakened his strategies, at the same time as acknowledging that more formal public health broadcasts had been relatively unsuccessful. One Health Officer questioned Mapa's respectability by joking that he was becoming like his patients. Dr Puloka's short-lived reputation as someone not to be trifled with when drinking alcohol extended as far as New Zealand after a fight in a nightclub with a New Zealand MP in 2002. His professional commitment, however, was publically unquestioned. He was more likely to be criticized for not dedicating enough time to church events or extended mourning at family funerals. Some academics in Tonga found his translations exciting. 'Okusitino Mahina identified powerful political implications in the diagnosis of 'Avanga Leke (a form of depression when the person stays in their room) because the place they would formerly run to- the bush and the sea- were no longer as accessible because of development, capitalism and denudation of the natural environment (Mahina, 1998, per com).

Humour and familiarity were the two common themes I identified in the many conversations I had about the reception of Dr Puloka's radio and TV appearances. His slightly eccentric and funny persona meant people felt comfortable referring to him as Mapa. After a presentation at 'Atenisi University in 2004 two attendees explained that it was peculiar to hear scientific concepts in Tongan and the metaphorical allusions, implied by some of the old Tongan words he used, were hilarious. Soon after I asked if he expected laughter at his first presentations?

Some of the time. Whenever I lecture I like to put in some humor just to make them wake up. Also humor facilitates understanding. It hits home faster and I understand some, I won't say most, is related to sexual things. We [Tongans] of course are very Freudian, that's what I am doing now, collecting a lot of things to do with sex. Names of places, myths, something in legend-most of them related to sex.

Early in my fieldwork I un-reflexively concluded that laughter was a form of resistance to the medicalisation of experience in Tonga. I expected resistance to Dr Puloka's project based on linguistic and cultural grounds. Now I recognize the critical assumption carried in that somewhat apolitical response and the need to recognize how the skillful epistemological, social and linguistic negotiations carried out by Dr Puloka in the 1990s, many of which were counter-cultural and implicitly critical of the medical establishment in their novelty, had a positive impact on public reception of his initiatives.<sup>15</sup>

The wider appeal and acceptance of his hybrid terms was precisely because they could be misused to comment humorously on people evidently worthy of teasing or critique while detracting from their religious implications. The assumption that greater public understanding of the biological foundations of psychiatric diagnosis would reduce stigma is flawed, even in industrialized nations (Schomerus, et al., 2012). In Tonga, psychiatric explanations for mental illness had the potential to strengthen prevailing ideas of punishment for past wrongdoing

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<sup>15</sup> Puloka's strategy for a modern audience is reminiscent of the advice of the traditional orator, Ve'ehala: 'You must not have too sweet a quality because everyone will doze. You must go in with good quality and must remember a little something, a little amusement, to keep the people's eyes open. There are people who know that and they go and inject in a little joke or something they keep them [the audience] giggling and they keep them awake. And when they finish, people say, "Aaah, too short, sir!" (Ve ehala. In Hahn, 1994, p. 106).

while also affirming ideas of independent and autonomous citizenry. More important to the more immediate goal of early diagnosis for psychosis, was Dr Puloka's use of novelty to attract patients to the ward through remaining memorable and accessible. In my discussions in Vava'u on families' choice of healer, the second most commonly mentioned reason to go to a healer after the fact of being connected in some way or close in residence, was the novelty of their treatment. The content of Dr Puloka's media communications, not only the terms, did have value for very particular audiences. More high functioning patients with bipolar disorder, some associated with or supportive of 'Atenisi, embraced their diagnosis, the enlightenment connotations of his project and associations with prominent scholars or artists who had shared their condition. They were in a minority of patients. The majority, Dr Puloka argued, lacked insight into their conditions.

### **(3) Freedom of Movement and Legal Appeal to Involuntary Admission**

In their key statement in *Nature*, the global consortium of researchers, advocates and clinicians constituting a GMH movement, understate both possible public resistance to psychiatric ideas and interventions and the political implications of psychiatric ideas serving their agenda (Collins, et al., 2011, p. 8-9). Conversely, it tends to be assumed by critics of psychiatry's expansion that the damage of medicalisation to local cultural practices emerges after people approach psychiatric services. Psychiatry's positive contribution to political process would typically be regarded as suspect.

Puloka's liberalisation of the process of psychiatric admission was key to maintaining the positive association psychiatry had gained in affirming citizen rights. He offered greater freedom of movement through the psychiatric unit and encouraged the use of clear and



publicly transparent legal procedures for non-voluntary admission. The complexity and diversity of the relationship between sufferers and their families had been simplified by the widespread argument of public health doctors and nurses that everyone avoided the psychiatric unit because of potential shame. In 1994 Dr Puloka's 'Open Door Policy' established the category of RDP (Revolving Door Patient) to encourage previous patients to voluntarily 'drop in' or seek respite-care without formal admission.<sup>16</sup> From 1994 to 1995 the number of patients defined in this category rose from 13 to 97 (Psychiatry Unit, 1998). Some psychiatric unit staff attributed the increase to patients valuing the escape from conflictual and demanding relationships at home. The 'Open Door Policy' was thus potentially preventative of future relapse. It also demonstrated that in many cases families had more to lose in terms of stigma than their suffering relatives.

By contrast involuntary admission for 7 days, a period not exceeding 28 days and a period not exceeding 2 years required orders carried out under Sections 9, 10, 11 respectively of the 1992 Mental Health Act<sup>17</sup>. These required the orders of a MHWO, medical officer (Psychiatry) or Psychiatrist for a section 9, a magistrate for section 10 and the supreme court for a section 11. Dr Puloka's encouragement to patients to appeal in writing against section 10 and 11 involuntary admission established due process and legal redress.

One such letter was written by a young Tongan man brought up in the United States and treated in US psychiatric institutions who I have given the pseudonym, Ray. His case raised challenging questions regarding compulsory treatment, mental health law, local interpretation

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<sup>16</sup> In English-speaking countries 'revolving door' patients typically have a high frequency of admission after relapse and are generally regarded as a strain on services (Haywood et al 1995).

<sup>17</sup> The 1992 Mental Health Act though regarded as a great improvement on the Lunatic Detention Act of 1948, was drafted and passed without significant psychiatric input and consultation. Doctors and lawyers alike acknowledged that it was difficult to implement and needed to be revised.

of human rights and the Tongan psychiatric unit's capacity to treat diasporic patients with different cultural backgrounds and pharmacological and institutional expectations. The letter described, and others confirmed, how his mother had delivered him to his Tongan father and stopped his medications with the hope that being in Tonga and traditional healing would cure him. In less than a week, the police locked him up for being a public nuisance before bringing him to the psychiatric unit. He appeared in the supreme court on the 13th May 1998 in front of an Australian judge. His Tongan lawyer contested Dr Puloka's application for a Section 11. The judge made reference to the case being used to establish new procedure, and supported the earlier section 10 magistrates decision to retain him. In court Ray did not speak. Outside the courthouse he was remarkably appreciative of Dr Puloka's previous advice. As he paced and stepped up and down, a side effect of haloperidol, he addressed him as 'the man' and said: 'If you love someone you must let them go. If you keep me for another 28 days after this one, you don't love me.' He then shared his love for his father, who had maintained a low profile and had not communicated with him during the proceedings. Pulling back his hair, Ray then showed me a bump on his head where a guard hit him, loudly complaining that other guards did not share the food gifted from the Free Wesleyan Church Conference, particularly the roast piglet. His reference to two important cultural values in Tonga- love and sharing food- did not sway Dr Puloka's clear response that many of the misunderstandings between him and the Psychiatric Assistants remained cultural ones. He was also accustomed to care and treatment which Dr Puloka acknowledged would be a lot better for him. 'The Tongan patients get used to the rhythm very quickly', he explained. Dr Puloka suggested he write a letter to the Embassy to request repatriation or mention it to the judge. His statement 'We can't afford to give you community care here,', referenced the unavailability of transport for community visits due to budgetary restrictions.

Twelve days later I was surprised to encounter Ray eating a mango ice cream with his father in the centre of Nuku'alofa. He explained he had been released the day before and invited me to join him to celebrate. That night he was arrested for assault in a well known night club and put into prison. Dr Puloka later revealed his decision to release him into the care of his father because he was too much of a distraction for the other patients. In Ray's case, he stated, the prison had better facilities in advance of expatriation to Hawaii or the US, where he would get better and more specialized care.

The case demonstrates that the Psychiatric Unit was ill equipped to deal with such cases as inpatients or outpatients. In the absence of a mental health policy that did not anticipate more challenging diasporic or deportee patients, the only solution was to improvise and in the process ultimately not provide the necessary care for Ray to not re-offend.

Despite being one of the most vocally critical patients I came across, most able on the basis of his experience in the US to criticize Psychiatric practice in Tonga, he was also one of the least credible at the institutional level. As long as he was perceived as a nuisance, by comparison to the benign eccentric behaviour of other mentally ill patients in public, criticism could only fall on Dr Puloka for not keeping him in the unit longer or on his mother for sending him to Tonga. Under law the psychiatric unit had retained the power to release patients without court proceedings. This was an important recourse for patients who did not want to leave, given the attraction of a restful space away from the challenges of their families with fun activities and frequent meals. Ultimately Ray's desire to be released was answered, though his father without support could not prevent him reoffending. Ray and other patients' movement through the psychiatric, police and legal institutions did however contribute to institutional knowledge and public awareness of the key role of open courts to decide on the basis of

evidence provided by Dr Puloka (Puloka, 2005, per com). The encouragement of patients' appeals established due process, greater transparency and visibility of involuntary admission that opened psychiatric practice to wider scrutiny while gaining credibility for valuing citizen rights. There is a particular irony in Ray's case. In the process of indirectly supporting his wish for release, while using his case to establish processes affirming citizen rights in Tonga, his human right to not be incarcerated in Prison for mental illness ran contrary to most international guidance.

From 1992 to 1995 the total number of forensic cases under section 10 in the Magistrates Court and under section 11 in the Supreme court were 21 and 21 respectively (Psychiatric Unit, 1995). In 1997 the number of all in-patients admissions that required court proceedings were: Section 9 (Power of the Psychiatrist), 28; Section 10 (Magistrate Court), 58 and Section 11 (Supreme Court), 9 (Psychiatry Unit 1998)- a total of 95. By contrast, the number of patients who chose to admit themselves as RDPs, were 97 (Ibid, 1998). At the midpoint of the period of dramatic increase in admission from 1996-98, slightly more patients wanted to be in the psychiatric unit than challenge the law that put them there.<sup>18</sup> The Psychiatric Unit had developed a reputation for accessibility and care valued by an increased proportion of patients and their families.

### **Discussion: Brokerage, Tongan Identity and Stigma**

In 2004, I asked Dr Puloka about some of the challenges of translating a psychiatric knowledge based on the autonomy of the person, in a Tongan context where culturally valued personhood is constituted in relationship (Morton, 1996). His tangential response addressed

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<sup>18</sup> The Mental Health Act 1992 gives the Psychiatrist power to authorize release of any patient under section 9, 10, or 11 without recourse to either the magistrates or supreme court simply "if he considers that his continued detention in hospital is no longer necessary" (Mental Health Act 1992, p. 4).

my then still unexamined assumption that an expanded psychiatric service was a profound contradiction to local modalities of care by claiming a cultural mandate for his initiatives: “I think *tauhi vaha’a* is one of the most important things here. Our consciousness and awareness of *tauhi vaha’a*. It affects every Tongan. Western society is much more individualistic, looking for self esteem, identity” (Puloka, 2004, per com). *Tauhi vaha’a* or “maintaining harmony of the 'space' between oneself and others” (Thaman, 1988, p. 120; Ka’ili, 2005), derived from *tauhi* (nurturing), *va* (space between), and *ha’a* (lineage), was central to the political success of his interventions. This Tongan form of brokering is one of the key Tongan values defined as central to a Tongan identity, and is one of the key ‘special meanings’ he attributes to traditional medicine (Poltorak, 2010). It suggests Dr Puloka’s success in raising admission figures strongly relates to his establishing social credibility for his interventions, attempting to maintain ‘a harmonious space’ between his patients, mental health workers, family, Tongan health institutions, regional organizations, global initiatives, the churches and media organizations. That his social credibility was occasionally tested by his personal life, only affirmed that he had an experiential knowledge and familiarity with the lives of the mentally ill he was seeking to improve. Patients and families were more able than before to address the stigma of their conditions through a similar brokerage. The greater accessibility to the psychiatric unit and the use of medication meant that patients were less likely to be in public when symptomatic. Exemplary cases of patients with bipolar disorder conflated mania with being symptomatic and influenced the perception that most episodes of mental illness would happen in the public domain. In the absence of unusual behaviour more people were likely to agree that the religious cause for their behaviour had been removed.

The Social Worker in the Psychiatric unit understated how Dr Puloka uniquely combined the qualities of a healer in the structural position of a doctor ‘Healers give a better

explanation and they treat you well. With doctors you wait and then you get Panadol. Doctors have a different attitude. If they have personal problems they bring them to the hospital. Some turn up at 10.30 and go home early. Mapa is very different, he talks to the patients' (2004, per com)

### **Conclusion: The Relevance for GMH Initiatives**

The importance of a culturally valued brokerage underlies the first of four contributions this ethnographic analysis of Dr Puloka's interventions makes to debates around GMH initiatives. Puloka instituted a 'respectful global-local alliance' (Campbell & Burgess, 2012) that led to the increased integration of novel translated psychiatric ideas into everyday discourse and increased awareness of what the psychiatric unit could offer. His resort to anthropological and transcultural psychiatry research confirmed the value of prior ethnographic studies before tackling mental health burdens (Desjarlais, et al., 1995).

Secondly, Puloka's translations reveal that in the process of recreating and redefining concepts, the accessibility and political implications of terms may, depending on the social and political context, trump the educative aspiration for improved biomedical understanding. The accessibility suggested by the need to build on "local institutions, traditions and values" (Desjarlais et al., 1995., p 281), needs to be complemented by political astuteness. If the challenges faced in Tonga resonate in other countries, this suggests that global mental health initiatives need to pay as much attention to how key individuals such as Dr Mapa Puloka and the MHWO can build an enduring cultural and political mandate for psychiatry as much as addressing the 'treatment gap'.

Thirdly, Dr Puloka's success suggests that critiques of the misapplication of medical categories may understate the potential depoliticisation of distress of some traditional therapies and the local utility and transformational potential of psychiatric terminology. Dr Puloka is both psychiatrist and cultural broker, who in translating psychiatric explanations is also helping Tongans balance cultural integrity with the contemporary challenges that follow engagement in an increasingly globalised political economic system. He is also located in a position of brokerage between the heterogeneity of local strategies of dealing with mental illness and the global recommendations and universalizing claims of institutions such as the WHO and systems of categorization such as DSM-IV. The absence of critique of the presence of psychiatry suggests that at least in Tonga, the misapplication of medical categories is not significant in improving access to mental health services.

Finally, the most serious critique of the GMH movement is that their initiatives will distract attention from the social inequalities underlying the uneven distribution of incidence of mental illness (Campbell & Burgess, 2012). Dr Puloka focused more attention on the Tongan social determinants of mental illness, rather than social inequalities, through his engagement with 'spirit' based explanations for mental illness. I have argued that his interventions both politicized and depoliticized suffering, in ways that both supported and critiqued the depoliticisation of distress present in traditional treatment for spirit possession. To do so, he relied on local, transcultural psychiatry and medical anthropology research, and an institutional freedom to develop translations that built on healers' conceptualizations. His openness to engaging with the 'special meaning' of traditional medicine was key to building a psychiatric service in community collaboration and dialogue. Dr Puloka's distinctive humor was a marker of conceptual and personal accessibility that was founded on a curiosity in and knowledge of public perceptions of mental illness and

their political implications. As a broker he walked an ethnographically grounded middle way between local and disciplinarily polarized debates on the merits of the increased expansion of psychiatry. It is in this role, more than as a joker, that he should be regarded as an inspiration for more accessible and successful local mental health strategies.

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Dr Mike Poltorak (PhD) is a lecturer in Social Anthropology in the School of Anthropology and Conservation at the University of Kent, Canterbury. He currently runs the Visual Anthropology programme. Dr Poltorak's medical anthropology doctoral research (UCL, 1996-2002) focused on local 'spirit' healers' and psychiatric modernisation in the South Pacific constitutional monarchy of Tonga. In subsequent research and published works he has focused on interdisciplinarity and mental illness, health policy, the efficacy of traditional healing and vaccination. As ethnographic filmmaker he has produced documentaries on Tongan comedy, volunteerism in Sweden and the dance form of contact improvisation. His collaborative video project on mental health in Tonga focuses on a healer, the psychiatrist and patients to integrate ethnographic and video research since 1998.

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