

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

China Mills^{a*} and Suman Fernando^b

^aDepartment of Education, University of Sheffield, UK; ^bFaculty of Social Science and Humanities, London Metropolitan University, UK. Corresponding Author – Email: china.t.mills@gmail.com

Embodied in the very concept of Global Mental Health (an area that is emerging as both a field of study and a global movement), mental health is conceptualised as being ‘global’; mental disorders are constructed as having ‘a physical basis in the brain...they can affect everyone, everywhere’ and are understood to be ‘truly universal’ (WHO, 2001a:x, 22). The construction of ‘mental disorder’ as universal is used to draw attention to inequalities in access to mental health care and treatment globally – the ‘treatment gap’ - and to push to scale up mental health services in low and middle-income countries (LMICs) based on those in high-income countries (HICs). This push arises from two separate, yet interrelated, arenas; the World Health Organization (WHO), and the Movement for Global Mental Health (MGMH) (www.globalmentalhealth.org).

Such a view - reducing complex matters of living, behaving and thinking to ‘mental’ health and disorder developed in a particular socio-cultural context - is strongly contested by groups of service users and survivors of psychiatry, or those who identify as psychosocially disabled, in the global North and South; by academics and professionals in the field of transcultural psychiatry; and by members of the Critical Psychiatry Network (CPN) (<http://www.criticalpsychiatry.net/>) (see Fernando, 2014; and Mills, 2014). Even more importantly, this drive to export mental health systems from HICs to LMICs is occurring at a time when serious questions are being asked about the utility and validity of psychiatric diagnoses. More specifically, there is a) concern that such psychiatrization constructs human experience (for example, emotional distress, problems of living, conflicts in relationships and social suffering) as ‘mental disorder’ treatable by drugs (e.g. Bentall, 2010; Boyle, 2002; Johnstone, 2000), and b) concern about the deleterious effects of prolonged use of psychotropic drugs - the hallmark of current bio-medical psychiatry (Angel, 2011a,b; Kirsch, 2009; Moncrieff, 2009; Whitaker, 2010).

Concerns about the scale up of mental health services (which are currently dominated by psychiatry) from the global north to the south have been raised from a multitude of arenas - including from those who have been diagnosed with ‘psychiatric disorders’. The publication of an article in the journal *Nature* by Collins, et al. (2011) describing and promoting the approach of the Movement for Global Health (MGMH) led to a contentious meeting in Montreal where many academics in transcultural psychiatry expressed serious misgivings

about it (Bemme and D'souza, 2012); comments critical of MGMH have appeared in many academic papers (e.g. Campbell and Burgess, 2012; Das and Rao, 2012; Shukla et al. 2012a; Summerfield, 2012); and letters have appeared in Indian journals strongly critical of the MGMH (Shukla et al. 2012b,c). One of these referred to the fact that *Nature* had refused to publish a letter critical of the ideas presented in the article by Collins et al. (2011) that appeared in *Nature*, and thereby raising the possible political nature of the MGMH itself (Fernando, 2011).

Furthermore, there is widespread critique that psychiatry, and the psy-disciplines more generally, construct distress as symptomatic of 'neuropsychiatric disorders' rather than as responses to socio-politico-economic conditions of conflict, entrenched social inequality, and chronic poverty (to name but a few of the lived realities of global capitalism and liberal individualism). Thus, the globalisation of psychiatry is met by a counter-globalisation of voices advocating the need to address social suffering, personal distress and community trauma in the global South in a context of poverty, political violence and environmental disasters; and calling for people given psychiatric diagnoses to have their human rights protected by disability legislation. Many users and survivors of the psychiatric system, including some who self-identify as psychosocially disabled, argue for the right to access non-medical and non-Western healing spaces, and to not have their distress labelled and depoliticised as 'illness' (see PANUSP, 2011, reproduced in this volume).

Questioning, critiquing, practising differently

It is possible to query or critique the MGMH from multiple and diverse positions, disciplines and backgrounds, as do the papers within this special issue. The paper by David Ingleby analyses the evidence on which the MGMH bases its arguments for scaling up services in LMICs; concluding that neither of its two fundamental principles— scientific evidence and human rights—appear to be sustainable when scrutinised. Specifically, Ingleby points to the scientific shortcomings of the MGMH: the weakness of the knowledge base it draws from; its tendency to over-estimate the likely benefits claimed from 'scaling up' psychiatry in LMICs; and how the Movement overlooks evidence of the lack of biological markers for 'mental disorder'.

In a similar vein, White and Sashidharan, in this issue, focus on recent WHO policies, such as the Mental Health Gap Action Programme (mhGAP) (2008) and the *Comprehensive Mental Health Action Plan 2013-2020*. They argue that the over-reliance on the scale up of medical resources, and a concern with diagnoses, within such policies diverts attention from the social and cultural determinants of human distress, and strengthens hospital-based care to the detriment of community support - a viewpoint presented by the same authors in a recent editorial in the *British Journal of Psychiatry* (White and Sashidharan, 2014). Furthermore,

the paper questions the validity of the WHO's contention that there is a global burden of mental health problems, stating that 'The cross-cultural validity of such psychiatric disease is highly questionable', and is based solely, and problematically, on 'western' expertise.

Rachel Tribe in this volume points to the importance of 'politics ... and power differentials ... in the way the global mental health debate is constructed'. Diagnostic manuals compiled for Europe and / or North America are being exported irrespective of social and cultural context and, in the case of 'treatment', the assumption is that 'one size fits all'. Arguably, the framing of 'mental health' or disorder as a global priority, and the push for a 'global norm for mental health' (Shukla, et al., 2012:292), and a 'standard approach for all countries and health sectors' (Patel, et al. 2011:1442), not only ignores local realities, but also works to discredit, replace and make 'vanish' local frameworks for responding to distress. In a popular book describing the impact of the globalization of North American constructions of 'mental illness' all over the world, Ethan Watters (2010) sees the loss of cultural diversity in understanding and responding to distress worldwide as one that leaves everyone the poorer, not just people in LMICs. The gap sustained by ignoring the knowledge (often embedded in religion or spirituality) available in cultures of the global south, is a loss to all cultures, not just to 'non-western' ones.

The case of 'vanishing "alternatives" in neo-colonial states', is discussed, in this volume by Bhargavi Davar - human rights activist and campaigner in the field of mental health, and the founder of the Bapu Trust - who analyses this process in the context of India, where the government is increasingly outlawing traditional forms of healing. This is a process by which power structures marginalize other ways of knowing, destroy diversity, make alternatives to psychiatry 'vanish', and create 'monocultures of the mind' (Shiva, 1993:5). Such reductionist systems of knowledge are dangerous because they deny complexity and overlook how any conceptions of wellbeing are embedded in webs of interconnectedness and of unequal power relations.

The experience of India is only one example of what seems to be happening all over the global South in a context of unequal geo-political power relations, where modernization' and now so-called 'globalization' is often a matter of 'westernisation'. Quite apart from everything else, this raises serious ethical questions: Is this sort of 'development' in the interests of the people who live in the countries concerned? Is it in keeping with people's human and collective rights? Is the Euro-American psychiatry that dominates mental health systems in the West so effective that it should be exported *globally*?

Attempts to scale up psychiatry are sometimes justified on the assumption that there is no formal care for the distressed in many LMICs, thus overlooking local or indigenous forms of healing where they do exist. When these are recognised, healing practiced at religious 'healing centres' that prevail in many LMICs are sometimes thought of as 'alternatives' to

bio-medical psychiatry. For example, *God of Justice* (Sax, 2009) deals with ritual healing in the Central Himalayas of north India; and *Caribbean Healing Traditions* (Sutherland et al 2014) collects together articles on systems of healing such as Obeah, Voodoo and Puerto Rican Spiritism, that draw their origins from many different cultural traditions. In fact, some centres providing religious healing have been compared favourably to modern psychiatric treatment in recent studies in India (see Raguram et al 2001; Halliburton, 2004). And, recently, Tobert (2014) has described the work of psychiatric practitioners in India who try to combine spiritual approaches with psychiatric ones.

In this context, we need to bear in mind that the major study by the WHO (1973, 1975), carried out in the 1960s and 1970s, at a time when bio-medical psychiatry was relatively weak in many LMICs, found that outcomes (measured in terms of relief of psychiatric symptoms and social recovery) for people diagnosed as ‘schizophrenic’ were actually *better* in non-western settings such as India and Nigeria. Although the WHO study was flawed by poor methodology (see Fernando, 2014:105-6) it would seem that the context for recovery from what may be called ‘serious mental illness’ may well have been better in India and Nigeria than it was in Western countries at that time - and part of this may have been the availability of indigenous systems of healing.

But just as we take a critical approach to (western) bio-medical therapies, it is important not to idealise what is seen as ‘non-western’, indigenous, or ‘religious healing’. The ‘care’ given to people held in centres of spiritual or religious healing, alongside many psychiatric institutions, in some LMICs may be oppressive and subject to human rights abuses (Kalathil, 2007). Taking a broadly critical historical approach to both the globalization of bio-medical psychiatry and the complexities of indigenous practices of religious healing, Siddiqui, LaCroix, and Dhar (2014), in this special issue, discuss the contemporary position of faith healing in India, as ‘not psychiatric and ... not strictly psychological, that is not institution-centric and that is not clinical in the modern western sense’. They advocate a *critique of critique*; recognition of what determines our responses to practices such as faith healing, and how this is often marked by either a ‘critique of culture and a defence of science’, or a ‘critique of science and a defence of culture’. Moving beyond this, Siddiqui et al. postulate the need for a ‘bidirectional or *dual critique* of both the hegemonic Occident and the Occident's hegemonic description of the Orient’...‘a culture of critique that does not defensively align with the one – the global or the local – to avoid the other’ (Siddiqui, et al. this volume).

The discrediting of locally relevant forms of healing and their replacement with ‘modern’ ‘scientific’ psychiatric interventions is one of the means by which some have drawn parallels between the MGMH and colonial practices of outlawing indigenous healing systems, in parts of Asia and Africa (Davar and Lohokare 2008; Summerfield, 2008; also see Davar, this volume; and Ibrahim, this volume). In the field of mental health, colonial psychiatry in

British and French colonies resulted in the under-development and suppression of indigenous ways of relieving social suffering. Often these methods carried little stigma, meaning that the colonial legacy of psychiatry not only provided little in the way of ‘treatment’ but actually increased stigmatization of the distressed (Fernando, 2014). Furthermore, the aftermath of colonialism, and the White-on-Black Atlantic slave trade fed into European racism, producing a legacy of oppression that permeates the bio-medical psychiatric system even today, and which is now being exported as a result of the MGMH. There is a wealth of literature that analyses the way racism plays out in multicultural societies of the Global North (Bhui, 2002; Bhui and Olajide, 1999; Fernando, 1988, 1991, 2010; Littlewood and Lipsedge, 1982).

The racism of psychiatry is also discussed by a number of authors in this special issue. Bruce Cohen traces how such forms of racism play out in one of the ‘souths’ within the global north - namely the Māori population of Aotearoa New Zealand. Taking as his point of departure the increasing rates of diagnoses of ‘mental illness’ among the Māori population, Cohen questions the current ‘social model’ of ‘mental illness’ that understands socioeconomic and cultural factors - such as increased urbanization - as ‘triggers’ or contributors to psychiatric disorders. He argues that this model uncritically accepts ‘mental illness’ as a self-evident truth, and reifies psychiatry as neutral, scientific technical expertise. Cohen advocates a critical model that understands growth in diagnoses as the increasing psychiatrization of Māori political consciousness and resistance, leading to both direct forms of control (such as, incarceration and coercive treatments), and indirect social control through the ‘identification and labeling of political opposition as *symptoms* of sickness’ (Cohen, this volume).

Similarly, but on a different continent, Mohamed Ibrahim explores the colonial legacy of psychiatric facilities and mental health legislation still used in many African countries, despite their political uses for ‘suppressing rebellion and detaining individuals or groups who appeared to be a threat to the colonial establishment’ (Ibrahim, this volume). In a similar vein, tracing the historical and global travels of one diagnostic category – neurasthenia - Louise Tam (in this volume) maps how diagnosis serves 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’. For Tam, ‘psychiatric knowledge has reproduced and maintained racial hierarchies at critical moments of counter-hegemony’, and as a means of social control of certain ethnic populations (this volume).

Cohen, Tam and Ibrahim give many examples of how racial categories have been constructed and used within psychiatry as a form of social control and political repression. They cite examples ranging from the 19th century diagnosis of ‘drapetomania’ - given by psychiatrists in the USA to black slaves who attempted to escape captivity; Dr Carother’s psychiatrization and pathologisation of the Mau Mau rebellion in Kenya; to the use of the schizophrenia

diagnosis as a racially codified method of controlling and pathologising resistance in the form of the Black Power movement in the USA (Metzl, 2009).

Both Tam and Cohen take this further in drawing attention to how a focus on some social determinants, such as increased urbanization for Māori or acculturation for migrants, as risk factors for ‘mental illness’, may serve to divert attention away from an interrogation of psychiatry as a racialized and colonial practice. Here, then, even the recognition that racism and oppression may contribute to, or cause, ‘mental illness’, may obfuscate the biopolitics of psychiatric expertise and diagnoses, and the racism and oppression of psychiatric knowledge. To counter this, Cohen calls for a ‘re-direction in research focus from Māori as *pathological* to colonial psychiatry in Aotearoa New Zealand as *pathologizing*’ (this volume).

The political economy of (global) mental health

Today, with neo-liberal economic systems dominating the global north and much of the global south, health services are becoming commodified and the concept of ‘health’ itself is seen as a resource subject to political manipulation (Bambra et al. 2005). Perhaps, for ‘mental health’ this has always been the case as evidenced by the scandals of abuse of psychiatry in the Soviet Union (Bloch and Reddaway, 1984) and the way hospitalised black people were oppressed and exploited in South African mental hospitals during Apartheid (Stone et al. 1980; Fernando, 1988). This calls for attention to the landscape into which conceptions of mental health are embedded - the ideology of global capitalism and the current political economy rooted in liberal individualism (Mooney 2012; Navarro, 2009). This is manifest in practises of economic liberalization, de-regulation of big business, open markets, and purported ‘free trade’ with its in-built biases towards and protection of western interests, privatization of state assets and overall promotion of the private sector (Fernando, 2014). Against this backdrop of neoliberal policies imposed worldwide, health inequalities have actually increased, both within and between countries (Navarro, 2009).

In a more general sense too, political systems determine the way mental health services are organised because political theories affect the way problems of the ‘mind’ are conceptualised. So when the governing ideologies affecting a country moves from one (political) system to another, changes in the delivery of mental health care may have a particular slant to them too, different from that in other countries. Shelly Yankovskyy (2014), in this special issue, focuses on issues associated with reforming the mental health system in Ukraine in the post-Soviet era, when the country’s political system changed from socialism to neoliberal capitalism. While not strictly within the global South, insights from Ukraine may be important for many countries transitioning to, or experiencing the effects of, neoliberalism. Yankovskyy poses the question of how to ‘mitigate the growing popularity of the medicalization of behaviour and its connection with corporate capitalism’ (Yankovskyy, this volume).

The medicalization of social and political issues, where ‘symptoms of oppression’, for example, due to gender relations, alcoholism, poverty, or environmental disasters, are psychiatrically reconfigured as ‘symptoms of illness’, is a thread that runs throughout the narratives of the people that Yankovskyy interviewed about distress within the Ukraine. Taking this into account, Yankovskyy stresses that ‘Getting sick...does not happen in a vacuum’, with ‘Political-economic forces shap[ing] who gets sick, why they get sick, what they get sick with, and what treatment is available’ (this volume).

Today there are many non-governmental agencies (NGOs) working in LMICs, many funded by sources in HICs. Inevitably, some of these may pursue agendas that are more suited to HICs than to LMICs and few appear to take on board the ground realities in LMICs, for example the lack of regulation of the sale of drugs (for discussion see Fernando, 2014; Mills, 2014). Calls to scale up access to psychotropic medications are further embedded against a background of lack of availability to many life-saving drugs in the global south, in part due to the pharmaceutical industry’s invoking of patents meaning refusal to distribute cheaper generic drugs, as well as the use of loans to LMICs by multilateral agencies to both increase access to medications while simultaneously increasing the conditions for poorer countries to become economically dependent on the global north (Shah, 2006). This represents a general dominance in global discourse on health by transnational corporations, and particularly the pharmaceutical industry, with their agendas of deregulation and privatisation, and tensions over prices of drugs linked to intellectual property, alongside the exploitation of indigenous resources and knowledge - enacted through biopiracy (Soldatic and Biyanwila, 2010; Shiva, 2012).

Bearing all of this in mind, are we to conclude, then, that nothing can be done? Can there be no exchange between countries about understandings of distress and wellbeing? In an article on doing collaborative mental health work between Canada and Cameroon, Suffling, Cockburn and Edwards (this volume) advocate for the importance of recognizing not just the production of tools and guidelines for cross-cultural work but of the *process* in making them: a process that for them led to the development of guidelines that they call ‘Tools for the Journey’. This stands in direct contrast to much GMH advocacy where there is a marked lack of transparency in decision making and agenda setting, which tends to be led by professionals.

Voices from the field

The ‘Voices from the Field’ section of this special issue acts as a space where the expertise of those who experience distress and those who live and work in LMICs is recognised. It is this expertise that forms the basis of the Cape Town Declaration (2011) of the South African based Pan African Network of People with Psychosocial Disabilities (PANUSP) - reproduced

within this special issue. PANUSP state clearly that ‘There can be no mental health without our expertise. We are the knowers and yet we remain the untapped resource in mental health care. We are the experts. We want to be listened to and to fully participate in our life decisions’ (this volume). For PANUSP, recognition of expertise also means recognising that psychosocial disability is deeply entwined with socio-economic conditions, meaning that ‘no medicines, treatments or sophisticated western medical technology can eradicate human rights violations and restore dignity’ (this volume). This means that the choice to draw upon non-medical and non-western forms of healing should be framed as a right.

Drawing upon the Cape Town Declaration, Linda Lee (in this volume) draws attention to the importance of choice between treatment options (where medication may be one among many viable options) in a context where the person experiencing distress is understood as an expert. In this way, genuine choice between alternatives also increases possibilities for more meaningful mechanisms of consent and refusal to interventions into distress, both individual and collective, to be imagined. Thus, as Lee points out, some of the worst ‘human rights violations in the mental health field lie in the nature of the [unequal power] relationship of the so-called “helper” and the receiver of this help’ (this volume). Situating this concern within the broader context of GMH, raises the issue of further unequal power relations being replayed at a global level, including historically entrenched colonial relations. For Mohamed Ibrahim, in this special issue, colonial relations were a lived reality in his work as a psychiatric nurse in Kenya, leading him to explain that ‘Reforming mental health in Kenya is not only a medical matter but an issue of justice and freedom - it’s about honoring those psychiatrized and treated unfairly by the colonial system. It is about decolonizing mental health’ (this volume). Similarly, Akomolafe stresses the need to decolonize understandings of ‘mental illness’ and healing in Nigeria, and begins to outline how this might be achieved when he points out that ‘It is important to the quest for decolonised futures that new spaces for critical enquiry, the co-creation of indigenous research methods, the unraveling of knowledge production systems, and the legitimisation of indigenous praxis be fervently pushed for’ (2013:732). This points to a wider need to decolonize the political economy of truth around distress, and the language through which we can talk about wellbeing; a project akin to the decolonizing of minds (Thiong’o, 1981).

This raises the question, asked by Kanyi Gikonyo, from the group Users and Survivors of Psychiatry (USP) – Kenya (in this volume), whether wellbeing and distress should be addressed by health policy and medical funding, or instead be understood outside of a medical framework. In common with other innovative programmes in countries of the global South (for example, see the work of the Bapu Trust in India, and PANUSP in South Africa), USP-Kenya use a holistic model of care that is sensitive to the everyday realities of poverty that their work is embedded within, and that emphasizes peer-support, and understands people who experience distress as being the ‘experts’.

As a space to document alternative ways of understanding and working with distress in LMICs, such accounts also challenge the criticism sometimes levelled at critiques of GMH: that at least GMH programmes are doing something, unlike those who criticize it. This approach is evident in the final paper in this special issue - a series of email exchanges between Arthur Kleinman and Derek Summerfield (and reproduced with their kind permission), where Kleinman seems to mark a distinction between a) critiques of psychiatry informed by psychiatric anthropology, and b) actual 'global mental health implementation programs that bring useful services to places where there are none for people who otherwise are without potentially helpful interventions' (cited in Summerfield, this volume). However, the papers within this special issue both question the assumption that many people in LMICs are without local forms of intervention, and further query how what HICs portray as 'helpful' interventions may either not be helpful, or may indeed be harmful.

'Global' Priorities or Globalised Localisms: Mental health development in Low- and Middle-Income Countries

More than passive critique, the papers in this special issue begin to lay the ground for (re)imagining and practising healing and support differently in LMICs and in HICs. As editors of this special issue, what, then, do we imagine as a future for mental health or wellbeing work in LMICs? The conditions we currently occupy are interwoven with our socio-historical, cultural and geopolitical positions, and thus any future thinking on wellbeing must grapple with the economic and cultural oppression of colonialism in the global north and south, and the holocaust that was slavery. Furthermore, there is a need to find ways to recognise different lived realities of suffering worldwide, to imagine different relationships between medicine and madness, and to map ways of responding to distress that are not necessarily psychiatric.

There seems to be an imperative felt in some sections of the global north that something can and should be done to relieve the social and psychological suffering evident in the global south. Reciprocating this, there appears to be a wish, even a demand, by people in the global south that more needs to be done to relieve suffering of individuals, while at the same time improving the social and political conditions that undoubtedly lead to much of that suffering. This is underwritten by a recognition that 'under-development' in the south is a direct consequence of development in the North, resulting in the current disparities of wealth and health between North and South. Clearly, any 'development' needs to happen in an ethical way—from what Edward Said (1994) calls a position of 'reconciliatory' post-colonialism—not solely by 'scaling up' the sort of services available in the global north (although some of these may well be taken on by people in LMICs) but by development that is independent of the North, owned and sustained by people in the South. Such frameworks should be *home-grown* within the local contexts from which distress emerges, privilege the knowledge of

those with lived experience of distress, and enable interventions based on self-help and peer-support. Such frameworks must be able to conceptualise the intertwining of the socio-economic with distress (politico-economic crisis with individual crisis), and try to understand distress as personally and politically meaningful.

This may also entail a move away from conceptualising mental health as a ‘global’ priority, to a recognition that priorities vary enormously within and between countries, meaning that there may be no global priorities, other than combating entrenched inequality, poverty and enormous global power imbalances (Katz, 2013). Here then the designation of ‘mental illness’ as a global priority effectively erases national and regional variations in people’s realities, affecting both socio-political, and mental health, priorities. For example, a country’s priorities may vary according to their past experiences of colonialism, geo-political position, ‘natural’ (often seen as exploitable) resources, experience of conflict, or according to donor agendas and involvement of multi-lateral agencies, such as the World Bank.

Recognition of these different priorities would mean understanding that psychiatrization is tethered to multiple oppressive systems, meaning that it is experienced and lived differently by different populations in different places, and by different groups within each population (Diamond, 2013). For example, the psychiatrization of children bears similarities and yet distinctions from that of racialized peoples, just as racialized women may experience psychiatry differently than, and be psychiatrized differently to, racialized men. This means recognizing that these different groups have different priorities in any project of decolonization (whether it is related to health or not), for example, for some addressing environmental degradation may be the first goal, while for others it may be the eradication of poverty (Connell, 2011). If priorities vary so widely, it begs the question of who has the power to designate any particular issue as a ‘global’ priority, raising Escobar’s concerns that here ‘the global is defined according to a perception of the world shared by those who rule it’ (1995/2012: 195), and is seen to transcend local and cultural contexts.

A key element in recognizing the problematic construction of mental health as ‘global’, then, is to understand that psychiatry, like forms of so-called traditional healing, is also local, and thus, that here the global/local dichotomy is misplaced. Western psychiatry itself is a local system of knowledge—one of many ethnopsychiatries (Gaines, 1992:3; Summerfield, 2008) - embedded within the history of a particular culture, and inevitably threaded throughout with assumptions that are classed, gendered, and racialised. Yet, psychiatry, like ‘modern science’, and the current neoliberal capitalist system, is a ‘globalised localism’ (Santos, Nunes and Meneses, 2007:xxxix), that is seen outside of the West as a form of ‘Western particularism whose specificity consists of holding the power to define as particular, local, contextual, and situational all knowledges that are its rivals’ (Ibid:xxxv). To recognise this is not to completely reject biomedical psychiatry, it enables an understanding that ‘We might employ biomedicine as a partial frame, useful at times, but incomplete and inadequate for much of

what we want to accomplish' (McGruder, 2001:77).

Any project that aims to interrogate the political economy of truth around distress must grapple with the role that the pharmaceutical industry plays in the production and marketing of the drugs that psychiatry prescribes. The widely documented unethical practices of an industry that also has a huge financial incentive in pushing specific understandings of, and 'solutions' to, mental health, marks a central area of contention for GMH – and yet it is one that, so far (and to our knowledge), the Movement has not engaged in debate, or shown transparency, about (Goldacre, 2012; Healy, 2012; Shah, 2006). There is no denying that medications may be helpful for some, and indeed there is surely a case for equality of access in such cases. However, the issue of regulation, as well as of preventing psychotropic medications from dominating the mental health landscape, the research agenda, and the public imaginary, not to mention replacing diverse and plural frameworks and practices in relation to wellbeing, all remain of the utmost concern.

The fight against a single global norm and its capacity to destroy diversity could be a way for diverse movements to retain their particularities (be they around agricultural practises, traditional forms of healing, or alternative economic models), while simultaneously establishing some threads of mutual intelligibility for joint mobilisation. Thus, a key form of resistance to current global capitalist systems would be to mobilise and recognise epistemological diversity in multiple forms (Santos, et al. 2007). This may allow the recognition and creation of plural ways to 'talk about how to co-exist in healthier ways that do not marginalize people' (Suffling, et al. this volume), and thus, ultimately 'creating the conditions for the existence of multiple interconnected worlds...that can coexist on the planet in a mutually enhancing way' (Escobar, 1995/2012:viii).

It is hoped that this special issue as embedded within and interconnected with multiple current projects that aim to think and 'do' mental health differently, serves to open up a discursive space to encounter alternative ways of conceptualizing and acting upon wellbeing and distress. Because discourse shapes what it is possible to think and how it is possible to act, and provides the very means through which we can understand ourselves and others, it is hoped that in the myriad papers of this special issue the vast epistemological diversity around wellbeing can be traced, with the aim that this might provide the very conditions for other ways of knowing, being, doing, and resisting, to flourish.

Acknowledgements and a dedication

The editing of this volume has been a great pleasure, and yet has borne a huge responsibility because each paper (in direct or more oblique ways) makes such an important contribution to theorising, questioning, rethinking, or decolonizing the Movement for Global Mental Health.

We would like to take this opportunity to thank all the authors for their time, critical engagement and incredible patience, and for sharing their work in this special issue. Thanks also go to our anonymous reviewers for erudite commentary and encouragement. Special, and enormous, thanks go to Michael Toth for astounding editorial assistance. Finally, a huge thanks to Shaun Grech, and all involved in DGS, for inviting us to co-edit this special issue, and most importantly for making the journal open access in a world where knowledge is often treated as a commodity.

Alongside acknowledging the immensely hard work of our contributors, we would also like to make a dedication, and this comes with much sadness. Just as this special issue was awaiting publication, one of our contributors, Kanyi Gikonyo, passed away. Kanyi was a self-advocate, who, in 2011, established the first peer support group in Nairobi, and continued to oversee the development of other such groups in other counties. From 2012 he worked as the CEO at the organisation *Users and Survivors of Psychiatry in Kenya* (the organisation that he writes about in this special issue), having served as the chairperson of the board from 2011. He worked tirelessly to ensure the inclusion of the voices of persons with psychosocial disabilities on key pieces of legislation in Kenya. Some of his work can be seen at www.uspkenya.com/index.php/programs/what-we-do/advocacy-and-public-education.

We dedicate this special issue to the life and work of Kanyi Gikonyo.

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