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The Globalisation of Mental Illness

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The globalisation of mental illness

Ross White asks whether recent developments are a problem or progress

The burden (notably and disability) caused by mental disorders across the globe is on the rise. Psychiatric services for treating mental health difficulties are well established in high-income countries such as the US and UK; and the World Health Organization has supported the setting up of similar services in low- and middle-income countries (LMIC).

But is the globalising of psychiatric systems of diagnosis and treatment the most appropriate line of action? This article critically reflects on biomedical explanations of mental health difficulties; highlights concerns about the death of research into mental health difficulties in LMIC; discusses the skewed emphasis that psychiatry places on cultural factors; and raises the possibility that globalising notions of psychiatric illness may cause more harm than good.

question

Is the scaling-up of psychiatric services in low- and middle-income countries serving to undermine indigenous sources of support for mental distress?

resources

Suman, F. (2010). *Mental health, race and culture* (3rd edn). Basingstoke: Palgrave Macmillan.
<http://transculturalpsychiatry.gla.ac.uk>

references

Alem, A., Kibretse, D., Fekadu, A. et al. (2009). Clinical course and outcome of schizophrenia in a predominantly treatment-naïve cohort in rural Ethiopia. *Schizophrenia Bulletin*, 35, 644-654.

Depression and Anxiety. *Journal of Clinical Psychology*, 62, 47-55.

Cohen, A., Patel, V., Thara, R. et al. (2008). Questioning an axiom: Better prognosis for schizophrenia in the developing world? *Schizophrenia Bulletin*, 34, 229-244.

Crocker, I. (2011). Making up hope: Multiculturally psychiatry, culture, and penis-stimulating practices. *Journal of the History of Medicine and Allied Sciences*, 67, 34-70.

Eaton, J., McCrely, L., Semman, M. et al. (2011). Scaling up of services for mental health in low-income and middle-income countries. *Lancet*, doi:10.1016/S0140-6736(11)61981-X

Gemmelton, J. (2002). *Prozac backlash: Zoloft, Paxil and other antidepressants win safe, effective alternatives*. New York: Simon & Schuster.

Hall, G.C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical and conceptual issues. *Journal of Consulting and Clinical Psychology*, 69, 502-510.

Haney, P.D. & Bellack, A.S. (2009). Toward a terminology for functional recovery in schizophrenia: A viable conceptual framework. *Schizophrenia Bulletin*, 35, 300-306.

Hopper, K., Harrison, G., Janka, A. & Sartorius, N. (Eds). (2007). *Recovery from schizophrenia: An international perspective*. Oxford: Oxford University Press.

Khanaka, J. (2011). *Depression in Japan: Psychiatric care for a society in distress*. Princeton, NJ: Princeton University Press.

Kleinman, A.M. (1972). Depression, socialization and the new cross-cultural psychiatry. *Cultural Anthropology*, 17, 3-10.

Kleinman, A.M. (1987). Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, 151, 447-454.

Kleinman, A.M. (2001). Social and cultural anthropology: Salience for psychiatric care. In M.G. Gidycz, J.J. Lopez-Lator & N.C. Andreasen (Eds). *New Oxford textbook of psychiatry*. Oxford: Oxford University Press.

Kleinman, A. (2009). Global mental health: A future of humanity. *Lancet*, 374, 603-604.

Lieberman, R.P., Kopelowicz, A., Ventura, J. & Galder, D. (2002). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry*, 14, 254-272.

Lopez, S.R. & Guernaccia, P.J. (2001). Cultural psychiatry.

There are huge inequalities in the availability of resources to support mental health needs across the globe; it is estimated that greater than 90 per cent of global mental health resources are located in high-income countries (WHO, 2005).

This is all the more alarming when we consider that around 80 per cent of the world's population live in low- and middle-income countries (LMIC; Saxena et al., 2006). In countries in Africa, Latin America, and south/south-east Asia under 2 per cent (and often less than 1 per cent) of expenditure on health tends to go to services for psychiatric conditions (compared to over 10 per cent in the USA) (Kleinman, 2009). And there is a gathering mental health storm: it is projected that by 2030, depression will be the second biggest cause of disease burden across the globe (Mathers & Loncar, 2006), second only to HIV/AIDS.

When four out of five people in LMIC who need services for mental, neurological and/or substance-use disorders do not receive them (WHO, 2006), we have a clear treatment gap – the difference between the levels of mental health services required by LMIC populations and what is actually available on the ground. Prominent clinicians and academics, as well as international organisations such as the World Health Organization (WHO, 2008, 2010), have called for the scaling-up of services for mental health in LMIC.

Scaling-up involves increasing the number of people receiving services; increasing the range of services offered, ensuring these services are evidence-based, using models of service delivery that have been found to

be effective in a similar context; and sustaining these services through effective policy, implementation and financing (Eaton et al., 2011). Yet in light of the limited resources available to support mental health, it is pertinent to ask whether it makes sense to try to export systems of service delivery that have been developed in high-income countries to LMIC. Will this venture be sustainable in the longer term? More importantly, will these systems actually deliver added value for the increase in budgetary expenditure that will be required?

The seductive allure of biological psychiatry

In high-income countries mental health services tend to gravitate around psychiatry; the branch of medicine that is concerned with the study and treatment of mental illness, emotional disturbance, and abnormal behaviour. *Biological psychiatry* is an approach to psychiatry that aims to understand mental illness in terms of the biological function of the nervous system.

The rise of biological psychiatry promised great things. Biological explanations of mental illness permeated the public consciousness; and the hunt was on to discover the magical compounds that could redress the chemical imbalances that were purported to cause mental illness. Various different medications have been developed and marketed. In the past 40 years the sales of psychotropic medications have increased dramatically. Yet despite the exponential rise in sales of these medications, the evidence for biological causes for mental illnesses such as depression and schizophrenia remain fairly weak (Nesler et al., 2002; Stahl, 2000). The continued absence of definitive evidence to support biological processes that are causal in mental illness has led to the suggestion that biological psychiatry is 'a practice in search of a science' (Wyatt & Midgoff, 2006). Despite these concerns, biological psychiatry continues to exert a strong influence on the delivery of mental

health services in high-income countries such as the UK and America.

The seductive allure of the rationale underlying biological psychiatry is plain to see. If mental illnesses were to have universal biological causes, then standard treatments could be readily applied across the world irrespective of local differences and associated cultural differences. If evidence-based practices led to positive outcomes in high-income countries, then similar positive outcomes will be observed in LMIC. Right?

This is where the picture gets a bit more complicated. Before we can answer this question we need to be clear on what we mean by: (1) 'evidence-based practices' and (2) 'positive outcomes'. What is considered to be 'evidence-based practice' can serve powerful economic and political interests (Kimmerly & Mims, 2000). In 2007 US citizens alone spent £25 billion on antidepressants and antipsychotics (Whitaker, 2010). All this in spite of the fact that claims about drug effectiveness are at times overstated, and that pharmaceutical companies have been found to employ questionable research methodologies (Gleimmlen, 2002; Valenstein, 1998; Whitaker, 2010).

Professor David Healy (Psychiatrist, University of Cardiff) has stated that a 'large number of clinical trials done are not' (Valenstein, 1998; Whitaker, 2010). More than 90 per cent of global mental health resources are located in high-income countries



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reported if the results don't suit the companies sponsoring the study' (imvurl.com/dsh55w). The evidence-base is heavily skewed towards research conducted in high-income countries. Since producing hard evidence depends on the costly standards of psychiatric epidemiology and randomised clinical trials, it can be difficult for clinicians or researchers in LMIC to contribute to the accumulation of knowledge (Kimmerly, 2006). The lack of mental health related research being conducted in LMIC countries is evident in the finding that over 90 per cent of papers published in a three-year period in six leading psychiatric journals came from Euro-American countries (Patel & Sumanthappa, 2001). An inductive, bottom-up approach to research emphasising the importance of local conceptualisations of mental health difficulties and focusing on local priorities in different LMIC is required.

Even if the research capacity in LMIC can be increased, difficulties remain. The issue of what constitutes 'positive outcomes' in relation to mental illness has plagued clinical practice and research for many years. There is currently no accepted consensus on what constitutes positive outcome for individuals with mental illness. Traditionally, psychiatry has been concerned with elucidating symptoms of mental illness. However, it is important to appreciate that clinical symptoms do not improve in parallel with social or functional aspects of service users' presentation (Lieberman et al., 2002). Functional outcome relates to variables such as cognitive impairment, residential independence, vocational outcomes, and/or social functions (Harvey & Bellack, 2009). In this sense, using symptomatic remission as an indicator of recovery can yield better rates of good outcome than using indicators of functional recovery (Robinson et al., 2005). Another important consideration relating to outcome

in mental illness relates to the extent to which particular outcomes are culturally sensitive and inclusive (Vahlant, 2012). Marked disparities have been highlighted between ethnic minority groups and white people in outcome, service usage and service satisfaction (Seshidharan, 2001). The lack of culturally inclusive understandings of positive outcome in mental illness is compounded by the underrepresentation of black and minority ethnic groups in mental health related research. This has led to some concluding that there is a lack of adequate evidence supporting the use of evidence-based psychological therapies with individuals from black and minority ethnic populations (Hall, 2001). Considering these issues, it seems that the jury is in no position to deliver a verdict on whether 'evidence-based' practices for mental illness developed in high-income countries deliver positive outcomes in LMIC.

Diagnosis and culture

Despite the question marks that remain about the causes of mental illness, the variety of the evidence base, what constitutes good outcome, and how inclusive mental health services are to cultural diversity within the population, the psychiatry-theory perspective has a powerful say in how mental health difficulties are understood in LMIC.

Dismissing voices have questioned the wisdom of this approach. One particular source of dissentation relates to the process of psychiatric diagnosis. The international classification systems for diagnosing mental illnesses (such as depression and schizophrenia) have been criticised for making unwarranted assumptions that these diagnostic categories have the same meaning when carried over to a new cultural context (Kleinman, 1977, 1987). This issue has potentially been obscured by the fact that the manuals that describe these diagnostic categories have been criticised for being unrepresentative of the global population. Of the 47 psychiatrists who contributed to the initial draft of the

most recent World Health Organization diagnostic system (ICD-10; WHO, 1992), only two were from Africa, and none of the 14 field trial centres were located in sub-Saharan Africa. Incidentally, this led to the omission of conditions that had been described for many years in Africa (Patel & Whinston, 1994), such as brain lag syndrome. (This was initially a term used almost exclusively in West Africa, generally manifesting as vague somatic symptoms, depression and difficulty concentrating, often in male students.)

ICD-10 does at least acknowledge that there are exceptions to the apparent universality of psychiatric diagnoses by including what are called *culture-specific disorders*. One such example is *koro*, a form of genital retraction anxiety which presents in parts of Asia. Prior to ICD-10 symptom presentations such as *koro* tended to be subsumed into existing diagnoses such as delusional disorder (Crozier, 2011). But the inclusion of culture-specific disorders only serves to perpetuate a skewed view of the impact of culture on mental health; cultural explanations seem to be reserved for non-Western patients/populations that show non-typical symptoms, and not for diagnoses that are more prevalent in high-income countries (e.g. anxiety neurosis). Indeed it has been suggested that many psychiatric conditions described in these diagnostic manuals (such as anxiety neurosis, chronic fatigue syndrome) might actually be largely culture-bound to Euro-American populations (Kleinman, 2000; Lopez & Guernaccia, 2000). Because people living in Western countries tend to see the world through cultural lenses that has been tinted by psychiatric conceptualisations of mental illness, they are blind to how specific to Western countries these conceptualisations actually are.

Transcultural psychiatry

Culture has been defined as 'a set of institutional settings, formal and informal practices, explicit and tacit rules, ways of making sense and presenting ones

experience in forms that will influence others' (Kimmerly, 2006, p.133). Interest in the potential interplay between culture and mental illness first arose in colonial times as psychiatrists and anthropologists surveyed the phenomenology and prevalence of mental illnesses in newly colonised parts of the world. This led to the development of a new discipline called *transcultural psychiatry*, a branch of psychiatry that is concerned with the cultural and ethnic context of mental illness.

In its early incarnation, transcultural psychiatry was blighted by the racist attitudes that prevailed at that time about the notion of 'native' minds. However, over time this began to change as people began to understand that psychiatry was itself a cultural construct. In 1977 Arthur Kleinman proposed a new cross-cultural psychiatry that promised a revived tradition that gave due respect to cultural difference and did not export psychiatric theories that were themselves culture-bound. Transcultural (or cross-cultural) psychiatry is now understood to be concerned with the ways in which a medical symptom, diagnosis or practice reflects social, cultural and moral concerns (Kirmayer, 2006).

Tensions exist in transcultural psychiatry. Clinicians, who are motivated to produce good outcomes for service users, may work from the premise that there is cross-cultural portability of psychiatric or psychological theory and practice. Although well intended, this approach can be met with disapproval from social scientists who are focused on advancing medical anthropology as a scholarly discipline. However, it is becoming clear that in this era of rapid globalisation, mental health practitioners, social scientists and anthropologists need to come together and engage in constructive dialogue aimed at developing cross-cultural understanding about how



Western narratives about 'mental illness' continue to dominate over local understanding

best to meet the mental health needs of people across the globe.

The need for interdisciplinary working in promoting improved understanding about the interplay between culture and mental illness has been demonstrated by a growing body of evidence indicating that exporting Western conceptualisations of mental health difficulties into LMIC can have a detrimental impact on local populations. Ethan Walters' book *Crazy Like Us* cites examples from different parts of the world (including China, Japan, Peru, Sri Lanka and Tanzania) where the introduction of psychiatric conceptualisations of mental illness has potentially changed how distress is manifested, or introduced barriers to recovery (e.g. the emergence of expressed emotion in the families of individuals with psychosis in Tanzania). Walters (2010) cites the work of Gailhn Fernando who has written extensively about the aftermath of the tsunami that struck Sri Lanka in 2006. Fernando claims that Western conceptualisations of trauma and the diagnostic criteria for post-traumatic stress disorder (PTSD) were not appropriate for a Sri Lankan context. Fernando found that Sri Lankan people were much more likely to report physical symptoms following distressing events. This was attributed to the observation that the notion of a mind-body disconnect is less pronounced in Sri Lanka. Sri Lankans were also more

likely to see the negative consequences of the tsunami in terms of the impact it had on social relationships. Because Sri Lankans people tended not to report problematic reactions related to internal emotional states (e.g. fear or anxiety), the rates of PTSD following the tsunami were considerably lower than had been anticipated. Fernando concluded that Western techniques for conceptualising, assessing and treating the distress that people were experiencing were inadequate. Walters also explores the way in which understanding about depression has changed in Japan over the last 20 years. This sobering tale allows Walters to

explore how the interplay between cultural factors and notions of mental illness can be manipulated for financial gain. In the 1960s Hubert Fellenbach had introduced the notion of a personality type called *Typus melancholicus*. This idea heavily influenced psychiatric thinking in Japan. Typus melancholicus had substantial congruence with a respected personality type in Japan, those who were serious, diligent and thoughtful and expressed great concern for the welfare of others... prone to feeling overwhelming sadness when cultural upheaval disordered their lives and threatened the welfare of others' (Walters, 2010, p.228). Although at the end of the 20th century there had been a psychiatric term in the Japanese language for depression (*utsushyo*), this tended to relate to a rare and very debilitating condition. Prior to 2000 there had been no real market for prescribing antidepressant medications in Japan. However, shifting public perception about Typus melancholicus closer toward the Western conceptualisation of depression would have huge implications for antidepressant prescribing in Japan. Walters (2010) claims that GlaxoSmithKline's enthusiasm to build a market for its new antidepressant medication in Japan dovetailed conveniently with a GlaxoSmithKline sponsored international consensus group of experts on cultural psychiatry discussing cross-cultural variations in depression (Ballenger et al.,

2001) concluding that depression was vastly underestimated in Japan. Depression is now conceptualised in Japan as affecting individuals (particularly men) who are too hard-working and have over-internalised the Japanese ethic of productivity and corporate loyalty. In the last few years, the market for antidepressants in Japan has grown exponentially. An important consequence of this aggressive pharmaceuticalisation, is that psychological and social treatments for depression are being ditched (Kitanaka, 2011).

Globalisation of mental health

There is a growing willingness to explore ways of addressing inequalities in the provision made for mental illness across the globe, but translating this willingness into effective action is fraught with potential danger. We must guard against assumptions that indigenous concepts of mental health difficulties in LMIC and strategies used in these contexts to deal with it are based on ignorance (Summerfield, 2008). Despite the apparent sophistication of laws, policies, services and treatments for mental illness in high-income countries, outcomes for individuals with mental health problems may not actually be any better than in LMIC. Research has failed to conclusively show that outcome for complex mental illnesses (such as psychosis) in high-income countries are superior to outcomes in LMIC (where populations may not had access to medication-based treatments) (Alem et al., 2009; Cohen et al., 2008; Hopper et al., 2007). The lack of academic and political engagement with alternative non-Western perspectives means that Western narratives about mental illness continue to dominate over local understanding (Thimint, 2010), yet we in high-income countries have much to learn about mental health provision, particularly in relation to promoting inclusion of black and ethnic minority members of the population. To conclude, I would like to come

back to the title. Rather than the globalisation of mental illness, perhaps what we should be aiming for is the globalisation of *mental health*. This is an immensely more inclusive aspiration. By promoting global mental health there is the potential for clinicians, academics, service users and policy makers from across the world to work together with a shared purpose. By exchanging knowledge, LMIC can benefit from hard lessons learned in high-income countries, and high-income countries can look afresh at how mental health difficulties are understood and treated. It will be important for clinicians and academics working in high-income countries to critically reflect on their own practice and question the accepted wisdom about mental health provision.

To assist with this knowledge exchange, a new MSc Global Mental Health programme has been launched at the University of Glasgow. Global mental health has been defined as the 'area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide' (Patel & Prince, 2010). The programme seeks to develop leaders in mental health who can design, implement and evaluate sustainable services, policies and treatments to promote mental health in culturally appropriate ways across the globe. Global mental health is an emergent area of study. Momentum is building. Although the challenges are both numerous and complex, the prize is a worthy one. The cost of not acting can be counted in the ever-increasing number of people whose lives are being affected by mental health problems across the globe.



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Uncovering the social world of mental illness. *Annual Review of Psychology*, 51, 571-598.

Mathers, C.D., & Lonergan, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *PLoS Med*, 3, 642.

Nesler, E.J., Barrett, M., Dillwone, R.J., et al. (2002). Neurobiology of depression. *Neuron*, 34, 13-25.

Patel, V. & Prince, M. (2010) Global mental health - A new global health field comes of age. *JAMA*, 303, 1974-1977.

Patel, V. & Sumathipala, A. (2001). International representation in psychiatric literature: Survey of six leading journals. *British Journal of Psychiatry*, 178, 406-409.

Patel, V. & Whinston, M. (1994). The universality of mental disorder revisited: Assumptions, artifacts and

new directions. *British Journal of Psychiatry*, 165, 437-440.

Rehman, D.G., Werner, M.G., Delman, H.M., & Kane, J.M. (2005). Pharmacological treatments for first-episode schizophrenia. *Schizophrenia Bulletin*, 31, 705-722.

Sasubirat, S.P. (2001). Institutional racism in British psychiatry. *Psychiatric Bulletin*, 25, 244-247.

Savenka, S., Paraje, G., Sharan, P., et al. (2006). The 10/90 divide in mental health research: Trends over a 10-year period. *British Journal of Psychiatry*, 188, 81-82.

Sahl, S.M. (2001). Four key neurochemical systems in S.M. Stahl (Ed.) *Psychopharmacology of antidepressants* (pp. 3-13). London: Martin Dunitz.

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *British Medical Journal*, 336, 9792-994.

Thimint, S. (2010). The Medicalization of childhood: Children's mental health in neo-liberal markets cultures. *Transcultural Psychiatry*, 47, 686-706.

Valiant, G.E. (2012). Positive mental health: Is there a cross-cultural definition? *World Psychiatry*, 11, 93-99.

Valenstein, E.S. (1999). *Banning the Brain: The truth about drugs and mental health*. New York: Free Press.

Walters, E. (2010). *Crazy like us: The globalization of the American psyche*. New York: Free Press.

Whitaker, R. (2011). *Antisocial epidemic*. New York: Crown.

World Health Organization (1992). *International statistical classification of disease and related health problems (ICD-10)*. Geneva: WHO.

World Health Organization (2005). *Mental health atlas 2005*. Geneva: WHO.

World Health Organization. (2008). *Mental health Gap Action Programme (mhGAP): Scaling up care for mental, neurological and substance abuse disorders*. Geneva: WHO.

World Health Organization (2010). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialist health settings: Mental Health Gap Action Programme (mhGAP)*. Geneva: WHO.

Wright, W.J. & Midgitt, D.M. (2006). Biological psychiatry: A practice in search of a science. *Behaviour and Social Issues*, 15, 132-151.