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Commentary

Afterword: Against "global mental health"

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> He began to wonder if we could ever make psychology so absolute a science that each little spring of life would be revealed to us. As it was, we always misunderstood ourselves and rarely understood others.
>
> Oscar Wilde, *The Picture of Dorian Gray* (1891)

The Western mental health field in Western countries

A surely foundational question for psychiatric science is the ontological status of "mental disorder". One attempt at a definition would be the one used in the UK Mental Health Act – this might be expected to be rigorous since it legitimates involuntary detention: a mental disorder is "any disorder or disability of mind". This is no definition at all, merely a circularity or tautology. In fact psychiatry has no answer to the question "what is a mental disorder?", and instead exalts a way of working it has devised: if there are sufficient phenomena at sufficient threshold, a mental disorder is declared to exist! This is as much alchemy as science.

Once something is declared real, it becomes real in its consequences. In practice, mental categories emerge as DSM or ICD committee decisions based on symptom clusters – clustered by us, not by nature. This has not retarded their use as if they were facts of nature identifiable "out there" as is, say, a tree or a broken leg. The authors of DSM and ICD do state that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no disorder" but this does not deter the American Psychiatric Association (APA), who aver that mental disorders will all eventually boil down to brain disorders (Kendell & Jablensky, 2003).

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In the UK, the Royal College of Psychiatrists and other opinion formers claim that at any one time about 1 in 4 of the general population have a mental disorder. Similarly, in the USA a National Institute of Mental Health survey in 2001-2003 found that 46% met APA criteria for at least one mental disorder (and often more than one) over a lifetime. Do readers of *Transcultural Psychiatry* believe this as they gaze out of the window at passers-by in the street, or at football crowds, or at their own family gatherings? These claims surely amount to disease-mongering, highlighting an urgent need to deconstruct a naive reliance on the capacity of screening instruments to generate hard data on population prevalences. Such instruments, with their demand characteristics and tendency to reify subjective consciousness through a mechanistic focus on ''symptoms'', produce estimates that insult our common sense and everyday social experience. Structurally unable to assess a whole person immersed in the dynamic complexity of a life and situation, they tend to recast the physiology of normal distress as pathology. We face an epidemic of false positive diagnoses of mental disorder promoted by a mental health industry in which pharmaceutical companies are significant actors. DSM 5 is going to make things worse.

There is now no more bloated category than ''depression'', threatening to all but expunge the nuances of language denoted by ''distress'', ''sadness'', ''despair'', ''gloominess'', ''pessimism'', etc., and the now epidemic rate of antidepressant prescribing – up fourfold in the UK in 15 years, and even more so in USA – has become a cultural phenomenon in its own right that will surely attract the attention of future anthropologists (Summerfield, 2006; Wakefield & Horwitz, 2007). The most compelling advertising for antidepressants is their very name, which implies that ''depression'' represents a discrete entity locatable in the brain, and that antidepressants are a specific treatment which work by going to that very spot.

Time trend analyses in Australia, the USA and Germany following up public attitudes toward mental disorder have demonstrated an overall rise in biological causal attributions over the past two decades. Schizophrenia or depression, for example, have been increasingly attributed to brain disease, chemical imbalances, or genetic causes. Over the same period, it would appear that attitudes towards people with mental illness have not become more tolerant as was expected, but that stigma persists or has even increased. It is clear that biogenetic causal models are an inappropriate means of reducing rejection of people with supposed mental disorders (Angermeyer, Holzinger, Carta, & Schomerus, 2011).

The Western cultural backdrop to these trends is of a relentless rise in the medicalisation and professionalisation of everyday life (Summerfield, 2004). In a momentous shift, the concept of a person in Western culture has come to emphasise not resilience but vulnerability, with ''emotion'' as its currency. This has its roots in the way that medico-therapeutic ways of seeing have come to dominate everyday descriptions for the vicissitudes of life and the vocabulary of distress. In what has been called the ''culture of therapeutics'', citizens are invited to see a widening range of experiences in life as inherently risky and liable to make them ill. The mental health field has played its part in promoting the idea that the trials of life reflect noxious influences easily able to penetrate the average citizen, not just to

hurt but to disable. This is to endorse a much thinner-skinned version of a person than previous generations would have recognised. The more the mental health field promotes its technologies (which boil down to either chemicals or what Thomas Szasz, perhaps whimsically, calls ''conversation therapy'') as necessary interventions in almost every area of life, and the more that people pick up that they are not expected to cope through their own recourses and networks, then the more that time honoured ways of enduring and coping may wither. As more resources are provided for mental health services, more are perceived to be needed – an apparently circular process. Has the mental health industry in the West become as much a part of the problem as of the solution? This is a critique nearly three decades old and yet seems more applicable than ever. *Medical Nemesis*, a brilliant and prophetic analysis by Ivan Illich (1975), led the way. Moreover, we should beware: the political and economic order benefits when distress or dysfunction that may connect with its policies and practices is relocated from socio-political space, a public and collective problem, to mental space, a private and individual problem.

Before we discuss the globalisation of Western mental health services, we should note that the evidence base regarding treatment efficacy in the West is patchy and contested, to say the least. Two generations of use of antipsychotics has not improved the overall employment prospects of those diagnosed as schizophrenics. Meta-analyses of studies of antidepressants indicate response levels that struggle to surpass the placebo effect (Kirsch et al., 2008). A World Health Organisation study in 15 cities around the world found that those whose ''depression'' was recognised by doctors did slightly worse than the ''depressed'' who were not recognised (Goldberg, Privett, Ustun, Simon, & Linden, 1998). Research into treatment effects in the talk therapies indicate that therapist-based factors may influence outcomes but not any particular form or theoretical school of therapy (Blow, Sprenkle, & Davis, 2007). A national survey in 1997 found that Australia had a high prevalence of mental disorders with low rates of treatment (Andrews, Henderson, & Hall, 2001). Since then, treatment availability has increased greatly but there is little evidence that the nation's mental health has improved (Jorm, 2011).

It is perhaps ironic that the mental health field seeks to demonstrate its efficacy within biomedical parameters, whereas its best arguments might well be anthropological – that is, it could assert that its services have over time become as familiar and customary in Western countries as those, say, of traditional healers in Africa have been. Some people choose to attend, others do not, but what has become a ''normal'' service requires no further justification, the argument would run.

The globalisation of the Western mental health field

What exactly is ''global mental health''? Can any standard of mental health be definitive universally? If not, the term seems an oxymoron. One of the most comprehensive accounts of the field, its operating assumptions and aspirations, is to be seen in *The Lancet* Global Mental Health Series (Prince et al., 2007). This was

intended to be a seminal compilation, and to represent the WHO position. The Series made three core statements:

1. Mental disorders represent a substantial ''though largely hidden'' proportion of the world's overall disease burden.
2. Every year up to 30% of the global population will develop some sort of mental disorder.
3. There was strong evidence for scaling up mental health services worldwide

I entirely take Professor David Ingleby's comment to me at the time that people who believed statement (2) must be living in a parallel universe (personal communication, 2007). Presumably, the people from whom these disorders are ''hidden'' include the millions supposed to be carrying them, but the Western-trained expert knows where to find them and what to do.

To address this spectre of mass casehood the WHO is in part promoting the development of ''community mental health services''. In India, Jain and Jadhav (2009) observed how official community mental health services in fact operate in isolation from communities and their everyday realities. A focus on the narrow biomedical aspects of the patients' lives and on Western diagnostic categories means that ''community mental health'' collapses down to prescribing a pill. Clinic interventions become irrelevant. A core theme is that the voices of patients and the general public, the object of policy, are missing from any discourse about ''mental health''.

An example of the globalisation of ''depression''

Globalising Western psychiatric categories and their treatment cannot but have socio-moral consequences. In a telling paper, Skultans (2003) describes the invasion of Latvia by ''depression'', prompted first by the translation of ICD into Latvian, and by conferences organised by pharmaceutical companies to educate psychiatrists and family doctors about the new diagnostic category. In turn, the doctors educated their patients in the language of depression. This meant a radical departure from the older language of (largely somatic) distress – notably ''*nervi*'', which was familiar to doctors and the general public. For a patient to present *nervi* was to invite the clinician to attend to a life story, to illuminate temporal and social aspects of the self. This story included a critical commentary on dysfunction outside the self, on wider society and politics. The shift from *nervi* to ''depression'' represented the internalisation of a heightened sense of personal accountability for one's life circumstances – but at the very time when post-Soviet Latvian society and economy had lost much of its former sense of stability and security. The discourse of ''depression'' switched the focus inward to the person who was now to hold himself individually responsible, yet with diminished control over things as a fact of life. Skultans comments that the narrative structure of these new accounts of distress indicates that people internalised the values of capitalist enterprise culture,

and the responsibility for personal failure that goes with it. Depression decontextualised their lived lives, whereas *nervi* embodied it.

The psychiatric literature and the core problem of validity

So how sound is the knowledge base of global mental health? The psychiatric literature is replete with studies of non-Western people and, in particular, publications on refugees and disaster-affected populations rose exponentially in the 1990s. However, in a review of 183 published studies on the mental health of refugees, Hollifield and colleagues (2002) found that 80% of these had been based entirely on Western instruments and categories. I once asked Professor David Goldberg, originator of one of the most widely used screening tools worldwide, the General Health Questionnaire, what it had been written to capture. ''Distress'', he replied (personal communication, 2010). Just that. But generic distress is shorn of the personal and social meanings that shape what is experienced, and thus what is said and done about it, including whether seen as connected to ''health'' or ''mind'' or ''situation''. The poorer the person, the more likely it will be ''situation'': there is a reflection of this in the work of Nobel prizewinning economist Amartya Sen, who compared subjective perceptions of health in Kerala, the state with the highest literacy and longevity rates in India, with the much poorer state of Bihar, where life expectancy is much lower, and medical and educational facilities far worse. Yet Kerala had the highest rates of reported morbidity in India, and Bihar the lowest, suggesting that it was only when people were more comfortably off, freed from the everyday imperatives of poverty and food insecurity, that they acquired the ''luxury'' of generating concerns about their health as a thing apart (Sen, 2002).

Western psychiatric templates cannot generate a universally valid knowledge base, since they so routinely fail the core test of validity, which relates to the ''nature of reality'' for the individuals under study. To put it in a broader way, invalid approaches will fail a basic test of humanism, and therefore will not be valued and cannot work. The problem in cross-cultural research is not accurate translation between languages, but accurate translation between worlds.

Although the global mental health field has largely ignored critiques like this one, a few researchers do sometimes concede that the scientific validity of Western mental health categories when applied universally is unproven, and until then ''reliability'' must suffice. But in my experience these are just ritual genuflections and are not meant to introduce serious doubt about current practice, nor the biomedical triumphalism this trades on. Such responses are no answer to the conceptual fallacies to which we point, rather a reaffirmation of business as usual. The foundational assumption that mental disorder can be seen as essentially outside society and culture remains. The claim sometimes made that indigenous categories in non-Western societies can be considered ''psychiatric diagnostic equivalents'' is one that relieves Western psychiatry of any obligation to examine the limits of its knowledge and epistemological traditions. Quantitative research methods based on Western paradigms are taken to other parts of the world, generating ''findings''

which are inserted into the self-same paradigms. Here again is the kind of circular thinking mentioned above. If research methodologies lack validity, they simply cannot be redeemed by ''reliability'' because the very ground they stand on is unsound. ''Reliability'' means using a standardised methodology but if the methodology is invalid, researchers are simply making the same mistake over and over again.

To the global psychiatrist, the socio-culturally determined understandings that people bring to bear on their active appraisal of their predicament, and on their modes of distress and help-seeking, seem little more than epiphenomenal. Underneath the cultural packaging lies the psychopathology, which she knows to be universal and the ''real'' problem. This universal psychobiological human is no more than a reductive caricature, an intellectual embarrassment.

As an entirely typical example of the research publications appearing in the high-impact academic journals, bearing out what Hollifield and colleagues found, I will briefly examine a population-based study of ''major depression'' (as defined by DSM-IV criteria) in Ethiopia published in the *British Journal of Psychiatry* (Mogga et al., 2006). Most of its authors were based at the Institute of Psychiatry, King's College London, a prestigious research and teaching institute with global reach. The Institute has an international mental health section with active links to the WHO. The study participants were rural and poor, mostly farmers and housewives. The instruments used were the Composite International Diagnostic Interview (CIDI) and the Self-Reporting Questionnaire (SRQ). The CIDI is described as ''a fully structured instrument produced by the WHO for use across cultures'', which is not to say it had been validated for use in Ethiopia – and probably cannot be since ''major depression'' is not a timeless, free-standing, universally presenting, pathological entity. So too with the SRQ, yet described as ''an instrument developed by the WHO to detect mental health problems in primary healthcare attendees in low-income countries'' (p. 241). Of participants with ''major depression'' at baseline, 26% also met criteria for this at follow-up 18-62 months later and were associated with raised scores on a WHO disability schedule (WHODAS-II), and with higher mortality rates. In the Discussion section the authors write, regarding possible limitation of CIDI performance, that ''in this part of the world, where there is much illiteracy, mental health constructs and the phrases used to describe them may not be well understood'' (p. 244). This is what I discuss below: whose knowledge counts? The second to last sentence of the entire paper reads: ''Much more information is needed regarding the characteristics, beliefs, knowledge, and illness attributes of those who are and those who are not inclined to seek help'' (p. 245). Such questions should have been the starting point for such a study, not a tokenistic afterthought. An invalid methodology condemns this study but how secure can the findings be when the authors know so little about the actual lives of participants? I don't doubt that something was ailing some of those with ''persistent depression'', but this was surely a very heterogeneous group –

some would have had undiagnosed physical illness, particularly the diseases of poverty, or spiritual or situational problems. The only solution offered was antidepressants and it is no surprise that compliance was poor.

Medical imperialism: whose knowledge counts?

Psychiatric universalism risks being imperialistic, reminding us of the colonial era when it was pressed upon indigenous people that there were different kinds of knowledge and that theirs was second rate. Socio-cultural and socio-political phenomena were framed in European terms and the responsible pursuit of traditional values regarded as evidence of backwardness (Summerfield, 1999). Said (1993) noted that a salient trait of modern imperialism was that it presented itself as an education movement, setting out consciously to modernise, develop, instruct and civilise. Global mental health workers are the new missionaries.

It is striking how often published studies of non-Western populations refer to subjects' ''limited knowledge of mental disorders'', their lack of ''mental health literacy'', or the need to ''teach'' health workers and the people they serve about mental health. Thus non-Western subjects are meant to understand ''us'', rather than the other way round, and their own cultural frameworks are likely to be seen as an obstacle to this understanding.

Consider this quote from an article on a mental health project brought to victims of the 2005 Pakistani earthquake, published in the Bulletin of the Board of International Affairs of the UK Royal College of Psychiatrists:

> Interestingly, when the team was about to start the work, some of the health professionals in the area were sceptical of the purpose of the team and said they had not encountered any mental health problems. But when the team members started their work and interviewed affected people, some of the local health professionals also accepted themselves as having experienced psychological symptoms in the aftermath of the earthquake, and requested help. (Chadda & Malhotra, 2006, p. 3)

Here is an example of how the thrust of a mental health project generates its own demand characteristics, bringing interventions that seem to carry from afar the imprimatur of Western modernity, with its knowledge and expertise presented as definitive – and perhaps also seen locally to offer employment possibilities.

A few years ago Afghan refugees in considerable numbers were landing in Australia from battered vessels, most of whom were interned in rural camps while a largely hostile Australian government sought alternatives to accepting them. In 2005 an organisation called Multicultural Mental Health Australia, along with the National Ethnic Disability Alliance, developed a programme for them called ''No More Mualagh''. ''Mualagh'' is a Dari word which means a feeling of floating or being in acute uncertainty, and one can understand why the refugees used this word to describe their predicament at that moment. So what was

the treatment for ''mualagh'' promised in the programme's name? Whereas the refugees would no doubt have primarily nominated the right to remain and settle in Australia, Multicultural Mental Health Australia stated that *''The 'No More Mualagh' project was developed in order to help Afghans living in rural Australia learn more about depression, how it is treated and how to safely use anti-depressant medication''*. To achieve this, fact sheets and audio files were prepared in Dari. So ''mualagh'' as a social and collective state was re-named as something individual and biomedical, ''depression'', and so it was now as mental health patients that these refugees were to take the proffered antidote, antidepressants. These were matters about which they needed to ''learn'': again, the use of this verb is telling.

Mental health and personhood in a broken social world

All healing systems rest on a version of a person. In globalising Western mental health, we are globalising a contemporary Western way of being a person. Consider the personhood that might be inferred from the following quote. Amina, a traditional birth assistant in Darfur, Sudan told a PhD researcher: *''Life is too short to worry too much. It is better to be satisfied with what is available''* (Jayawickrama, 2010). Amina's world could hardly have been more different from the largely war-free, stable, well resourced societies of the West, and with the assumptions of entitlement carried by most of their citizens. She above all has to keep going, to endure chronic scarcity and insecurity, and where ''rights'' count for little. This moral economy shapes the person. How would the Western version of a person, with Western psychological-mindedness, fare in Darfur? These reflections have particular resonance because of the state of the world, where the fortunes of the haves are diverging implacably from those of the have-nots. Across the non-Western world, structural poverty and injustice, violent conflict, crippling national debt repayments, environmental degradation, and grossly inadequate or absent provision of health, education and social services mean that hundreds of millions of people are mired in mere survivalist mode. Around 85% of Kenya's population growth in the 1990s was absorbed into just two squalid slums, in Nairobi and Mombasa, reflecting a rapid withering of traditionally self-sufficient rural ways of life (Davis, 2006). What is ''mental health'' in a broken social world? The largely short-term technical fixes of mental health approaches are likely to be mere distraction or indeed another source of stupefaction.

A *Lancet* article on the plight of India's farmers stated that: ''debt and distress has driven tens of thousands of Indian farmers to commit suicide in the past two decades... [highlighting] the increased need for mental health services in the country'' (Chatterjee, 2004, p. 1160). We see here the sleight of thinking by which a crisis around the increasing unviability of small-time farming as a way of life elides in an international medical journal into a supposed mental health crisis with its unmet need.

A comparison with Dr Juma's claims

Lastly, I have a photo of the large sign that Dr Juma has erected outside his clinic in a South African black township. On the sign Dr Juma advertises the problems he can treat: *''Bewitched person, swollen body, lost lover, insanity, diarrhoea, meanness, make men's penis strong, women with pregnancy problems, vomiting all the time, misfortunes, demand debts, remove misunderstandings with anybody, court cases, casino specialist, bad luck, customer attraction*.'' His patients are urban dwellers, not rural peasants who might be expected to have retained traditional ideas longest. I live in a borough in South London, Peckham, with a large African population. One of the leaflets I am often handed in the street advertises the skills of ''Mr Madiba, from birth a gifted African spiritualist, healer and adviser''. He offers treatment for a range of problems very similar to Dr Juma's in South Africa. It might reasonably be argued that these claims are grossly over-pitched, but in this they are no match for those of Western mental health. Dr Juma's claims and treatments are meant to extend only to a specific local population well-known to him, and of which he is culturally a part. The three core statements of *The Lancet* Global Mental Health Series, noted above, proclaim a standardised understanding of distress and disturbance, and of how it is to be treated, across the whole planet! Dr Juma would doubtless have no problem in accepting the statement that his was merely one of many ethnopsychiatries in the world. Western psychiatry simply refuses to do the same.

Concluding remarks

Max Weber talked about the ''methodological pestilence'' of the human sciences, the problems of objectivity and generalisability that arise when researchers ask questions they think important of people who may or may not agree, and are likely to have other ideas of their own. I am afraid I must reiterate that in large part the published research literature that supposedly comprises the knowledge base of global mental health is scarcely worth the paper it is printed on. Validity is the bugbear (Summerfield, 2008).

The Western psychiatric canon is pinned to the structural limitations of its foundational assumptions and modelling. Following this, the WHO too, seem to have opted for a conceptual distinction between social and mental health interventions, reproducing the traditions since the Enlightenment that regard the physical confines of the human individual as the basic unit of study, and for the mind to be examined by technical methodology akin to that applied to the body. Thus, mind (constructed as ''psychology'') is to be located inside the body – between the ears – whereas what is ''social'' is outside the body and outside the frame of reference. It might be more realistic to see our psychology as having a root outside the body, in the way that we live, and to consider the meaning of things – in particular a sense

of coherence – as arising from our practical engagement with the world. What just might be a universal truth is that lack of coherence is bad for people.

Mainstream psychiatric thought runs too much along straight lines, and remains firmly wedded to quantitative approaches. Anthropological insights seem to carry no weight in psychiatric research, yet there is much to learn from them. Anthropology has a far more sophisticated approach to the subject as social being, and to notions of memory, causation and time. Research likely to generate robust and useful data needs ideally to engage with subjects in a way that carries no pre-formed notions of what is ''mental health'' or ''health'' in their world: local concepts must be the starting point for the creation of valid instruments for screening or diagnosis. This is a test that even instruments supposedly adapted to local conditions will generally fail, since they retain their Western template. We need qualitative approaches to ensure grass-roots ownership of the terms of reference of these endeavours since data must come from bottom up if it is to properly inform public health policy.

There is also the ethical question of informed consent. In general, the business of other peoples' minds, even when troubled, is rather more a matter of philosophy than science. The mental states of these hard-pressed people is none of our business, unless we were invited in, and even if they did this it would not be mental health help per se they necessarily had in mind.

We need to challenge the relentless self-aggrandisement of the Western mental health industry, forever claiming that yet more funding is required to tackle ''massive'' unmet mental health needs. This is an industry out of control, risking hubris and arguably deserving it. Not just ''mental health'' but the whole industry and its pharmaceutical motor is being globalised.

In 2005, a WHO paper on post-emergency mental and social health acknowledged critiques of the indiscriminate globalisation of post-traumatic stress disorder and advised against vertical trauma programmes (Van Ommeren, Saxena, & Saraceno, 2005). That apart, the WHO has appeared to be an uncritical articulator of the claims of biomedically-driven global mental health. Yet, even in the West, the nature of the so-called ''common mental disorders'' is not subject to consensus, nor regarding the effectiveness and safety of treatments, which in addition are scarcely cheap. Who in non-Western subject populations is asking for these approaches? The WHO is ignoring basic principles of good practice and development policy, and the preposterous prevalence figures it gives for mental disorders worldwide gravely mislead health planners and providers. I think its ''common mental disorders'' agenda should largely be discarded.

To conclude, are we saying that mental health services are a good thing everywhere, and that we are merely trying to improve their intelligibility and effectiveness for local populations in culturally diverse, resource-poor settings? Or is there still a question as to whether non-Western societies do need ''mental health services'' at all as we understand them in the West, and if so, which bits? The strongest arguments would concern organic neuropsychiatric conditions, whether infective

(e.g., HIV encephalopathies), nutritional, post-injury, congenital, as well as, say, epilepsy, which in Africa is commonly regarded as a mental disorder – though there is no compelling reason why these conditions could not be seen within physical health services.

> A humanity which refuses to recognise that what is philosophically false cannot be scientifically true is not worthy the name.
>
> Thomas Mann, *The Magic Mountain* (1924)

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