Transcultural Psychiatry 2014, Vol. 51(6) 850–874 © The Author(s) 2014
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DOI: 10.1177/1363461514539830 tps.sagepub.com
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transcultural psychiatry

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# Global mental health and its discontents: An inquiry into the making of *global* and *local* scale

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## Abstract

Global Mental Health's (GMH) proposition to "scale up" evidence-based mental health care worldwide has sparked a heated debate among transcultural psychiatrists, anthropologists, and GMH proponents; a debate characterized by the polarization of "global" and "local" approaches to the treatment of mental health problems. This article highlights the institutional infrastructures and underlying conceptual assumptions that are invested in the production of the "global" and the "local" as distinct, and seemingly incommensurable, scales. It traces how the conception of mental health as a "global" problem became possible through the emergence of Global Health, the population health metric DALY, and the rise of evidence-based medicine. GMH also advanced a moral argument to act globally emphasizing the notion of humanity grounded in a shared biology and the universality of human rights. However, despite the frequent criticism of GMH promoting the "bio"-medical model, we argue that novel logics have emerged which may be more important for establishing global applicability than arguments made in the name of "nature": the procedural standardization of *evidence* and the *simplification* of psychiatric expertise. Critical scholars, on the other hand, argue against GMH in the name of the "local"; a trope that underlines specificity, alterity, and resistance against global claims. These critics draw on the notions of "culture," "colonialism," the "social," and "community" to argue that mental health knowledge is locally contingent. Yet, paying attention to the divergent ways in which both sides conceptualize the "social" and "community" may point to productive spaces for an analysis of GMH beyond the "global/local" divide.

## Keywords

Community, global/local dichotomy, global mental health, scale-making

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## Introduction

Over the past 7 years, the movement for Global Mental Health (GMH) has put forward the ambitious goal to address mental health needs globally by calling for efforts to "scale up" evidence-based services around the world, but particularly in low- and middle-income countries (*Lancet* series 2007 and 2011). This call was articulated in response to a set of statistics, presented to epitomize the dramatic "treatment gap" in mental health. These numbers suggest that mental disorders make up 7.4% of the global burden of disease (Whiteford et al., 2013), that 75% of people with severe mental illness in low- and middle-income countries receive no care (Patel & Prince, 2010), and that 25% of the world population will be affected by a mental disorder at one point in their lives (World Health Organization [WHO], 2001). In the face of these numbers, GMH researchers called for concerted action to close the "treatment gap" and lamented the lack of moral outrage about these conditions as a "failure of humanity" (Kleinman, 2009; Patel & Prince, 2010).

In short, the founders of the movement for GMH make a statistical as well as a moral case for the development of a *global* mental health strategy built around the promotion of evidence-based treatments, human rights, mental health policy, and novel models of care delivery, such as "task sharing" (Patel, 2012; Patel et al., 2011). Engaging an assemblage of diverse actors (e.g., NGOs, academic institutions, public and private funders) GMH has engendered a new institutional landscape and significant financial support,[1] but also elicited a range of critical responses to its agenda, often from the ranks of transcultural psychiatrists and anthropologists.

What has been characteristic of ensuing debates is the reflex by these critics to highlight the "local" dimension of mental health experiences and forms of care around the world, particularly in response to the "global" claims articulated by GMH. This polarization between the "global" and the "local" pervades the GMH controversies and we would like to build our review around this dichotomy for several reasons: The critique of Global Mental Health has often borrowed its terms from the critique of other "global" endeavors such as colonialism, imperialism, and capitalism, which conjure up the imagery of harmful expansion, hegemony, extraction, and exploitation. We argue, however, that GMH's claim to globality should be examined on its own terms and within the concrete "global" infrastructure it draws on and contributes to.

We thus investigate GMH as a *project* of globalization in the sense of anthropologist Anna Tsing, who suggests that globality can be examined through the very processes of "scale-making" (2000, p. 330). Such an investigation, she suggests, brings into view the "material and institutional components through which powerful and central sites are constructed, from which convincing claims about units and scales can be made" (p. 330). A focus on infrastructures of knowledge allows us to ask how "local" and "global" spheres are crafted, and by what means and conceptual frames they can be connected. As the historian Markus Krajewski (2006) wrote, without the existence of "Bradshaw's Railway Guide" (and the institutions

that produced it), Jules Verne's famous character Phileas Fogg could not have possibly imagined the "world" as a totality of intersecting connections, let alone successfully circumnavigated it in 80 days. So, we might ask, what enables us today to conceptualize the illnesses of the mind/brain as a global problem that can be translated into concrete programs of action as proposed by GMH?

Reviewing the GMH agenda and debates we are neither interested in reinforcing the global/local conceptual binary, nor in positioning ourselves on either side of the arguments made in their names; rather, we hope to loosen its grip on our thinking by drawing attention to the underlying assumptions that uphold it. Thus, we ask how the current controversies delineate and at times antagonize "global" and "local" spaces and epistemologies as radically different. We argue that, while such incommensurability may be productive for propelling a debate, it may also obscure emergent spaces, concepts, and fields of inquiry between and beyond such divides.[2]

The first part of this paper traces how the current conception of mental health as a "global" target of public health intervention became possible through the formation of Global Health as a field beginning in the 1980s, the introduction of novel health metrics (e.g., Disability Adjusted Life Years [DALYs]), and the rise of evidence-based medicine (EBM) in the early 1990s. We will also discuss how GMH evokes a shared humanity that transcends national and cultural boundaries creating a moral obligation to act on a global scale.

The second part investigates the conceptual vantage points and disciplinary stakes that are invested in the making of the "local" as a source of alterity, resistance, and critique. Since the "global" is often depicted as an abstraction, doing injustice to the specific "local" realities "on the ground," this paper aims to challenge this assumption by highlighting the *concrete* elements constitutive of the "global" while also posing the question of what kind of *abstractions* are invested in the making of the "local" as a space of alterity and resistance.

Discomfort with the local/global binary is certainly not new. Without detailing a genealogy here, it is fair to say that the division between a "global" and a "local" strata of the world emerged concurrently with the concept of globalization, and has since become a self-evident referent. In anthropology, a rich body of scholarship has attempted to think of the "global" and the "local" together productively; Appadurai's global imaginary of "scapes" (1996), Escobar's repatriation of "place" through "glocality" (2001), and Tsing's theorization of the "friction" occurring within gobal/local "zones of awkward engagement" (2005) are just a few examples. With regards to global health projects in particular, Adams and colleagues have suggested to conceive of "the global *in situ* as always itself a local phenomenon" (Adams, Burke, & Whitmarsh, 2013, p. 13).

Most productive for our thinking through GMH has been Stephen Collier and Aihwa Ong's notion of "global assemblages" (Collier, 2006; Collier & Ong, 2005), which they offer as an alternative to the local/global binary. The notion has been a particularly productive lens for this article because it ties together "global forms," commonly viewed as "broadly encompassing, seamless, and mobile", with the idea

of "assemblage," as a "heterogeneous, contingent, unstable, partial, and situated" object (2005, p. 12). "In the space of assemblage," Collier writes, "a global form is simply one among a range of concrete elements" (Collier, 2006, p. 400). Understanding complex projects of modernity as "global assemblages" emphasizes their heterogeneity and perpetual movement and traces their limitations through "technical infrastructures, administrative apparatuses, and value regimes" (Collier & Ong, 2005, p. 11). Guided by this analytical curiosity for modes of thought beyond the global/local divide and by an interest in the *concrete* assemblage GMH presents, this article interrogates the historical, conceptual, and material infrastructures constitutive of GMH's "globality," and examines the arguments and assumptions invested in the making of the "local" by transcultural psychiatrists and anthropologists.

## Scaling up: Making globality in GMH

At first glance, GMH emerged with the publication of the *Lancet* series in 2007, the foundation of the online platform MGMH, and was further defined programmatically through key publications, practice guidelines, and its newly established institutions, training programs, and partnerships that have expanded its profile over the past 7 years.[3] Yet, to understand GMH only within the frame of its own discourses, programs, and institutions as a stand-alone endeavor would miss the importance of those health infrastructures and conceptual configurations that made it possible for GMH to "go global." We will elaborate on four aspects of globality in GMH, namely (a) GMH as part of GH; (b) the emergence of the DALY metric, (c) the role of evidence-based medicine and "reduction" as a strategy to globalize, and (d) the construction of a discourse on global humanity.

### *History: Global mental health as global health*

GMH aligns itself with the wider field of Global Health (Patel, 2014; Patel & Prince, 2010), which began to distinguish itself from International Health in the early 1980s when the World Bank started investing in population health based on the rationale that an investment in health results in the growth of "human capital" (Rees, in press; Rigillo, 2010). As the leading institution in matters of international health, the WHO subsequently saw itself increasingly side-lined by the World Bank's funding power and programmatic direction; a shifting distribution of power that was renegotiated under the new WHO leadership of Gro Harlem Brundtland, who in 1998 embraced the World Bank's new direction towards "Global Health" (Brown, Cueto, & Fee, 2006; Katz, 2008) and created the Commission for Macroeconomics and Health under the leadership of Jeffrey Sachs. This institutional reconfiguration, Rees (in press) argues, brought about a shift in the conception and delivery of international health interventions—from "social" projects in the programmatic tradition of Alma Ata, to global health interventions as projects conceptualizing health in biological and economic terms.

In addition, GH's institutional assemblage and target of intervention moved beyond the mechanisms and populations of the nation state (Lakoff, 2010), increasingly focusing on populations constituted by diseases which do not map onto national boundaries. Such interventions required a new "stateless assemblage" (Rees, in press), involving diversified actors such as NGOs, philanthropic organizations, and research institutions to collaboratively undertake projects through novel models, such as public–private partnerships. The shift from "international" to "global" health was therefore not simply nominal; it reflected a concrete organizational reconfiguration of the institutional landscape involved in population health, as well as their funding and research mechanisms. Most importantly, GH accomplished an entirely new way of conceptualizing health and illness on a global scale by developing the concepts and techniques to quantify what is now known as the "Global Burden of Disease" (GBD; Murray & Lopez, 1996b, 1997) as measured through the population health metric DALY.

## *Measuring health in the currency of "time" (DALYs)*

The emergence of novel health metrics like the Disability Adjusted Life Years (DALYs) had an enormous impact on the perception of mental health as a "global" problem. This metric was developed by the Harvard School of Public Health for the World Bank's influential *World Development Report: Investing in Health* (1993), and later became the backbone of the "Global Burden of Disease" (GBD) study (Murray & Lopez, 1996b). DALYs established a style of reasoning that expressed the health status of a population in the unit of "time" by quantifying not only mortality ("years of life lost," YLL), but also for the first time, the effects of disability ("years lived with disability," YLD) in one summary measure. As such, the DALYs have become the "common international language" that William Foege hoped for in his foreword of the first GBD study (Murray & Lopez, 1996b, p. xxvi); a shared mode of conceptualizing health disparities, expressed in the currency of one DALY signifying "one year of healthy life" lost. DALYs are also cost-effectiveness tools designed to guide resource allocation, because "years of healthy life" are not only lost to the individual human, or to a population, they are also productive years lost to the national and global economy.

For mental and neurological disorders, the new measure created an entirely new level of visibility as unexpectedly large contributors to the overall GBD, with estimates ranging from 10.5% to 15.4%.[4] With their highly disabling effect, yet low mortality, mental illnesses were rather suddenly elevated to one of the most pressing fields of intervention. Major unipolar depression for example, was (and still is) predicted to become the leading cause of disability worldwide by 2020 (Murray & Lopez, 1996b). Additionally, since the GBD quantifies the *relative* burden of diseases, their gravity only became perceptible in direct *comparison* to other conditions. Thus, when mental disorders began to be assessed in DALYs they became comparable, not only geographically, but also across diseases placing them in the same numerical rank as cancers and exceeding HIV/AIDS and tuberculosis. It is

through this framework that mental disorders became conceivable as not only a "global" problem, but also as an enormous one; a new and abrupt visibility of mental health which, according to Becker and Kleinman (2013), "catalyzed a transformative narrative for global mental health" (p. 66).[5]

The now firmly established GBD project—its institutions, metrics, online databases, and sophisticated forms of visualization[6]—provide a conceptual and material infrastructure for "globality"; a site which produces not only knowledge about the global health status, but also the very "global" scale it sets out to describe. Its specific "globality" remains stable despite the continuously changing operations invested in the calculation of the GBD itself. Such changes to the calculation had a particularly strong effect on the disease burden of mental illnesses: for 2005 (based on the 1990 data set) "neuropsychiatric disorders" accounted for 13.5% of the total GBD (Prince et al., 2007) while the 2010 data showed an overall contribution of only 7.5% (Whiteford et al., 2013, p. 1577). What led to such a dramatic change was not an improvement in the world's mental health status, but the operations and procedures constitutive of its calculation, namely, a shift from incidence- to prevalence-based calculation of YLDs, and the lack of age weighting and discounting in the 2010 data set (Whiteford et al., 2013). The "global" dimension of projects like GMH thus relies first and foremost on a *statistical* embrace of the globe and its health problems; resting on the confidence that the world is in principle standardizable and that comparable units can be found on a global scale; an assumption, which has been challenged for mental disorders (Brhlikova, Pollock, & Manners, 2011).

While the GBD study was able to render mental health a "global" *problem*, it required another conceptual infrastructure to design *solutions* that aspire to a similar "global" reach. The rise of evidence-based-medicine (EBM) in the early 1990s (Guyatt et al., 1995; Sackett & Rosenberg, 1995) provided precisely such a conceptual infrastructure that set out to standardize and consolidate diverse medical knowledges on a large scale.

## *The role of evidence-based medicine in GMH*

Evidence-based medicine is commonly associated with the promise to simultaneously rationalize and standardize medical practice through tools and procedures that allow for the ranking of knowledge into different degrees of "evidence" (Timmermans & Berg, 2003; Weisz, 2005). Such rankings attribute the highest form of "evidence" to meta-analyses of randomized controlled trials (RCTs), making the RCT research design itself the "gold standard" of medical knowledge production over any other form of observational knowledge (Timmermans & Berg, 2003). Condensing evidence even further, EBM made prominent the medical practice guideline as a tool to translate evidence into concrete recommendations for clinical practice. First emerging in the late 1980s, practice guidelines have grown into a vast global production (Weisz et al., 2007), including their own institutional

landscapes and meta-tools standardizing and regulating them (e.g., NICE [UK], NGC [US]).

These modes of evidence-based knowledge production have also been foundational for GMH. The WHO practice guideline *mhgap* (2008b), for example, outlined the treatment of six mental and neurological conditions in low-resource settings based on such meta-analyses of evidence. Furthermore, GMH focuses on the publication of systematic reviews (Elsabbagh et al., 2012; Lund et al., 2011; Patel et al., 2007), RCTs (Patel & Prince, 2010), and uses standardized consensus techniques, such as the Delphi panel (Collins et al., 2011; Ferri et al., 2006) to facilitate processes of "global" agenda-setting.

The selective validation of highly formalized forms of knowledge (especially RCTs) and the potentially increasing uniformity in the practice of medicine around the globe have frequently been criticized (Lambert, 2006). However, a more nuanced picture as to what exactly EBM globalizes has emerged from Knaapen's (2013) recent empirical study on EBM guideline production, in which she found that *procedural* standardization had become more important to guideline production than the standardization of their content. As such, guidelines helped to "legitimize diversity" and to "accept pragmatic judgment and localized routines" by formalizing diverse types of knowledge (Knaapen, 2013, p. xviii).

## Emerging forms of globality: Procedural objectivity, modes of integration and reduction

For GMH in particular there is a larger argument to be made about the role of EBM and standardization that intersects with the history of psychiatry's claim to universality—namely its struggle to ground mental health in biology and the *bio*-medical model. Revisiting this historical tension vis-à-vis GMH's current program of action brings into view conceptual shifts and ruptures in the way universality is claimed. Recognizing these discontinuities, we argue, may productively unsettle the assumption that GMH predominantly expands the biological model.

A biological imaginary of mental illness has been somewhat difficult to mobilize for GMH due to the contestation of psychiatry's foundational disease categories. Historically, the first two manuals of the American Psychiatric Association, the DSM-I (1952) and DSM-II (1968) followed a psychodynamic paradigm, conceiving symptoms as a reflection of psychological dynamics and reactions to life problems. The emergence of DSM-III (1980) radically changed this approach, from such etiologically defined entities to standardized symptom-based lists. Although psychiatric diagnostic continued to rely on patients' narratives rather than biomarkers, this form of classification allowed for the standardization of practice between clinicians, insurance companies, the pharmaceutical industry, and government institutions like the FDA, and turned mental illnesses and their treatment into stable and increasingly mobile knowledge objects (Young, 1997). While such procedural stability was reached, the contestation of the descriptive nosology did not subside. In fact, in recent years the critiques of psychiatry's knowledge base have increased,

leading some to speak of a general crisis of the discipline (Bracken et al., 2012; Kleinman, 2012). Such sustained criticism arose from the DSM-5's expansion of diagnostic criteria, the lowering of diagnostic thresholds, the question of its cross-cultural validity, and the absence of biological markers despite increased but largely unsuccessful investments in the neurosciences in recent years (Singh & Rose, 2009). Such discontent culminated in 2013 when the DSM was officially abandoned as a basis for research funded by the National Institute for Mental Health (NIMH) in favor of the Research Domain Criteria (RDoC), a new classificatory system working from biology towards symptoms, rather than the other way around (Insel et al., 2010).

Against the backdrop of these conceptual tectonic shifts, the movement for GMH seems surprisingly unaffected by the sense of uncertainty within psychiatry. Vikram Patel describes the current classificatory system as "inevitably arbitrary" but "the only reliable method currently available" (2013, p. S26). Its uncertain biological underpinning, however, has not posed a problem to the project of GMH. The question of biology has merely been placed in temporal suspension—a "not yet" situation, in which biology is not directly decipherable, but readable through its secondary expression, its "phenotype." Patel writes,

> Put simply, in order to identify the biological basis of a sickness (the "disease"), one has to first define the phenotype (the "illness"). Without the latter, the former will always be elusive. So, in rejecting the phenomenological approach adopted in psychiatric diagnosis because there is no biological correlate, the critics in effect reject any possibility of ever identifying one!" (Patel, 2014, p. 5)

While the assumption of biologically grounded disease entities may help facilitate the global claims of GMH, the lack of "bio-markers" and the uncertainty of psychiatry's knowledge base have not deterred the movement from insisting that mental health care can be "scaled up." Yet, contrary to scholars who see GMH primarily as an expansion of the biomedical model of psychiatry (Campbell & Burgess, 2012; Fernando, 2011; Summerfield, 2012), we suggest that it might not be GMH's claim to biology or *bio*-medicine that establishes universality, but rather its commitment to a different kind of objectivity engendered by procedural logic and new technical conventions in the making of "evidence."[7] Such evidence no longer necessarily grounds in biology; it is increasingly tied to particular research *designs*. The RCT design, for example, has since the early 2000s expanded beyond the realm of strictly bio-medical research (Jatteau, 2013; L'Horty & Petit, 2011), and is now used to evaluate psychosocial interventions (Patel et al., 2011) or poverty reduction programs (J-Pal Poverty Action Lab; http://www.povertyactionlab.org/). In short, "evidence" on efficacy, impact, or health outcomes has been increasingly divorced from notions of "biology," or in the older trope, "nature."

The trend towards favoring RCTs in GH has been criticized as costly, insensitive to context, and not necessarily producing better outcomes (Adams, 2013; Farmer,

Murray, & Hedt-Gauthier, 2013), in addition to creating new obstacles to research in low-resource settings (Hickling, Gibson, & Hutchinson, 2013). From the perspective of globalization as a *project*, however, such standardized research protocols lead to the synchronization of conceptual frameworks, research designs, and vocabularies across different institutions, actors and stakeholders generating an epistemological space that can be called "global." Since the psychiatric nosology is entrenched in those larger infrastructures of standardization—the GBD study, guidelines and research protocols—its conceptual continuity across time and space is facilitated. It is thus not surprising that the current priority of GMH is not a push for grounding mental illnesses in the brain, but its aspiration for further *integration* into other global health domains and their conceptual infrastructures. For example, GMH has made itself relevant to the development agenda linking mental health to poverty (Lund et al., 2011), to the platform of primary care (Patel, 2013), to maternal health (Rahman, Surkan, Cayetano, Rwagatare, & Dickson, 2013) and to noncommunicable diseases (Ngo et al., 2013). Similarly, the WHO's Mental Health Action Plan 2013–2020 promotes the "integration of mental health into general healthcare settings and through maternal, sexual, reproductive and child health, HIV/AIDS and chronic and non-communicable disease programs" (WHO, 2013, p. 8).

We might even go one step further by asking whether GMH is deliberately creating *discontinuity* with psychiatry's institutional and conceptual infrastructure. As Behague has observed, the inaugural *Lancet* series was able to articulate its call for action with almost no mention of psychiatry (Béhague, 2008), and Vikram Patel stresses on several occasions, including this current issue, that GMH "is firmly rooted within the discipline of global health, not psychiatry" emphasizing that it rather "espouses its values of multidisciplinary approaches" (Patel, 2014, p. 8). In other words, although GMH is frequently interpreted as a global expansion of psychiatry, it has in fact persistently displayed ambivalence towards the discipline, which is seen as overly specialized and reliant on experts, and ultimately of limited use in low-resource settings where trained human resources are sparse and psychiatry as an institution has not always existed.

One might even say that GMH has decidedly black-boxed academic psychiatry's central questions such as exact disease causation and classification, focusing instead on the language of providing "access to care," for example, interventions proven to "work," based on a logic of "evidence." This approach is consistent with Vikram Patel's earlier career during which he worked towards increasing "access to care" and devising ways to simplify psychiatric knowledge—most famously through his field manual *Where There Is No Psychiatrist* (Patel, 2003). What emerges from this is something rather new: The global *expansion* that GMH proposes is operationalized through modes of knowledge *reduction*. This is further exemplified by interventions such as "task sharing" (Patel et al., 2010); a transformation of psychiatric expertise into units of knowledge, practice, and material elements that can be transferred to nonexperts anywhere in the world. *Global knowledge* here emerges through simplification and reduction.

By juxtaposing psychiatry's disciplinary struggle with universal claims with the strategies GMH pursues we sought to highlight how the "global assemblage" GMH presents has subtly shifted its vocabulary and discursive rules (nature vs. evidence), its actors (multidisciplinary), and modes of knowledge production (EBM) in such a way that it generates a different kind of universality, now formulated as the question of global applicability of mental health interventions.

## Building a global humanity

GMH has, furthermore, built its claims to globality on the construction of an all-encompassing humanity that transcends national and cultural boundaries, and thereby provides a *moral imperative* to act on a global scale. Two argumentative strands have been central here: (a) that people suffer from mental illness in similar ways around the globe, and (b) that all humans are protected by universal human rights.

*Global suffering.* GH more generally has situated its project precisely on the plane of humanity (rather than society), grounding the human first and foremost in the recognition of a shared biology (Rees, in press). For Global *Mental* Health, as we have discussed, such biological claims are harder to substantiate in the present, yet the assumption of shared biology and the temporal projection of future discoveries have allowed GMH to similarly mobilize mental suffering as a "global" imaginary (without necessarily drawing on the language of biology directly). At the ASI conference in 2012, Patel for example said:

> This is a fundamental humanitarian crisis. A failure of humanity. But, there is no global outrage about these conditions. And the reason for this is that some of us perpetuate the myth that mental illness doesn't exist.... Every aspect of the mental health experience—every aspect can be identified in all parts of the world. Let's not distract from the moral imperative to tend to this suffering. Do not pretend that mental illness is an invention of America. (ASI conference verbatim field notes by Bemme, July 7, 2012)

What becomes clear in this citation is that localizing and particularizing perspectives on mental illness pose a challenge to the very idea of humanity that GMH promotes; a humanity that conceptualizes humans as equal in suffering.

*Rights-based humanity.* The notion of a shared humanity emerges from the discourse of human rights, which in GMH clusters around two themes, (a) the denunciation of stigmatization and abuses, and (b) an emphasis on "health as a human right." The first argument focuses on the concrete forms of maltreatment related to mental illness, such as physical abuses, chaining, and confinement (Colucci, 2013), as well as forms of social exclusion, which Kleinman has described as "social death" (2009). The image of an impoverished child chained to a tree used in the agenda

setting *Nature* article "Grand Challenges in Global Mental Health" (Collins et al., 2011) symbolizes this type of human rights argument. The impetus here is similar to Western mental health movements that protest inhumane treatment and discrimination against people suffering from a mental illness. However, as Jenkins, Baingana, Ahmad, McDaid, and Atun have argued (2011), relatively little overlap exists between the human rights activism in rich and poor countries; while the former commonly confront large psychiatric institutions, such structures are absent in poorer countries where the lack of "access to care" itself is framed as a human rights violation.

Thus, it appears that it is this latter argument that GMH has "scaled up" by denouncing the "absence of care" as a *global* human rights problem, which, again, is supported by the statistical globality produced by the "treatment gap." The basic human right to access mental health care, they argue, is contravened when "75% of those identified with serious anxiety, mood, impulse control or substance use disorder sin the World Mental Health surveys in LMICs received no care at all" (Patel & Prince, 2010, p. 1976). This line of argumentation dovetails with the discussions about a "right to health" led within the UN institutions,[8] which was reinvigorated by prominent GH activists such as Paul Farmer. He and others argued that the current human rights framework focusing mostly on civil and political rights should be balanced with an emphasis on socioeconomic rights, such as access to medical care (Farmer, 2003; Farmer & Gastineau, 2002; London, 2008). GMH has crafted similar arguments to build a "moral case" for its global advocacy campaign, explicitly modeling its efforts on the human rights arguments leading to the successful mobilization of care for HIV/AIDS worldwide (Patel, Saraceno, & Kleinman, 2006). In this kind of arguments, humanity (or famously its "failure" [Kleinman, 2009]) emerges as a moral obligation; an all-encompassing responsibility towards the universality of human suffering.

To sum up, in the first part of this article, we emphasized how GMH's problematization of mental health as a "global" *problem* is tied up with the field of Global Health and its new population measures (DALYs), while the concurrently emerging standards and research designs of EBM engender the imaginary of "evidence" as a proxy for "global" *solutions*. Furthermore, we showed how GMH evokes a notion of humanity that grounds in the assumption of a shared biology and the discourse on human rights. However, the coherence created by the seamless serration of discourses, standards, and procedural conventions that make up the "global" has also been raised as a problem. *Lancet* editor Richard Horton (2014)—who was also chiefly involved in launching GMH's foundational series—cautioned that the larger field of GH has "built an echo chamber for debate that is hermetically sealed from the political reality that faces billions of people worldwide" (p. 111), a reality, which he describes as "social chaos" characterized by armed conflict, internal displacement, and fragility (Horton, 2014). Resounding here is a discomfort with the particular "globality" and internal coherence GH has given rise to; a critique that contrasts the "global" forms of GH with the seemingly unmediated "local" realities "on the ground," which are typically

said to be "messy" (Adams et al., 2013; Mills, 2014), "complex," and "fine grained" (Bartlett, Garriott, & Raikhel, in press) and "incalculable" (Adams et al., 2013). It is those critical positions that the second part of the paper will tend to.

## Scaling down: Making the "local" a ground for critiques of GMH

The critiques of GMH have been articulated both from within psychiatry, but also from grounds that are presumed to lie outside its spatial and epistemological reach. The notion of the "local," which is often drawn on in this context by transcultural psychiatrists and anthropologists encompasses more than a simple spatial marker; as a label it often designates exactly that which is not commensurate with "global" knowledges, and therefore conveys a sense of sheer differential. Such *provincializing* arguments are the most common critique directed against GMH. Yet, not unlike claims in the name of "globality," the construction of a particularly "local" claim requires a set of disciplinary assumptions and conceptual frameworks to turn "locality" into a scale in its own right. Or, as Anna Tsing (2000) might say, scale-making goes both ways. Perhaps unsurprisingly, the construction of the "local" as a site "from which convincing claims about units and scales can be made" (Tsing, 2000, p. 330) operates through a set of universals as well.

In this second section we review the critiques of GMH through an analysis of four frequently used analytical scripts invested into laying claims to "local" perspectives on mental health and illness based on: (a) "culture" in its capacity to articulate alterity; (b) "colonialism/imperialism" as a predefined relationship between global/local spheres; and the multiple ways in which (c) the "social", and (d) "community" are mobilized for or against GMH.

### *Culture*

The notion of "culture" has been central to the work of transcultural psychiatry and anthropology alike, yet it has also undergone a long history of problematization and reconceptualization (Gupta & Ferguson, 1992; Kirmayer, 2006), including calls for its abandonment as an analytic in anthropology (Collier, 2006; Rees, 2010).

"Culture" has also played a particularly important role within the conceptual infrastructure of international health. Within the early WHO mental health programs, "culture" mapped onto nation states, making it one of the institution's primary tasks to facilitate collaboration between nations, and to provide standardized tools to engage in "cross-cultural" research. The International Schizophrenia Studies (IPPS, Determinants of Outcome of Severe Mental Disorders [DOSMED], International Study of Schizophrenia [ISOS]) are a striking example of this kind. What started out in 1968 as an effort to reduce the impact of "culture" (i.e., differently trained researchers and varying nomenclatures of schizophrenia) through standardized diagnostic tools,[9] led to the surprising finding that—once variation in

the disease entity and in its observers was controlled for—the course and outcome of schizophrenia was more favorable in "developing" compared to "developed" countries (WHO, 1975). This "outcome paradox" (Padma, 2014) was attributed to the influence of "culture," and while the differential was repeatedly reproduced over the next 25 years (Hopper & Wanderling, 2000; Leff, Sartorius, Jablensky, Korten, & Ernberg, 1992; Sartorius, Gulbinat, Harrison, Laska, & Siegel, 1996), it was also continuously challenged (Cohen, Patel, Thara, & Gureje, 2008; Edgerton & Cohen, 1994; Patel, Cohen, Thara, & Gureje, 2006).

Critics, among them some of today's leading GMH researchers, criticized not only the design and potential bias of the studies, but especially the use of "culture," which according to these scholars appeared as a "synonym for unexplained variance" (Edgerton & Cohen, 1994, p. 228), a "gloss for the 'environment'" (p. 230), or a factor that remained essentially black-boxed (Cohen et al., 2008). While we cannot give a more detailed account of these debates here, they serve as an important backdrop to the current controversies surrounding GMH. Not only do they involve some of the same actors, but their juxtaposition shows how "culture" as a heuristic has mutated from a discrete entity mapping onto nation states, to a factor influencing the course of schizophrenia, to arrive at an articulation of "culture" as a ground for epistemological alterity from which Western psychiatry can be questioned altogether.

In the debates surrounding GMH, "culture" is predominantly articulated in its adjective form—"cultural"—attached to entities such as "communities," "knowledge," and "practices." Not necessarily spatially bound, it nonetheless points towards a coherence that engenders new boundaries between "cultural" entities. One line of critical argumentation against GMH hence emphasizes cultural boundaries in order to provincialize Western psychiatry, bringing it into view as a culturally and historically contingent institution itself, and suggesting for it to remain within its own local realm of cultural relevance (Fernando, 2014; Mills, 2014; Summerfield, 2002). The DSM and International Classification of Disease (ICD) in this view appear simply as one set of folk knowledge among many (Summerfield, 2002, 2012). Summerfield, for example, argues that GMH researchers assume "that mental disorder can be seen as essentially outside society and culture." Instead he calls on psychiatry's "obligation to examine the limits of its knowledge and epistemological traditions" (Summerfield, 2012, p. 5).

However, "cultural" claims are not necessarily entirely incommensurate with GMH's mode of knowledge production. Kirmayer and Swartz (2013), for example, have similarly argued against the assumption of "culture-free universal syndromes" (p. 46), but they suggest the integration of a "pluralistic view of knowledge" into the GMH agenda as part of the empirical paradigm. They urge GMH to "work with models that have emerged from local practices," which should be included in EBM outcome measures (Kirmayer & Swartz, 2013, p. 57). Kirmayer (2012) also stresses that the current GMH agenda does not do justice to cultural diversity as the "paucity of evidence on cultural minorities" may lead to interventions informed by evidence based on the majority population, making them potentially irrelevant

to specific cultural groups. Fernando, although arguing strongly against GMH, strikes a similar chord by envisioning psychiatry as "flexible, culturally sensitive and capable of being adapted for local conditions and cultures in different parts of the world" (Fernando, 2014, p. 142). Such relativizing arguments articulated through "cultural" difference, construct the "local" as a sphere of singularity and incommensurability at odds with the universalism of GMH. As such, critics have presented the "local" as the necessary *starting* point of research and interventions (Adams et al., 2013; Summerfield, 2012), rather than the endpoint and implementation stage of a "global" project. Adams et al. (2013), for instance, write,

> The tyranny of the global is mapped out here as a problem of political investments in global scale interventions, and an unwillingness (or inability) to accommodate and adjust to specific local circumstances that might actually improve outcomes. (p. 6)

Health outcomes are at the heart of both "global" and "local" projects, however, what seems to differ between these two visions are their conceptions of the human. While GMH undertakes its project in the name of a shared "biological" and "moral" humanity, anthropology and transcultural psychiatry are committed to a conception of the human as predominantly "cultural" and "locally" situated beings.

## *Colonialism*

A further polarization between "global" and "local" spheres becomes apparent when their relationship is defined through the historical model of colonialism or imperialism. This critique describes psychiatric knowledge as imposed by GMH in a hegemonic manner reinforcing a new type of domination by the "global North" over the "global South"; a geo-political divide within which "local" and "global" designations serve to highlight spheres of unevenly distributed power, often negotiated within the realm of knowledge, rather than territory.

The question "Whose knowledge counts?" has thus come to epitomize this debate (Fernando, 2014; Mills, 2014; Summerfield, 2008, 2012). Summerfield (2013) speaks of GMH as "medical imperialism" criticizing that GMH exports the Western biomedical model which thereby renders local knowledge invisible, but also that the evidence base for most psychiatric treatments is weak and contested in the global North. GMH, he argues, reproduces the dynamics of the colonial era by continuing to speak for the people it claims to serve (Summerfield, 2012, 2013). Tracing psychiatry's colonial history back concretely, Fernando (2014) shows how the mental health care services implemented by governments during the colonial period in Asia, Africa, and America led to the suppression and underdevelopment of indigenous systems of mental health and healing. The current "global" movement for mental health, he argues, sustains neocolonial forms of oppression because it is dominated by powerful agencies such as the WHO, Big Pharma, and North American funders, all of which promote solely Western

psychiatric knowledge (Fernando, 2014). Elaborating on Rose's (2006) argument of the expanding scope of psychiatric diagnosis, Mills argues that psychiatric assumptions "creep" across geographical borders through the use of the DSM and ICD in the Global South and the mobilization of GMH and WHO policies, which can be understood as a form of colonial discourse (Mills, 2014).

## *Multiplicities of the "social"*

A similar concern with the political dimensions of GH informs critiques articulated in the name of the "social." Adams (2013), for example, argues that the increased reliance on EBM research protocols in GH seems to "eliminate the need for data collection about complex social realities" (p. 55). Such perceived disregard of the "social" dimension of health, Rees (in press) argues, is not an oversight by GH, but integral to its very project. He argues that contrary to its predecessor International Health, Global Health strives to build an inclusive humanity grounded in "biology" rather than "society" and the "social." GH's "stateless assemblage" of institutions and public–private funding partnerships decidedly does not engage with the political stakes and social projects commonly seen as a responsibility of the state (Rees, in press).[10]

As we have outlined above, GMH inhabits a slightly different space in that regard. It departs from GH in that the "social" remains an inextricable dimension of mental health care, not only because the current psychiatric paradigm conceptualizes the human as a "biopsychosocial" being (Patel, Minas, Cohen, & Prince, 2014) best treated in the context of "community" health care (WHO, 2013), but also because mental health care relies largely on interpersonal interactions rather than technological solutions typical for GH (e.g., vaccines, diagnostic tools). However, we suggest that despite its own emphasis on social aspects, GMH emulates the larger GH strategy in that it does not conceptualize health interventions as a project of society building. Instead, GMH operationalizes the "social" in specific ways, which critics have perceived as narrow.

The broader social framework that scholars suggest has been missing from GMH is that of the Social Determinants of Health (SDH), and with it a concern for the socioeconomic and political factors involved in the causation of disease (Das & Rao, 2012; Pedersen, 2009). Most famously articulated by Michael Marmot (2005; WHO, 2008a), the SDH have also been found to be relevant for mental health and its distribution along a social gradient (Fisher & Baum, 2010; WHO, 2008a). Pedersen (2009) has thus called for a stronger incorporation of the SDH into GMH in order to balance the biomedical model and to realize a research paradigm informed by ethics, social justice and equity. Other critics have argued that GMH foregrounds interventions centered on the individual, rather than on the person's socioeconomic, structural environment and its impact on the disease process. Campbell and Burgess (2012) write that by focusing on the individual, GMH draws "attention away from the need to create social contexts that enable and support peoples' opportunities for improved health" (p. 381). It is precisely this

kind of society building and improvement, which, according to Rees (in press), GH as a "global" project is deliberately not pursuing.

However, this does not mean a complete disregard of the "social," but a difference in its conceptualization on both sides of the debate. Patel, for example, readily agrees that "virtually all health conditions are influenced by social determinants," even though he sees them as "ultimately mediated through biological pathways" (Patel, 2014, p. 6). It is thus not a question of "either/or" but a preference for a specific directionality in which interventions are imaged to work best. In this imaginary successfully intervening on the disease will *result* in better social relations, social status, and ultimately a better society. For example, GMH does inquire heavily into "social" problems like poverty, by asking how access to mental health care may improve people's economic situation (Lund et al., 2011; Patel, 2014). However, the investigation of the reverse mechanism—how poverty reduction may alleviate mental health problems, comes up against the difficulty of producing formalized evidence (e.g., RCTs) and remains therefore inconclusive (Lund et al., 2011). Another way in which GMH mobilizes the "social" is through "social interventions" which work "alongside biomedical interventions" (Patel, 2014, p. 6); here the "social" refers to concrete treatment strategies within the paradigm of "community" care. Yet, it is this notion of "community" which emerges as similarly multiple as the "social," and we would like to conclude this review in its realm—for one, because "community" is often presented to be the epitome of the "local," but also because the fluidity of its boundaries is extraordinarily productive and may therefore point to space beyond the "global"/"local" dichotomy.

## Community

The notion of "community" is ubiquitous in GMH, transcultural psychiatry, and anthropology alike, yet the way it is utilized differs significantly.

In GMH and WHO publications concerning mental health, "community" is first and foremost a model of care delivery, which "implies the development of a wide range of services within local settings" providing "good care and the empowerment of people with mental and behavioural disorders" (WHO, 2001, p. xvi). Historically, this idea of "community care" delimits itself from the asylum, a model of care based on social control and segregation; its de-institutionalization beginning in the 1960s, alongside the emergence of community-based mental health care infrastructures was motivated by both, the rights and well-being of the patient but also by the desire to reduce costs (Warner, 1989).

Critics of GMH, on the other hand, may be wary of this ambivalent history when they question whether GMH emphasizes "community" as an "argument of economic efficiency," instead of "the right to social participation in the community" (Das & Rao, 2012, p. 387). Campbell and Burgess (2012) have similarly argued for "a broader conceptualization of 'community'" in GMH, which does not view lay health workers as "handmaidens of biomedical expertise" (p. 381). What becomes clear in these and similar arguments (Fernando, 2014; Kirmayer,

2004) is that for these scholars "community" entails the idea of an organic socio-cultural collective in a Durkheimian sense; a cohesive social entity endowed with history and culture able to transcend the individual, rather than a site of care delivery. Yet, this seemingly clear-cut distinction should not suggest that the notion of "community" is necessarily well-defined. On the contrary, reference to "community" is commonly made in a self-evident manner, with little indication as to what exactly it encompasses—a village, a neighborhood, family members, a group of peers, a place of care that is not a hospital— all of which can designate "community."

From the perspective of an inquiry into the modalities of "scale-making," the notion of "community" is compelling because it is able to transgress the "local/global" antagonism so characteristic for this debate. "Community", we argue, while often an ill-defined entity is highly versatile and productive in GMH precisely because it can take *any* scale. For example, a wholly different notion of "global" communities is expressed in Jeffrey Sachs's remarks at the press conference of the GMH launch in 2007, which give a vivid sense of the novel "globality" GH engenders. In his statement, he welcomed the "mental health community" to GH with the following words:

> You are joining an esteemed tradition now. The HIV community got organized about a decade ago, it has had a big effect . . . Malaria, finally, is getting organized for a breakthrough . . . the TB community has presented several years ago a quite remarkable global TB plan . . . the Ob-gyn community has demonstrated that women can be saved through simple measures at the local level . . . the cardio-vascular and diabetes community are showing what can be done with lifestyles . . . so, all of these, what can be called epistemic communities, are the communities of experts, that say "get on with it." (Sachs, 2007)

Such global "epistemic communities" neither follow the boundaries of locally situated collectives, nor the political geography of nation states that pursue "society" building through health interventions. The boundaries, differences, and collectives imagined here solely depend on the affiliation of a diverse group of actors rallying around the solution of a particular health problem.

## Conclusion

By way of concluding, we would like to offer a series of questions that move the discussion of GMH beyond the global/local dichotomy, which we show to be an outcome of various disciplinary and institutional practices of "scale-making" (Tsing, 2000) rather than a self-evident, ontological reality. By pointing to two conceptual spaces and heuristic devices beyond the "global/local" divide, we explore the possibility of different kinds of "scales," and with it the potential of a different kind of analysis/critique. First, Collier and Ong's analytic of "global assemblages" (Collier, 2006; Collier & Ong, 2005) proves helpful in its emphasis of

heterogeneity and historicity and informs this article in that it directs our attention towards the emergence, composition, and modalities of knowledge production of GMH. The second angle from which the "global/local" template is productively unsettled emerges from *within* the debates. The most salient example is the concept of "community" which has the ability to articulate projects of changing scale, variously reinforcing "local" specificity, or expanding to capture "global" epistemic communities completely detached from spatial markers in GMH. What we might ask then is: what can be mobilized *in the name* of "community" and *through* its very formation as an entity?

As Rose (1996) has argued for "advanced liberal democracies," the notion of "community" has begun to increasingly replace the historical configuration of "the social" as the prime target of government.[11] "Community," in Rose's account, has become an "*imagined territory*" (original emphasis, p. 331) that is on the one hand fragmented, but has on the other hand also given rise to "images of plural affinities" (Rose, 1996, p. 353); i.e., the coexistence of overlapping stakes through multiple allegiances with multiple communities. We find this last aspect particularly relevant for understanding GMH as a project that emphasizes multidisciplinarity (Patel, 2014). From our observation, GMH has a remarkable degree of reflexivity built into its project, demonstrated by its leaders' abilities to easily change conceptual frameworks depending on their "plural affinities" with different communities.[12] Investigating *what exactly* enables GMH to work through shifting and plural allegiances, conceptual frameworks, and with a great range of actors across the globe, may offer an alternative analytical lens to the imaginary of GMH as a hegemonic and colonial project eradicating "local" conceptions of mental health.

## Funding

Doerte Bemme: Fonds de recherche sur la société et la culture (FQRSC) – Doctoral Award; Global Health Research-Capacity Strengthening Program (GHR-CAPS) – Doctoral Award; Nicole D'souza: Fonds de recherché du Quebec-santé (FRSQ) – Doctoral Award; Global Health Research-Capacity Strengthening Program (GHR-CAPS) – Doctoral Award.

## Acknowledgements

We would like to thank Fiona Gedeon Achi, Julianne Yip, Kristin Flemons, Raad Fadaak, Emilio Dirlikov, and Loes Knaapen for their comments on an early draft of this paper. Our special thanks go to Stephanie Alexander, whose thoughtful input improved the manuscript at every stage of the process. The workshop series on the "neoliberal social" and the "biological social" organized by Tobias Rees in 2014 at McGill contributed to the development of these ideas. We would also like to thank our three anonymous reviewers for their very helpful feedback.

## Notes

1. Grand Challenges in Global Mental Health Canada, NIMH, Wellcome Trust, Joint Global Health Trial Scheme (UK Department for International Development, Medical Research Council, Wellcome Trust).

2. This article is based on an analysis of the current GMH core debates, as well as on participant observation during a 7-day series of meetings that included the 2012 Advanced Study Institute summer school, workshop, and conference at McGill University on "Global Mental Health: Bridging the Perspectives of Cultural Psychiatry and Public Health." An earlier summary of the debates during these events was published as a blog post on *Somatosphere* (Bemme & D'souza, 2012).
3. The movement for GMH has since made strides in communicating its aims through a series of special issues (Harvard series, 2012; *Lancet* series, 2011; *PloS* series, 2013), its website (http://www.globalmentalhealth.org/), and the emergence of new institutes in the USA (Harvard's Department for Global Health and Social Medicine *Program in Global Mental Health and Social Change*; NIMH *Office for Research on Disparities and Global Mental Health*), London (*The Centre for Global Mental Health*, a collaboration between the London School for Hygiene and Tropical Medicine (LSHT) and King's College partners), Canada (University of Toronto, Department of Psychiatry *Global Mental Health Affairs*), South Africa (*Department of Psychiatry and Mental Health*, University of Cape Town), and Australia (Melbourne School of Population and Global Health, Centre for International Mental Health).
4. The 15.4% GBD estimate is one of the most frequently circulated numbers in early publications for the total contribution of neuropsychiatric conditions to the GBD in 1990. This number, however, is sometimes noted to only refer to "established market economies" and to include suicide. Although these publications reference the original GBD study (Murray & Lopez, 1996b), we were, with significant effort, not able to find this number in the original publication.
5. This narrative, was first formulated by Harvard's medical anthropologists in the *World Mental Health Report* (Desjarlais, Eisenberg, Good, & Kleinman, 1995), which formulated a first call for action.
6. See http://www.healthmetricsandevaluation.org/gbd
7. Cambrosio, Keating, Schlich, and Weisz (2009) have coined the term "regulatory objectivity" to define a "new form of objectivity in biomedicine that generates conventions and norms through concerted programs of action based on the use of a variety of systems for the collective production of evidence" (p. 654).
8. The "right to health" is part of Article 25 of the Universal Declaration of Human Right (1948, Art. 25) and was further developed through a number of UN treaties and conventions (ICESCR [1966], CEDAW [1979], CRC [1989]. In 2000, the additional "General Comment 14," further clarified the "right to the highest attainable standard of physical and mental health" emphasizing that "the *right to health* is not to be understood as a *right to be healthy*" (UN Economic and Social Council, 2000, Art. 12.8).
9. The study framed the problem as follows: "Variability of diagnostic practice gives rise to problems in research even within one country. When transcultural investigations are undertaken, this problem is compounded by differences in the sociocultural backgrounds of patients and investigators, and by difference in the training and theoretical orientation of investigators" (WHO, 1975, p. 15).
10. While GH's embrace of biology and economy in the conceptualization of health is traditionally criticized as a neglect of the "social" by social scientists, some scholars in anthropology have started pointing to the limits of the "social" as a presumably universal analytic (Rees, 2010), arguing that the notion of the "social" itself must come into view as a historically contingent (Jacques, 1984; Rose, 1996) and at times

limited framework for productively capturing the effects of emergent, ever-shifting, and increasingly global projects of modernity (Collier, 2006, 2011; Ferguson, 2009; Rees, 2010).

11. Yet, we suggest to also bear in mind that Rose's observations are based on the particular history of "advanced liberal democracies" and their legacy of the welfare state that gave rise to the "social" as a specific problem (Donzelot, 1984). Spaces and assemblages in which such institutions have never existed need to be studied in their own specificity, and may produce unexpected perspectives. For example, Ferguson (2009) has provocatively asked (regarding unconditional cash transfer programs in South Africa) if the work of the social can be done in the name of "neo-liberalism" (rather than through a welfare and social insurance logic, which has never existed in South Africa); a thought that is possibly as counterintuitive as asking with regards to GMH if poverty as a social problem can be addressed through mental health interventions in the name of "biology" (Lund et al., 2011).
12. At the ASI 2012, for example, Patel elaborated on the strategic use of language in GMH: "What bothers people is the word 'global.' But we need to see it is completely strategic. One uses labels for particular purposes. GMH is about generating resources and we have to use these kinds of figures to shock governments into action." (ASI conference verbatim field notes, by Bemme, July 7, 2012). Furthermore, there were frequent reminders towards the audience that the GMH agenda was not designed with academics in mind, but targeted to other communities, such as activists, policy makers, and funders.

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