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Globalising Mental Health or Pathologising the Global South? Mapping the Ethics, Theory and Practice of Global Mental Health -- A special issue of Disability and the Global South

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By Aaron Seaman

The open access journal, **Disability and the Global South**, currently has a special issue, “Globalising Mental Health or Pathologising the Global South? Mapping the Ethics, Theory and Practice of Global Mental Health“. The issue is edited by China Mills and Suman Fernando, who offer an introduction and editorial to the issue, which is followed by nine articles and several short “Voices from the Field” pieces. (All pieces can be accessed from the link above.)

Globalising Mental Health or Pathologising the Global South? Mapping the Ethics, Theory and Practice of Global Mental Health
China Mills and Suman Fernando

How ‘evidence-based’ is the Movement for Global Mental Health?
David Ingleby

> A central claim in publicity for the Movement for Global Mental Health is that the movement is both ‘rights-based’ and ‘evidence-based’. In this article we focus on the second claim, critically examining the evidence on which the movement’s programme is based. The concepts and methodology of the movement are those of mainstream Western psychiatry, so we first review briefly the inadequacies and inconsistencies of this framework, in particular the problems of identifying, measuring, explaining and treating ‘mental illnesses’. We conclude that the scientific knowledge base of contemporary psychiatry has been gravely distorted by its dependence on financing from the pharmaceutical industry, which has led to exaggerated attention on biomedical theories and treatments with a corresponding neglect of social factors and prevention. Second, we examine the problems of transferring this framework to low and middle-income countries. Adopting a biomedical view enables the movement to evade awkward questions regarding the cultural embeddedness of the issues it deals with and their relation to social, economic and

political conditions in these countries. Confident claims are made by the movement about the nature and prevalence of 'mental illnesses' across the world, the burden they represent, and the benefits to be expected from tackling them by 'scaling-up' mental health services based on Western knowledge. However, cross-cultural psychiatric epidemiology is not sufficiently developed to be able to support any of these claims and the considerable quantities of data that are produced as 'evidence' turn out to be largely based on guesswork. The article concludes that Western psychiatry can certainly provide low- and middle income countries with instructive examples – but they are mainly examples of what not to do.

Reciprocity in Global Mental Health Policy
Ross White and Sashi Sashidharan

In an attempt to address inequalities and inequities in mental health provision in low and middle-income countries the WHO commenced the Mental Health Gap Action Programme (mhGAP) in 2008. Four years on from the commencement of this programme of work, the WHO has recently adopted the Comprehensive Mental Health Action Plan 2013-2020. This article will critically appraise the strategic direction that the WHO has adopted to address mental health difficulties across the globe. This will include a consideration of the role that the biomedical model of mental health difficulties has had on global strategy. Concerns will be raised that an over-reliance on scaling up medical resources has led to a strengthening of psychiatric hospital-based care, and insufficient emphasis being placed on social and cultural determinants of human distress. We also argue that consensus scientific opinion garnered from consortia of psychiatric 'experts' drawn mainly from Europe and North America may not have universal relevance or applicability, and may have served to silence and subjugate local experience and expertise across the globe. In light of the criticisms that have been made of the research that has been conducted into understanding mental health problems in the global south, the article also explores ways in which the evidence-base can be made more relevant and more valid. An important issue that will be highlighted is the apparent lack of reciprocity that exists in the impetus for change in how mental health problems are understood and addressed in low and middle-income countries compared to high-income countries. Whereas there is much focus on the need for change in low and middle-income countries, there is comparatively little critical reflection on practices in high-income countries in the global

mental health discourse. We advocate for the development of mental health services that are sensitive to the socio-cultural context in which the services are applied. Despite the appeal of global strategies to promote mental health, it may be that very local solutions are required. The article concludes with some reflections on the strategic objectives identified in the Comprehensive Mental Health Action Plan 2013-2020 and how this work can be progressed in the future.

Culture, Politics and Global Mental Health
Rachel Tribe

This paper critically examines some of the assumptions and politics which underlie the global mental health (GMH) movement; and explores the issue of cultural awareness within western psychiatric thinking and practice. The way distress is labelled has a range of consequences for the individual, their family and society, as well as those who may control or negotiate the descriptors used, the actions taken as a result of these and the resources subsequently allocated. This paper will examine if these are the most useful principles, and if so, who might be the main beneficiaries of these. The importance of context, international, national and health politics, in addition to wealth and power differentials cannot be ignored in the way that the global mental health debate is constructed. Diagnostic classification systems, such as the Diagnostic Statistical Manual (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD), are not neutral documents as is frequently assumed but carry a range of assumptions and represent a number of interest groups. Different cultural constructions, explanatory health beliefs, idioms and local ways of dealing with distress often appear to be seen as additional layers of meaning within the current debate, rather than as the central organising concepts they are for many people. Yet the transfer of western psychiatric ideas and the uncritical generalisation of them around the world (even if made with the best of intentions) can undermine the rich traditions and cultural heritage of many low- and middle-income countries (LMICs) and could be viewed as a form of neo-colonialism. There are many angles to this debate, including the use of language and the fact that some cultures have concepts and long traditions around ‘mental health’ which are different from those used in ‘the west’. The paper will use the diagnostic category Post Traumatic Stress Disorder (PTSD) as an example to illustrate many of the points made.

Globalizing psychiatry and the case of 'vanishing' alternatives in a neo-colonial state
Bhargavi Davar

> Analysing 'modernity' in India is a complex exercise, as the movement of the 'modern' is locally determined and may be non-linear at different sites and contexts. General medicine and psychiatry are illustrative of the difference in how 'patienthood' has been historically constructed, with each wave of 'modernisation' changing the subjecthood of the 'mentally ill'. Unlike the public health sector in India, the mental health sector is driven by the 'mental asylum' archetype, continuing through late colonial times into contemporary science in refurbished designs. A related set of changes also concomitantly happened in the domain of indigenous healing, with each epistemic shift pushing this domain to the margins of knowledge and healing practice. The paper is set against the time period covering 1850s until recently (2014).

Faith Healing in India: The Cultural Quotient of the Critical
Sabah Siddiqui, Kimberly Lacroix, and Anup Dhar

> We have had two 'cultures of critique'. One is where critique of a culture's own principles is generated internally. The other is when critique is mounted from the outside. This paper is an attempt to shore up the two-fold nature of both culture of critique and critique of culture through a close examination of an extant and entrenched cultural practice provisionally called 'faith healing' in its interlocution with western mental health models that are incumbent upon the Indian setting. This paper will explore what critical theory may need to consider in the context of India. Would it need a cultural turn, a culturalising? What is meant by culturalising? Would 'culturalising', in turn, be premised on a bidirectional or dual critique, that is, a critique of both the West's hegemonic principles as well as principles that hegemonize the East, emanating from either the West or from the East? What relation would critique set up with an existing culture and cultural practice? What relation would culture set up with an existing culture of critique? In the process, this paper is also an attempt to inaugurate and locate the beginning coordinates of a critique of critique through the turn to culture in conditions called 'faith healing'. The paper is also about the tense and troubled dialogue between the current globalization of certain frameworks in mental health, and local (faith-based) practices of health and healing that have survived in India; survived even in mutation and transformation, through colonialism,

civilizing mission, welfarism and developmentalism. How would the knowledge and practice of mental health take shape in India – a landscape crisscrossed by on the one hand, aggressively modern institutions of mental health science and on the other, extant and surviving institutions of faith-based healing practices? While we remain critically mired in faith-based practices, while we cannot but be critical of some faith-based practices, we also cannot announce the silent demise of all Other imaginations of health and healing and let One global discourse take hold of all cultures. Hence, perhaps the need for what we have called the difficult 'dual critique'. For critique also means an account of and an attention to experience and practice; an account formulated on its own terms and not on terms put in place by globalizing discourses.

Mental Health Care, Diagnosis, and the Medicalization of Social Problems in Ukraine
Shelly Yankovskyy

This paper focuses on cultural issues associated with reforms of the mental health system in Ukraine. Specifically, the paper will explore the adoption of the International Classification of Diseases (ICD-10), with its heavy focus on biomedical definitions of health and illness, and the applicability of applying this model cross-culturally. Using first hand ethnographic data with psychiatrists, social workers and advocates, as well as patients or 'bolnoi' (bolnoi translates literally as 'an ill person') of psychiatric services, I argue that 'mental illness' is not always, or solely, biological, but also culturally shaped, and therefore a 'one-size-fits-all' approach to mental health becomes problematic. I follow this argument with a discussion of how social problems more generally come to be redefined in Ukraine as medical in nature, where issues such as gender relations, alcoholism, poverty and environmental disasters are subject to medicalization. Here 'symptoms of oppression' or 'distress' are diagnosed within a psychiatric framework and become 'symptoms of illness', to be treated within the biomedical arena. This redefinition places the responsibility for larger societal issues on the individual and ignores the social and environmental underpinnings of suffering – a dynamic that was also operative in the Soviet system. I argue that the growing popularity of the medicalization of behavior coupled with its relationship with the pharmaceutical industry is thus a moral issue, and one with harmful results.

Passive-Aggressive: M?ori Resistance and the Continuance of

Colonial Psychiatry in Aotearoa New Zealand
Bruce Cohen

This article offers a comparative discussion on the encroachment of psychiatric imperialism in the Global South through considering the continuance of western psychiatry in a colonized part of the Global North. Whereas the Indigenous population of Aotearoa New Zealand were considered mentally healthier prior to the 1950s, current statistics show that M?ori are much more likely to experience a 'mental illness' and be admitted to psychiatric hospital compared to settler groups. A review of the literature highlights socio-economic variables and 'acculturation' issues as key to understanding the difference in prevalence rates. However, utilizing a 'critical model', influenced by writings on colonial psychiatry and race, it is demonstrated in this discussion that a crisis in colonial hegemony between the 1960s and 1980s led to an increased need for colonial psychiatry to pathologize a politically conscious M?ori population. As the first academic article to attempt such a critical de-construction of psychiatric practice in Aotearoa New Zealand, it is recommended that future research is re-orientated towards a focus on the psychiatric institution, and the institution of psychiatry, as a site of colonial power and social control.

Neurasthenia Revisited: Psychologising precarious labor and migrant status in contemporary discourses of Asian American nervousness
Louise Tam

Neurasthenia—a term first coined by American neurologist George M. Beard in the 1860s—was a 'malady of civilization' associated with cerebral overpressure from the stresses of modern industrial life (Rabinbach, 1992:154). Many scholars of neurasthenia assume this psychopathological 'disease of the will' was a white disease that disappeared from Western medical practice since the early twentieth century. However, in this paper, I argue that not only has neurasthenia traveled to non-Western contexts, but that its genealogy as a culture-bound syndrome continues to haunt the present in North American cross-cultural counselling. Through a textual analysis of multicultural psychology textbooks published over the last decade, I argue these 'traits' serve to sequester problems of oppression into the private, apolitical space of family and culture, renarrativizing experiences of racial profiling, classroom segregation, worker disablement, and poverty as culturally determined mental health problems.

Tools for the journey from North to South: A collaborative process to develop reflexive global mental health practice
Kate Suffling, Lynn Cockburn, and Kim Edwards

> ICDR-Cameroon is a group working on disability and inclusion issues in Cameroon. Through their mental health work, various complex social, ethical, and relational issues have been encountered and the need arose to engage in a reflexive process that would integrate shared experiences, the broader discourse on global mental health, and other resources. The group participated in discussion, story sharing, research, and critical analysis, a process from which a document called 'Tools for the Journey' was created as a road map for the group's work. The document includes a position statement outlining the group's stance on various issues, in addition to additional resources. This paper describes the group's reflexive process in creating Tools for the Journey, the benefits of this process in terms of group and individual understanding and development, and the challenging themes encountered in their work in Cameroon.

Voices from the Field

The Cape Town Declaration (2011)
Pan African Network of People with Psychosocial Disabilities (PANUSP)

Global Mental Health, Human Rights and Development
Linda Lee

Mental Health in Kenya: Not yet Uhuru
Mohamed Ibrahim

Should wellbeing and distress be addressed by health policy and medical funding, or be understood outside of a medical framework? The work of USP-Kenya
Kanyi Gikonyo

A short conversation with Arthur Kleinman about his support for the global mental health movement
Derek Summerfield

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