



Genealogies and Anthropologies of Global Mental Health

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Abstract Within the proliferation of studies identified with global mental health, anthropologists rarely take global mental health itself as their object of inquiry. The papers in this special issue were selected specifically to problematize global mental health. To contextualize them, this introduction critically weighs three possible genealogies through which the emergence of global health can be explored: (1) as a divergent thread in the qualitative turn of global health away from earlier international health and development; (2) as the product of networks and social movements; and (3) as a diagnostically- and metrics-driven psychiatric imperialism, reinforced by pharmaceutical markets. Each paper tackles a different component of the assemblage of global mental health: knowledge production and circulation, global mental health principles enacted in situ, and subaltern modalities of healing through which global mental health can be questioned. Pluralizing anthropology, the articles include research sites in meeting rooms, universities, research laboratories, clinics, healers and health screening camps, households, and the public spaces of everyday life, in India, Ghana, Brazil, Senegal, South Africa, Kosovo and Palestine, as well as in US and European institutions that constitute nodes in the global

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network through which scientific knowledge and certain models of mental health circulate.

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Introduction

This issue of *Culture, Medicine and Psychiatry* aims to move beyond the often polarizing debates surrounding “global mental health and its discontents” (Bemme and D’Souza 2014) by taking “global mental health” itself as an object of inquiry. We approach global mental health not as a hegemonic given, but as an unstable, dynamic and provisory assemblage of, among others, international agencies such as the World Health Organization (WHO) and the World Bank, academic institutions, research funding bodies, philanthropists, non-governmental organizations (NGOs), advocacy groups, metrics and their architects, professional bodies and those identified as service users, engaged in the production and circulation of technologies, principles and practices. Such engagement aims at improving mental health care specifically in low- and middle-income countries (LMICs).¹ Drawing on historical and anthropological methodologies we attempt to discern how new transnational relationships, practices and technologies materialize around the values identified with global mental health—and, at times, despite them. Yet, as the contributions to this issue illustrate, “the global”, “globalization” and even “mental health” shift in meaning through time and across scales, further destabilizing common frameworks and taken-for-granted readings of what constitutes global mental health.

Approaching the field in this way necessitates dynamic observation, and, as in Latourian approaches to the history and anthropology of science-in-the-making (Latour 1987), following the social actors, knowledges and tools through which global mental health materializes. These include not only mental health, humanitarian and religious practitioners, persons affected by mental illness and their communities, but also diagnoses and standards, training modules and therapeutics, policies and practices circulating between centers of established or emerging global influence and sites of experimentation and innovation, primarily in poorer regions of the global South. To this end, we examine the processes, networks, moral economies, cultures of healing and therapeutics which enable, and are in turn shaped by, the circulation of global mental health components and their intersection at multiple levels. We observe the sites and moments where the relevant bodies of knowledge, tools and bodies in flesh-and-blood come together, engendering new subjectivities. In short, rather than beginning with global mental health as a fixed

¹ Some researchers argue against the notion that global mental health is aimed at poorer regions of the world (Henckes 2019). Yet the ‘global’ of global mental health is often equated more with sub-Saharan Africa and the Indian sub-continent than other regions. Studies of ethnic minorities in high-income countries or indigenous or migrant mental health sometimes fall outside this framework.

entity or set of unifying conceptual practices, we trace its numerous constellations in-the-making.

Each contribution mobilizes one or another aspect of this strategic choice in exploring global mental health, as discussed below. Taken as a whole, they center on globalization *and* mental health, as well as global mental health. They reveal components of the global mental health assemblage, re-situate the global or examine globalization's effects on the everyday management of mental health, within a plurality of locales, bodies of knowledge and traditions. In this introduction, we have chosen to frame this diversity along two dimensions. First, we situate the quest for understanding global mental health within a broader attempt to trace genealogies. Second, we acknowledge the plurality of anthropologies—epistemic and material, methodological and geographic—with which the papers engage.

Tracing Genealogies of Global Mental Health

Problematization, the sociologist Robert Castel suggested, requires not only a critical (re) reading of history (Castel 1994), but also the identification of narratives and plot-lines. Genealogies, as one such critical method, problematize the space of the present in which the work of anthropological, historical and related inquiry is immersed. The genealogical perspective derived from Nietzsche and read through Foucault rejects essentialism—an origin, a totalizing and thus carefully closed history—in favor of discerning the contingencies, uncertainties, and fragilities from which networks of knowledge, power, values, and practice emerge and shift (Foucault 1977; Nietzsche 2013[1887]). Genealogies work against the notion of absolute ruptures, such as one that would clearly separate the era of global mental health from that preceding it. For our purposes, genealogies excavate the traces of specific yet numerous ideologies, practices, and social formations—colonial and post-colonial, psychiatric and economic, sacred and secular, institutional and everyday—through which mental illness and mental health care as worldwide topics of concern have been co-produced, managed, and sometimes resisted. Careful tracing can untangle the multiple threads which are woven into “global mental health”. We have identified three such threads.

Global Mental Health: A Singular History or a Component of the Globalization of Health?

One thread places global mental health within the larger sphere of global health. According to some historians (Brown, Cueto, and Fee 2006; Packard 2016), the current globalization of health follows the era of international health and development (circa 1946–1980), during which international and foreign aid programs and policies re-organized relations between the then-called “developed world” and rapidly de-colonizing “developing countries”. During this period, long-standing goals for controlling the spread of epidemics across borders expanded into a broader vision of eradicating tropical and infectious disease altogether. The multiple concerns of global health—health risks, social inequalities, technical and

organizational solutions—are not new. Even the neo-liberal shaping of global health had its predecessor in 19th century liberal laissez-faire policy (Yach and Douglas 1998). However, the magnitude, interdependencies and specific components of the global health assemblage indeed crystallized, intensified and expanded from the 1980s on. The current configuration of global health is characterized by health governance stemming from a configuration of public private partnerships (PPPs) between governmental agencies and programs, NGOs and charitable foundations, including the omnipresent Bill & Melinda Gates Foundation and other “philanthrocapitalists” entwined with the neo-liberal order (Birn 2014; Birn, Nervi, and Siqueira 2016; McGoe 2014). The global health era is equally marked by the decline of WHO’s external influence and its internal shift to extra-budgetary and private financing (Chorev 2012; Lee 2008), the rise of the World Bank’s economic model of health (Gaudillière 2014), the influence of neo-liberalism in general and of the pharmaceutical industry in particular (Keshavjee 2014; Packard 2016), and the primacy of metrics (Adams 2016) and audit culture through performance-based budgeting, implementation science and other newly forged tools of health sciences and governance (Reubi 2013, 2018). In short, the politics of health shifted radically from the late 1970s through the present.

While within a *longue durée*, some continuity runs from the international health and development era to that of global health (including, for example, attention to resurgent diseases like tuberculosis), the transition to a new configuration of health governance is clearly marked by an “economic turn”, particularly that manifested through the role the World Bank came to occupy in health from the late 1980s on (Gaudillière 2014). The economic turn within international health, and the health turn within development institutions such as the World Bank, are two sides of the same coin. Until the 1990s, development institutions, and the World Bank in particular, saw economic growth as necessary to improving health in poor nations, hence their investment in economic and infrastructural development. Until then, responsibility for health programs had been left to the WHO and some UN programs. After 1987, the World Bank, partly in response to the perceived limits of infrastructural development, began to provide loans for improving health in countries of the South, particularly in the area of nutrition and maternal and child care. But the definitive turning point, as Gaudillière and Gasnier have shown, was the publication of the World Bank Report, *Investing in Health*, in 1993 (Gaudillière and Gasnier 2019) which promoted diversity and competition in funding for health, including private sector involvement, under the rationale of cost-effectiveness. Much of the decrease in health status in countries receiving international aid resulted from the impact of structural adjustment programs imposed by the World Bank, its shift away from infrastructure development, and the subsequent disinvestment in state-led health systems (Gaudillière 2014). Despite this, the World Bank remains a major player in global health today.

Tracing the origins of global health nevertheless raises the question of the extent to which global *mental* health is merely another manifestation of these larger processes, or whether its origins must be sought in parallel, if not elsewhere. Despite the major historical role played by WHO in shaping international health and development—one which diminished with internal strife, corruption, and, as

mentioned above, the rise of private health governance and the new space occupied by the World Bank—mental health had remained relatively marginalized within the Organization (Lovell 2014), though cross-cultural and ethno-psychiatry flourished elsewhere.

Three turning points support the idea of a specific genealogy of global mental health, even if the actual markers are common to global health more generally. The 1978 Alma Ata Declaration on “Health for All by the Year 2000” reflected the rising presence of “Third World” actors in international health and the shift from curative towards primary care. The Declaration itself omitted mental health, though the background conference documents did not (Ivbijaro et al. 2008). Yet even before Alma Ata, mental health and development specialists were already experimenting with incorporating mental health as a component of primary care (Harding 1979; Ivbijaro et al. 2008).² Despite WHO’s broad international research on outcomes of schizophrenia and other major psychiatric disorders (Hopper et al. 2007), only at the end of the 1970s did the Organization finally raise the coordination of its mental health research and policy to the status of a Division and include mental health among WHO research priorities (Lovell 2014).

The second turning point with specific ramifications for global mental health coincides with the publication of the Global Burden of Disease (GBD) statistics almost two decades later (Murray and Lopez 1996). The 1996 World Bank/World Health Organization/Harvard University-sponsored GBD report revealed the until-then “unseen burden of psychiatric disease” (Murray and Lopez 1996:21). The development and analyses of the DALYs (Disability-Adjusted Life Years) shifted health surveillance emphasis from mortality to disability—the causes of each are not the same—with the result that uni-polar depression emerged statistically as the fourth cause of disease burden worldwide and the leading cause among women.³ (How disability is measured in the GBD remains contested.) Re-analyses have since placed mental, neurological and substance use-related disorders (MNS) as the leading source of years lost to disability in the world (Whiteford et al. 2015). GBD and DALY metrics and the notion of productivity lost to MNS-related disability thus became powerful rhetorical devices that could be used to raise awareness and ultimately generate funding for mental health research and interventions. GBD statistics for mental disorders were presented in a widely-cited Harvard University-produced report on ‘world mental health’. Commissioned by charitable foundations, the Report was developed under the aegis of Harvard psychiatrists and anthropologists Arthur Kleinman, Leon Eisenberg and Byron Good, with illustrative case studies from anthropological fieldwork from around the world (Desjarlais et al.

² During this period, high-income countries experimented with reforming the asylum, deinstitutionalization and the promotion of community mental health care (Scull 1977). The Euro-American bias in histories of deinstitutionalization and community care nevertheless require considerable revision. For example, India and some other Asian nations were already experimenting in asylum reform and community care in the mid-twentieth century, if not earlier (Minas and Lewis 2017). See also Lang (2019).

³ In sub-Saharan Africa, however, the report’s results showed the burden attributable to psychiatric and neurological conditions to be far more modest (Murray and Lopez 1996:11).

1995).⁴ In retrospect, despite being presented with much fanfare to the UN, the Report produced few effects. The GBD, however, provided the impulse to place mental health on the world map, even in popular media.

The development of the GBD metric as a new style of reasoning (Reubi 2018) permitted a comparative evaluation of the cost-effectiveness of interventions which policy makers could use to assess priorities and ‘aid the rational allocation of resources’ (Murray and Lopez 1996:6). The metric intended to provide vital data to support the shift to ‘selective’ primary health care, in which limited resources were to be used to target only those conditions which it was deemed could be treated most effectively at the lowest cost (Cueto 2004). In so doing, it illustrated cost-effectiveness and success-driven definitions of need, at the risk of once again rendering invisible highly disabling and costly conditions.⁵ The degree to which global mental health policies and interventions are metric-driven, however, remains an empirical question.

Only the third turning point, however, clearly signposted the arrival of mental health within global health policy: the dedication of the WHO’s annual World Health Report for 2001 to mental health. The report, entitled *Mental Health: New Understanding, New Hope*, also deployed the GBD statistics on the burden of mental disorders, but placed significant emphasis on improving access to treatment through community-based services and the integration of mental health into primary care (WHO 2001). In so doing, it introduced a key notion, that of the mental health “treatment gap”, i.e. the difference between the number of people estimated to need treatment for mental illness and the number of people actually receiving treatment (Kohn et al. 2004). Like the GBD, this became a powerful rhetorical device for spurring global mental health action, while shifting the emphasis from counting to policy, planning, and programs. If the WHO Mental Health Atlas, with country-by-country mental health care resources data (WHO 2001), “quantified” the treatment gap (Bemme 2018:63), the 2007 *Lancet* series on global mental health, discussed below, brought it to a wider audience.

The most striking contradiction of global mental health is the chasm between the GBD indicators and the stated priorities of global health, on the one hand, and the disproportionately small of national health budgets and donor funds allocated to mental health prevention and intervention, on the other. Global health policies have favored signature vertical programs like the Global Fund, which targets the HIV/

⁴ The Harvard Report’s use of narrative and case studies illustrates how mental health—or a related phenomenon—is constructed across social worlds. In this sense, the Report incorporates a contradiction between universal psychiatric disorders versus local, culturally, socially and otherwise constructed experience, without questioning the psychiatric diagnoses themselves as a construction. (Interview by the editors with Robert Desjarlais, June 22, 2017). Similar contradictions characterize much of the engagement of anthropologists with global mental health today, challenging anthropologists to think together two types of phenomena: subjectivity, the local, the global and what lies in-between; and self-designated “universal” sciences. These issues are adroitly laid out in what are now medical and psychological anthropology classics: Jenkins (2015); Jenkins and Barrett (2004); Lock and Nguyen (2018).

⁵ Such invisibility is not new, of course. An earlier era defined mental health needs through assessment and evaluation tools, often excluding conditions for which effective treatment did not (yet) exist, thereby ignoring the multiplicity of needs attached to chronic conditions refractory to treatment. (Lovell 1993).

AIDS, tuberculosis and malaria epidemics, hence omitting mental health by definition. Some critics point out that the consolidation of within-country efforts (such as national health policy, funding and training) around these diseases, driven by the availability of global health funding, has penalized resources for other diseases (Eboko 2015). Furthermore, until recently, UN development priorities—namely, the Millennium Development Goals (MDGs)—excluded mental health (Miranda and Patel 2005) as well as most non-communicable diseases, although the concept of well-being, often considered a dimension of mental health, has long been incorporated into certain development theory (Sen 1993). Only with the Sustainable Development Goals (SDGs), adopted by the UN General Assembly in 2015, did mental health and well-being become explicit development priorities, and this as a consequence of strong advocacy by key, self-identified global mental health players.⁶ The World Bank is since emerging as a visible institutional actor in global mental health (and not simply health), its collaboration with WHO consolidated by the high-level Washington-based meeting of civil society activists, academics, finance ministers, and businesses held in 2016 to “move mental health from the margins to the mainstream of the global development agenda”.⁷ Nonetheless, as in other policy domains, global responses to needs through funding do not follow the narrative drawn from the GBD and treatment gap about the impact of psychiatric disorders and the absence of treatment (Charlson et al. 2017).

Quite possibly, the SDGs will in and of themselves constitute a fourth turning point differentiating the specificity of GMH within global health. The recently-published report of the Lancet Commission on Global Mental Health and Sustainable Development (Chisholm et al. 2018) urges moving beyond policy efforts to reduce the treatment gap for those already afflicted with “biomedically defined mental disorders”, the general failure of which it admits. Instead, it proposes to refocus the agenda on protecting and promoting the mental health of “whole populations” as a “global public good” while reducing the contribution of mental disorders to the GBD. How this and other re-orientations of GMH within the report will play out on the global stage remains to be seen.

Networks, Social Movements and Human Rights in Global Mental Health

The second thread traces the coming together of global networks of actors and organizations specifically concerned with mental health, and the consolidation of a common discourse through which they attempt to push for change. Unsurprisingly, this morally-charged discourse draws on the above-mentioned interconnected GBD and treatment gap indicators (Kohn et al. 2004) to argue that a crisis of need compels urgent action. The publication of a dedicated *Lancet* Series on global mental health in 2007 (and follow-up series in 2011) has perhaps been most productive in crafting an identity for global mental health among actors, particularly

⁶ Even by 2014, mental health had still not been included in the SDGs. Major network mobilization changed that (Thorncroft and Votruba 2016), such that mental health is mentioned in two sub-sections of Goal 3 and is a target priority. http://www.who.int/mental_health/SDGs/en/.

⁷ <http://www.worldbank.org/en/events/2016/03/09/out-of-the-shadows-making-mental-health-a-global-priority>.

researchers, in the Global South and North, and in pushing the domain of mental health as a target of international research and policy. The *Lancet*, the leading medical journal worldwide and the first to publish the GBD findings, has been an enthusiastic proponent of the metric and the associated ‘epidemiological transition’.⁸ The global mental health series represented a deliberate framing of mental health as a ‘new global health field’ (Patel and Prince 2010), deploying the language of evidence-based medicine and cost-effectiveness, which makes a previously marginal field of medicine palatable to prominent global funders and influencers like the World Bank and the Gates Foundation. In keeping with earlier assessments of WHO’s declining international role and criticisms of its stubborn adherence to prioritizing infectious disease, the 2007 *Lancet* Series editorial decried the Organization for being unable ‘to convert fine words into tangible action at the country level’ (Horton 2007) and called on global donors, foundations and research funders to finance mental health research and intervention. Co-ordinated by psychiatrists based in the U.K.⁹ and at WHO, the 2007 *Lancet* Series was crucial to consolidating a nascent international network that utilized the platform to launch what they defined as nothing less than a “social movement for global mental health” (Horton 2007). Publications by members of the network in the *Lancet* Series and elsewhere deployed the global health language of ‘scaling up’ evidence-based treatments (Lancet Global Mental Health Group 2007) and, in keeping with the logic of GBD, set out key indicators through which progress would be measured. The Movement for Global Mental Health (MGMH) was officially launched on World Mental Health Day, 2008. Currently, according to its website, some 200 institutions and 10,000 individuals are members.¹⁰ The MGMH maintains its visibility through a website, e-newsletters, bi-annual conferences and publications in the *Lancet* and other journals. The *Lancet* Series has been followed by the launching of significant funding streams, such as the Grand Challenges initiative (Collins et al. 2011), in several countries. Overall, however, the governments of the U.S. and the U.K. remain by far the largest national donors to global mental health.¹¹

The MGMH was, of course, neither the first nor the only international network in mental health. WHO’s first Director, Brock Chisholm, a psychiatrist, was instrumental in the World Federation for Mental Health (WFMH) becoming the first NGO recognized by WHO in 1948, the same year the UN and WHO were

⁸ A journalistic account of how the *Lancet* and its editor, Richard Horton, promoted the strategy of the GBD’s architects is found in *Epic Measures*, a biography of Chris Murray (Smith 2015).

⁹ From the Institute of Psychiatry (IoP) and the London School of Hygiene and Tropical Medicine (LSHTM).

¹⁰ <https://www.globalmentalhealth.org/about>.

¹¹ From 2000 to 2015, the largest amount of development assistance for mental health (DAMH), as measured in US dollars, came from private philanthropic organizations (435.3 million), with another 12.3 million from the Gates Foundation alone. The United States led assistance from national governments (270 million) followed by the UK (74.3 million). However, in the Global South all non-communicable diseases (NCDs) are disproportionately funded; according to IHME analyses, NCDs account for 67% of deaths in low- and middle-income countries, but receive only 2% of development funds for health (<http://www.healthdata.org/infographic/high-burden-low-budget-non-communicable-diseases-low-and-middle-income-countries>? Visited August 23, 2018).

established. The WFMH's roots reach back to the U.S. mental hygiene movement founded by the former patient, Clifford Beers. It was subsequently internationalization in 1930 (Brody 2004). WFMH promoted humanitarian ideals and the idea of 'grassroots' representation, prefiguring the later emergence of mental health 'service user' or 'survivor' networks inspired initially by the politics of self-representation. The WFMH inaugurated the annual World Mental Health Day in 1992 and has close links with the World Psychiatric Association (WPA), a network of psychiatrists formally established in 1961 which also holds regular conferences and regional meetings and publishes ethical guidelines for the practice of psychiatry as well as an academic journal.¹² The World Network of Users and Survivors of Psychiatry (WNUSP) was formed much later, in 1991, bringing together national and regional activist and advocacy groups. Founded and run by persons with experience of psychiatric illness and treatment and until recently based predominantly in high-income countries, its positions are overtly critical and activist. Despite variations in the particular focus of these collectivities, all share a consensus about the need to alleviate human suffering which transcends state boundaries. Implicit in this vision is a recognition of a shared human propensity to mental distress (however defined), shaped by culture or other social determinants. In anthropological terms, this vision fits Jenkins' and Barrett's view of severe mental illness as an extraordinary yet profoundly human experience (Jenkins 2015; Jenkins and Barrett 2004).

In keeping with this humanitarian approach, a human rights discourse runs through these organizations and movements, including MGMH. The post-war focus on ameliorating conditions within psychiatric asylums in high-income countries and reducing coercive treatment has since shifted to include addressing abuses by traditional and faith healers, families and psychiatric institutions in low-income countries. These concerns are backed by international organizations like Human Rights Watch and the UN Human Rights Council. Alongside the 2006 UN Convention on the Rights of Persons with Disabilities and efforts to garner country signatories, the framing of persons with mental illness within the ambit of disability rights has been widely promoted internationally, tapping into broader claims to social, economic and cultural rights, as well as freedom from discrimination and mistreatment (Dudley, Silove, and Gale 2012). (For an anthropological perspective, see Read 2019). The UN Special Rapporteur's recent report for the Human Rights Council urged a 'paradigm shift' focusing on human rights in the promotion of mental health and calling for action to address continued discrimination against

¹² Though the WPA and the MGMH share some actors and stated ambitions, the WPA is a corporatist organization, with a more explicitly psychiatric national and regional focus. These distinguish it from the MGMH's ambitions of adaptation, scale up and cost-effectiveness of global mental health, in which pragmatic simplified interventions are delivered by lower-cadre workers through 'task shifting'.

persons with mental illness (Puras 2017).¹³ It remains to be seen the extent to which these principles will be put into practice are to the declaration.¹⁴

Despite these common orientations, several characteristics distinguish the MGMH from earlier movements like the WFMH. The first concerns its relation to the state. Whereas the postcolonial era envisioned states working together to ameliorate health and wellbeing worldwide, the current neoliberal world order has diminished the state's role in healthcare. Instead health services are increasingly funded by trans-national donors, corporations and philanthropists and provided by 'strategic partnerships' (Herrick 2017) of private institutions, NGOs and others with state services. The MGMH similarly embraces a coalition of diverse 'partners', including NGOs, international experts and advocacy groups. These are expected to work *with* the state to 'strengthen' health systems and include mental health care (Semrau et al. 2016). As in other arenas of global health, a focus on targeted technical interventions to improve access or delivery evades larger debates about the political or social context of health systems (Storeng and Mishra 2014). This includes how and by whom health systems are financed. Whilst the 2018 Lancet Commission on Global Mental Health and Sustainable Development urges states to commit to dedicating a larger proportion of national budgets to mental health care and to integrate mental health into health insurance schemes where these exist, partnerships with development agencies, philanthropists, the private sector, and civil society are considered vital for mental health financing (Chisholm et al. 2018).

The second characteristic is the deployment of global mental health through a new discourse on human rights, which the MGMH accomplishes by adopting the contemporary language of humanitarianism and community-based activism, similar to earlier mental health user movements (Crossley 2006; Reaume 2002) and to HIV/AIDS activism (Nguyen 2007). Yet because MGMH's founders and leading advocates are predominantly psychiatrists, this opens up two contradictions. The movement self-consciously seeks to present itself as inclusive and to engage NGOs and persons with lived experience of mental illness as partners in advocacy and research. Hence, it seeks to engage with, and even actively shape, the emergence of new identities and subjectivities as 'service users' or 'persons with psychosocial disabilities' in low-income countries (Kleintjes, Lund, and Swartz 2013).¹⁵ The recent formation of the Global Mental Health Peer Network is the latest innovation to this end. Under the banner of 'the right to health' (Dudley, Silove, and Gale

¹³ However, whilst campaigns against stigma and discrimination have proved relatively uncontroversial, the issue of the right to autonomy in decision-making about treatment has tapped into one of the central controversies of psychiatry. In the era of global mental health, the debate is not simply between psychiatrists and patients, as in the antipsychiatry movements in the UK and US, but between differently positioned service user groups in the Global North and South (see below).

¹⁴ As an example, the report of the Lancet Commission on Global Mental Health and Sustainable Development notes the tension between the right to autonomy in decision-making about treatment of people with disabilities due to mental illness and the principle, enshrined in mental health laws, that severe mental disorders can interfere with judgment and require "substituted decision-making in the best interests" of the patient (Chisholm et al. 2018, p. 8).

¹⁵ Critical readings of such fashioning include Mol's larger point about the problems posed to health care as a public good by the individualism reinforced in the fashioning of patients as marketisable consumers (Mol 2008).

2012), the push for access to mental health services can thus be reframed as responding to the voices of a neglected and suffering local constituency, rather than as an imposition from without. This approach enables the Movement to refute those critics who accuse it of becoming a tool to impose “Western” notions of mental health on the Global South through the medicalization of mental illness and spread of pharmaceuticals (see below). As in other global health fields, the MGMH considers NGOs to be giving voice to civil society, while helping to plug the gaps in public services.¹⁶ From the perspective of NGOs, affiliation with global networks such as the MGMH facilitates access to international resources and partnerships.

However, the notion of therapeutic citizenship (Nguyen 2010) brings to the surface particular tensions in the area of mental health. The attraction of identities such as ‘service users’ or ‘persons with psychosocial disabilities’ must be weighed against the stigma that accompanies these. Many diagnosed with mental illness may be unable or unwilling to embrace such identities, with some refuting the label as a conscious act of resistance to the psychiatric worldview (Crossley 2004; Montenegro 2018). Psychiatric treatment is also neither unambiguously lifesaving nor life-enhancing, and it may actively be refused. Furthermore, although MGMH increasingly seeks to position itself as an umbrella collective of institutions, organizations and individuals, including service users, for a common cause, important user organizations like WNUSP and its affiliated regional groups are conspicuous by their absence. A marked irony of global mental health is that while MGMH and other campaigners in low-income countries, including those positioned as service-users, push for access to psychiatric treatment as a human right, key campaigners in the global North, such as WNUSP, vociferously oppose the expansion of psychiatric treatment as exporting abusive practices (Minkowitz 2006).

Tracing the genealogies of global mental health thus involves excavating not only what has come to be present within such networks, but what has come to be excluded (Ecks 2016). The MGMH has garnered affiliations from over 200 organizations equally divided between those from Asian, African and other countries of the Global South and North American, European and other wealthier countries. Indian organizations are most prominent in the first group as are the US, followed by the UK ones, in the second group.¹⁷ However the extent to which these organizations are active is unclear. Despite this regional diversity, half of the 2017–2020 advisory board members are from South Africa, India, the US and the U.K. reflecting the origins of the movement and its Anglophone orientation. Furthermore, leading research publications, such as those in the *Lancet*, reveal the dominance of certain trans-national research clusters within global mental health which intersect with these centers of influence. In a response to the recent WPA-Lancet Commission on the Future of Psychiatry (Bhugra et al. 2017), the former director of the WHO Division of Mental Health, Norman Sartorius (Sartorius

¹⁶ Examples in global mental health include the British international NGO BasicNeeds, founded in 2004 and now operating in several low-income countries in Asia and sub-Saharan Africa (Raja, et al. 2012). Others have visibly proliferated elsewhere, such as Ghana and India.

¹⁷ Information was taken from the mgmh website, <https://www.globalmentalhealth.org/about/structure/advisory-group> and <https://www.globalmentalhealth.org/members/organisations>, consulted on December 23, 2018.

2017), cautioned against the silencing produced by the Anglophone bias in global mental health arising from particular colonial, political and psychiatric histories. Also muted are voices from what have been dubbed ‘counter clinics’ (Davis 2018), which adopt approaches to engaging with mental distress drawing on political, social or religious orientations that diverge from normative clinical practices in centers of global psychiatric influence, be they in the US or India (see Béhague, this volume). This troubles the usual comparisons between global and local, or high-income or low-income countries, as sources of influence and innovation in global mental health.

Global mental health leaders like Vikram Patel claim that colonial dynamics, at least at knowledge production sites for global mental health, have been displaced by a “new collective ethos”. Countering critiques of top-down knowledge flows from the ‘developed’ to the ‘developing world’, Patel notes, “global mental health emphasizes what all countries can learn from each other and do to address the health of all the people [...]” (Patel, cited in Bemme 2018, p. 40). However, mapping the uneven geographic spread of MGMH reveals ways in which the ‘global’ can efface hauntings of older colonial relationships and infrastructures (Street 2014)¹⁸ in the era of tropical medicine and their transformation into pathways for contemporary economic markets, development aid, and international partnerships (Herrick 2017). Other absences in global mental health are rooted in epistemic power differences (see Lovell and Diagne 2019) which persist, despite the homage to inclusion. To take but one example, despite longstanding calls for collaboration with religious and traditional healers in the treatment of mental illness (Gureje et al. 2015), they remain unrepresented in the MGMH. This raises the question of how such representation is possible, to what extent it is desired and by whom.

Critics and the Construction of Global Mental Health

The final thread follows a critical genealogy, disseminated through journalistic writings (Waters 2010), critical psychiatry (Summerfield 2008) and critical social science (Ingleby 2017; Mills 2014; Mills and Fernando 2014). Here, global mental health is viewed as the most recent manifestation of an imperial psychiatry. To some extent, these critiques grew out of earlier, often practice-based critiques such as anti-psychiatry movements (Crossley 1998) and democratic psychiatry (Lovell and Scheper-Hughes 1987). But they are also influenced, though unevenly so, by the critical history of madness and psychiatry (Foucault 1977); labelling theory and the critique of psychiatry’s evidence base (Horwitz and Wakefield 2007; Kirk and Kuchins 2017); and anti-colonial analysis (Fanon 2008).¹⁹ Each genealogical substrand provides some relevance to the contemporary phenomenon of global mental health.

¹⁸ On colonial psychiatry see, for example, Keller (2001) for a review of historical studies of colonial psychiatry and Vaughan (1991) for a counter-Foucauldian history of missionary approaches to mental illness.

¹⁹ Interestingly, most critiques ignore the very rich literature on colonial psychiatry in Asia and Africa. Also, some historians have now turned to examining effects of exported mental health technologies (Vaughan 2016).

Some of these critiques identify, if not reduce, global mental health to the indiscriminate exporting of Western psychiatric diagnoses and interventions to low-income countries without acknowledgment of psychiatry's own cultural and historical production. The result, it is feared, creates “monocultures of the mind” (Shiva 1993) through which the world becomes “crazy like us”, what Watters (2010) refers to as the globalization of the “American psyche”. It is argued that global mental health perpetuates psychiatric imperialism (Summerfield 2013) and a (neo)colonizing of non-Western others that ignores ‘local culture’, particularly in the export of components of mental health systems developed in high-income countries to LMICs (Mills and Fernando 2014). Much of this critique focuses on the dangers of expanding access to psychopharmaceuticals, the erosion of local expressions of distress and the medicalisation of political, economic and social factors.

In a similar vein, critical psychiatrists and social scientists argue that global mental health indiscriminately promotes the same psychiatric nosologies that have long been critiqued in the global North for their lack of a valid scientific evidence-base (Summerfield 2008). Some draw inspiration from social constructionist, anthropological and historical studies of the emergence and stabilization of psychiatric categories (Hacking 1998; Young 1997). The treatment packages advocated by global mental health productions such as the mhGAP intervention guide adopt the language of ICD diagnostic classifications and promote disease-specific pharmaceuticals, which contributes to further stabilizing psychiatric categories and their presumed universality (Healy 2003; Moncrieff 2010) while undermining local notions and practices of healing. However, recent anthropological research counters this critique by revealing the instability of psychiatric categories in practice and research. For example, as Bemme (2019) highlights, in practice universalisms can remain ‘contingent’. The issue is also short-circuited when global mental health advocates propose ‘pragmatic classification’ (Jacob and Patel 2014) that addresses ‘contextual issues’ and differences in the expression of distress.

The argument that global mental health ultimately exports pharmaceuticalization, in turn expanding markets for the pharmaceutical industry (Fernando 2011), finds some support in the case of antidepressants. The transformation of depression from a rare and severe mental disorder to a common public health problem was not only the consequence of marketing strategies of pharmaceutical companies (Gerber and Gaudilliere 2016; Healy 2003) but has also been mediated by the policies of international and global organizations. These include the high-level joint World Bank/WHO 2016 Washington-based meeting “Out of the Shadows”²⁰ and the WHO’s 2017 World Health Day “Depression. Let’s Talk”.²¹

Yet this genealogical strand is more complicated than it first seems. First, increasingly psychopharmaceuticals are not exported solely from the global North but are circulated within ‘south-south’ networks by large pharmaceutical

²⁰ See Footnote 7.

²¹ https://www.who.int/mental_health/management/depression/en/.

corporations in India as well as smaller localised companies (Ecks 2013).²² In addition, global mental health standardized ‘packages of care’ for depressive and anxiety disorders, which are developed for and from research-based interventions and then distilled into mhGAP treatment guidelines, currently focus primarily on psychosocial interventions rather than pharmaceuticals (Patel et al. 2009). Indeed, proponents of global mental health themselves stress the limitations of treatment based solely on pharmaceuticals (De Silva et al. 2013; Patel et al. 2018). Others, however, point to the omnipresence of locally-produced psychopharmaceuticals in India in the toolkit of a broad range of doctors, healers and “quacks” as evidence against the existence of a treatment gap, particularly for depression (Ecks and Basu 2009).

Critical anthropologists and others are concerned that that global mental health arouses political sentiments akin to earlier colonial suspicion against traditional healing and epistemologies (Cooper 2015). The wide treatment gap attributed to the global South is seen by some to be “structurally blind” (Sax 2014) to ritual healing, with the result that the latter is sometimes criminalized (Sood 2016) and the mental health care provided by already existing alternatives to psychiatry are ignored, destroyed (Davar 2017) or not counted as “treatment” within the confines of ‘evidence-based’ definitions (Bartlett, Garriott, and Raikhel 2014; Davis 2018). Scholars like Murphy Halliburton attribute the well-known reports of better recovery rates for schizophrenia and other mental illnesses in low-income countries (Hopper et al. 2007) to this pluralism (Halliburton 2004).

Finally, global mental health is criticized for the depoliticization diagnostically-driven mental health care brings about, in particular how it ignores the social determinants of health and reconfigures distress and oppression into a psychiatric condition (Fernando 2017; Kirmayer and Pedersen 2014). Similar to yet updating traditional medicalization theories of the last century (Clarke and Shim 2011), this critique argues that the focus on the brain and neurochemical imbalance transforms social and economic problems and conflicts into individual pathologies, epitomized, for example, in the invention of post-traumatic stress disorder (Young 1997) and the rise of “victimology” (Fassin and Rechtman 2009). The impoverishment and conflict aggravated by neo-liberalism are mobilized in these critiques, as illustrated in more general ethnographies of suffering and trauma that connect to mental health, such as recent work on Chile (Han 2012; Parson 2013).

Interestingly, these depictions of the globalization of psychiatry contrast with the perspectives of many psychiatrists from former colonial territories during the era of international health and development. For some, demonstrating the universalism of psychiatric categories became a stake in the modernization and the decolonization of psychiatry, reclaiming psychiatry from racist and eugenicist influences (Keller 2007; Vaughan 1991). Historical scholarship reveals that some psychiatrists in decolonizing states, such as Nigeria, rejected a purely ethno-psychiatric emphasis on cultural and racial differences in psychopathology, seeing it as a colonial

²² In her fieldwork in Ghana conducted by between 2016 and 2018, Ursula Read observed that the majority of generic psychopharmaceuticals provided by government health services are manufactured in India and Ghana. As in other health fields, there are however concerns among patients and practitioners regarding the quality and regulation of pharmaceuticals (Nayyar et al. 2012).

enterprise that deprived colonial subjects of the same humanity and psychological complexity as the colonizers (Heaton 2013). Senegalese psychiatrists critiqued French ethno-psychiatry along similar lines (see Lovell and Diagne 2019). Proponents of global mental health take up a similar universalist argument when they argue that the emphasis on cultural difference fails to recognize the reality of individual suffering and deprives persons in need from access to treatment (Kohrt and Jallah 2016).

These three critical genealogies could benefit from more grounded understandings of the ways in which psychiatric treatment and the experience of altered or distressing states not only often escape the strictures of globalised categories and treatment algorithms, but also become intertwined with local notions of madness, mental illness and healing. For example, in India, clinicians sometimes deploy ICD diagnoses and symptoms of depression which are at the same time destabilized by the inclusion of local specific manifestations or phenomenologies such as anger, pain and heat (Lang 2018). Similarly, models of mental health care being built, developed and tested in LMICs under the aegis of global mental health, particularly in South Asia and sub-Saharan Africa, include explicit attempts to adapt interventions to the local culture and engage in what is called ‘reverse innovation’ (see Bemme 2019).²³ Indeed, global mental health productions, as reflected in the Lancet Commission on Global Mental Health and Sustainable Development (Patel et al. 2018), increasingly engage with such critiques, not only in seeking to articulate a position in the context of renewed debates on diagnosis in psychiatry (Stein et al. 2013), but also in urging attention to social determinants, in keeping with the framing of mental health as a development concern. Clarifying such phenomena in situ are tasks for which careful anthropological observation is particularly well-suited. However, relating on-the-ground social worlds to complexities of standardization, circulation, and scale, as well as new subjectivities, calls for a pluralized anthropology.

Pluralizing Anthropologies Around Global Mental Health

Having problematized global mental health through possible genealogies and the questions they raise, we discuss how the contributions to this issue of *Culture, Medicine and Psychiatry* explore aspects of mental health and the global through a pluralized anthropology. Taken together, the articles present highly divergent localities, practices and imaginaries through which a globally-inflected mental health is improvised, realized, translated, hybridized or ignored. Observation sites include meeting rooms, universities, clinics, Pentecostal churches and health screening camps, households, and the public spaces of everyday life, in India, Ghana, Brazil, Senegal, South Africa, Kosovo and Palestine, as well as in North American, South African and European research locations that constitute nodes in the global network through which scientific knowledge and certain models of

²³ Dixon Chibanda’s Friendship Bench which originated in Zimbabwe, is one of the most widely cited examples of this approach (Bemme 2019).

mental health circulate. The papers trace connections which span between and within countries of the Global North and South, hence materializing a certain understanding of the “global”, “local” or “global”. Beyond diversity of sites, “pluralizing” refers also to the multiple methods employed, which range from classical long-term immersion and observation (Béhague, Lang, Lovell and Diagne, Read) to the above-mentioned Latourian approach (Latour 1987) of “following the actors”, material and virtual, human and non-human (Henckes, Lang, Bemme), and to multi-site ethnography (Marcus 1995; Lovell 1997), that Bemme, Henckes, and Lovell and Diagne use in their respective articles in this issue. Most contributions are informed by all of these methods: the classic traditions of social anthropology are crossed with those of the anthropology of science and technology, although ethnography is privileged. Some of the papers, attentive to the historical construction of psychiatric science, incorporate archival research (Henckes, Lovell and Diagne). The papers also mobilize and contest notions of circulation and scale already present in anthropologies of global health (Dilger, Kane, and Langwick 2012) but rarely of global *mental* health, by tracing norms and knowledge (Lang, Read) and technologies (Bemme), from points of production to their local application and, often, modification. Still other papers discern in the work of globalization itself social inequities and the flow of material and informational resources (Lovell and Diagne) and forms of knowledge-in-the making (Henckes) that trouble any nominalism or simplistic idea of what is “global” about mental health. How might these methods, then, differ from those of recent anthropological studies that fall under the rubric of global mental health?

Continuity or Break with Cross-cultural and Transcultural Psychiatries?

In the decades since Arthur Kleinman (1977) laid out the basis for a “new cross-cultural psychiatry”, developments in the neurosciences and other biological fields, attention to the “global political economic contexts” of mental health care, and a broadened inter-disciplinarity in sync with more complex models and means of mental health care have transformed the field (Kirmayer 2006). Yet much anthropology of global mental health is in continuity with earlier studies framed through transcultural and cross-cultural psychiatry. An overriding concern then was to establish evidence for the universality of disorders—the metaphoric bones over which the plasticity of expression shaped by culture formed the skin.²⁴ Various, oft-converging interests shaped this mission. In Nigeria, the search for universals through the appropriation of “Western” science by local psychiatrists and epidemiologists fed the project of nation building through science production (Heaton 2013). At the same time, in the United States, the ability to describe universal disorders across highly different parts of the world proved crucial to the project of psycho-pharmaceutical development (Lovell 2014). And while psychiatric anthropologists of the “new cross cultural psychiatry” shared a belief in the universal reality of mental illness (Kleinman 1988), they focused on the

²⁴ To modify a metaphor offered by Robert Desjarlais.

ethnographic local, validating varying culturally defined ‘idioms of distress’, particular ‘explanatory models’ or healing practices.²⁵

Much anthropology falling under today’s self-identified rubric of “global mental health” continues to position anthropology on the side of ‘culture’ and ‘context’, though there are clear positional oppositions. A more ‘applied anthropology’ approach views culture and context as resources to be mobilized or barriers to overcome in the treatment of mental illnesses (Kohrt and Mendenhall 2016). For others, as the critical genealogy above suggested, culture is paramount and undermines misbegotten attempts at imposing universals. However, an anthropology has emerged which goes beyond these tensions and questions the very terms through which its questions are framed (Bemme and D’Souza 2014). Although it is possible to identify at least four ways in which anthropology engages global mental health, these are fluid and overlapping.

The first anthropology is directly engaged with global mental health project of ‘cultural adaptation’. This approach shares much of the ‘cultural competence’ narrative psychiatrists use when providing services to ethnic minorities and indigenous groups in high-income countries (Kirmayer 2012) and taps into anthropology’s claims to cultural expertise (putting aside anthropology’s long debates on the concepts of “culture” and “adaptation”). These anthropologists focus on applying qualitative methodologies to understand “local context”, including concepts of distress, such as “thinking too much” (Kaiser et al. 2014) and “soul loss” and influences on help-seeking (Khoury et al. 2012), to support the delivery of mental health care to previously underserved populations, whether in low-income countries or to vulnerable groups in high-income countries.

Closely allied with this strand of anthropology in global mental health are those studies concerned with political, economic and social contexts. This work draws on concepts of ‘structural violence’ (Farmer 2004) and ‘social suffering’ (Kleinman, Das, and Lock 1997) and takes an in-depth, ethnographically-located perspective on the public health concept of social determinants, promoted by the WHO since the 2001 World Health Report. However, while some anthropologists consider context as influencing the etiology and experience of mental illness (Jenkins 2015; Luhrmann et al. 2015), and thus necessary for informing mental health interventions, for others the subjective experience of suffering grounded in a particular cosmology or political economy eclipses psychiatric categories, placing them outside a recognized or recognizable anthropology of global mental health. Mental health and globalization are brought together in numerous ethnographies of poverty, political crisis, precarity, forms of violence and historical change, without necessarily referencing *global* mental health per se (Behrouzan 2016; Good et al. 2008; Han 2012; James 2010).

A third approach explicitly positions ethnographic evidence to question rather than inform global mental health premises. For example, authors in a special issue of *Transcultural Psychiatry* used ethnography to examine what global mental health

²⁵ The examples are far too numerous to list. But see contributions in recent edited volumes (Kohrt and Mendenhall 2016) and journals such as *Culture, Medicine and Psychiatry* and *Transcultural Psychiatry*.

looks like on the ground, across various locales.²⁶ In this work, global mental health may sometimes be conflated with the globalization of psychiatry, rather than concerned with particular forms of knowledge production and evaluation adopted by interventionists in the global mental health field. Indeed, in much close ethnographic work, reference to global mental health is more noticeable by its absence (Ecks 2016), betraying the fragmented nature of its reach.

A fourth anthropology examines global–local–global differences in mental health in terms of alternative epistemologies, raising the issue of power differentials between the epistemological communities involved (Cooper 2016; Kirmayer 2012). This literature is often concerned with unmasking the cultural assumptions of global mental health itself. Recent work in this field engages science and technology studies to unpack the ways in which mental health is constructed as a global field or assemblage through metrics, technologies and networks (Bemme 2018).

Finally, anthropological studies incorporate mental health statistics or use them to justify the need for their particular research topic. A typical stance is to use the mental health treatment gap or GBD statistics as the rationale for examining barriers to care (Cooper 2016), understudied mental health problems (Jenkins and Kozelka 2017) or mental health problems previously identified only with wealthier countries (Becker 2004).

The Shift to Global Mental Health as Object of Inquiry

The papers presented here differ from the existing body of anthropological work in that they establish lines of inquiry opened up when *global mental health* itself becomes the object. First, they recognize in different ways that, contrary to the typical opposition of global and local, “localized experience” and science production in the South have long been crucial to producing “universal knowledge” more commonly associated with leading centers of psychiatric research in the global North.²⁷ In Nigeria, for example, the creation of a specifically African-inflected psychiatry by African psychiatrists was not only viewed as responding to the needs of the local populace in an independent nation state. It also contributed to the international expansion of psychiatric knowledge and psychiatric epidemiology, while remaining a project of modernity and the evolving nation-state (Heaton 2013). In India, efforts to ‘Indianize psychiatry’ were particularly intense between the 1960s and 1980s, including the integration into psychiatric theory and practice of Indian notions of the self, psyche, body, spirituality and the therapeutic relationship; different symptomatology, diagnoses and therapies (Ecks 2013; Lang 2018).²⁸

A similar vein flows through this issue. Henckes provides a historical framework and identification of the conditions that allow psychiatric knowledge to circulate in the first place, leading him to question how “global mental health” is usually

²⁶ In his commentary on this special issue, Stephen Ecks concludes that the supposed changes brought about by global mental health initiatives are in fact not new, and what is observed on the ground is not necessarily attributable to global mental health (Ecks 2016). In other words, “plus ça change, plus c’est la même chose”.

²⁷ For science generally, see Tilley (2011). For psychiatry, see Wu (2017).

²⁸ Especially yoga, meditation and Ayurveda.

conceived. In parallel, Béhague traces the formation of child and adolescent mental health in contemporary Brazil, a country in which longstanding medical and other health faculties, Marxist and Freire-influenced social movements, and psychoanalysis shape a unique terrain for global mental health. Lovell and Diagne's research in peri-urban Senegal similarly reminds the reader that some LMIC lie outside the reach of global mental health—often self-consciously so—despite North–South incursions into mental health beginning in the 1960s. Together, the papers question the hegemonic construction of global mental health, portraying pragmatic psychiatric knowledge production (Henckes), adolescents' engagement with psychiatric practice (Béhague) and the nexus of care beyond the clinic (Lovell and Diagne). Each of the other four papers examine a specific component of the *assemblage* of diverse actors, knowledge, practices and technologies constitutive of global mental health. They share a focus on the partial ways in which global mental health policy is enacted in situ—whether depression policies and programs in Kerala, India (Lang); collaboration between Pentecostal healers and health workers in Ghana (Read); or the scaling up of mental health reforms in conflict-affected regions (Kienzler). Bemme on the other hand, makes the original argument that such uncertainties and contingencies may be the very qualities which enable mental health research and policy to go global.

More specifically, the contributions fall along three lines of inquiry: “Knowledge production and circulation” (Part I), “Patients, Practitioners and Principles of Global Mental Health in Action” (Part II), “Interrogating Global Mental Health from Subaltern Modalities of Healing” (Part III).

Part I, “Knowledge Production and Circulation”, examines how knowledge production influences and is modified where global circulation and local processes intersect. In “Schizophrenia Infrastructures: Local and Global Dynamics of Transformation in Psychiatric Diagnosis-Making in the Twentieth and Twenty-First Centuries”, Nicolas Henckes anchors the globalization of mental health in “diagnosis infrastructures” beginning in the early twentieth century. He makes the strong claim that such infrastructures—architectural, regulatory, and research, treatment and professional arrangements—shape global mental health more far more than do the circulation of categories and knowledge or the commonality of underlying biological and psychological processes. In this light, the knowledge produced at sites around the world by the WHO's International Pilot Study of Schizophrenia (IPSS) is notable less for establishing the universality of schizophrenia than for providing the data from which US research infrastructures were able to redefine schizophrenia as an internally-coherent disorder rather than the highly diverse grouping of symptoms through which it was diagnosed until then by the NIMH.

In “Finding ‘What Works’: Theory of Change, Contingent Universals, and Virtuous Failure in Global Mental Health”, Doerte Bemme examines global mental health “in the making” through the application of Theory of Change (ToC), a methodology increasingly mandated by funders of global mental health programs. Her ethnography of ToC at a South African “flagship” site funded through the WHO-UK PRIME global mental health consortium reveals a bottom-up, collaborative process in which the evaluation design formalizes reflexivity, scrutiny, and

malleability. In contrast to the randomized clinical trial standard for evidence-based mental health interventions, for which real world “messiness” constitutes statistical “noise”, Bemme’s interlocutors take “contingent universals” to be valid as long as they work. The paper thus challenges both the assumption by many critics that RCTs are the gold standard of global mental health research interventions (Adams 2017) and critiques by others, who see global mental health as exporting western diagnostic categories and therapeutics (see above). Henckes and Bemme draw on different genealogies of global knowledge production at diverse points in time. Yet both challenge the notion of stable, universal categories in mental health, while recognizing its centrality to psychiatric knowledge production. It is the formalization of complexity and contingency themselves that make possible the application of these categories across time and space.

Part II, “Patients, Practitioners and Principles of Global Mental Health in Action”, traces the conditions for and consequences of integrating into national- and local-level practice and policy, the principles of global mental health as they are defined by international organizations and by advocates such as the Movement for Global Mental Health. Claudia Lang’s contribution, “Inspecting Mental Health: Depression, Surveillance and Care in Kerala, South India”, highlights the moral and economic challenges of implementing a local mental health program that includes screening for and treatment of depression, the set of conditions made visible by the GBD metrics and local and national mental health surveys. Lang traces Kerala’s community-based approach to depression to far older national and local efforts and laws in India. Some predate WHO, as does the circulation of experts that facilitate new policies; others follow WHO-led experiments and reports that precede the rise of primary care and global health. Lang examines medical productivity around depression in present-day Kerala, for years regarded as a successful “model of development”. The health inspectors and community health workers (ASHAs) she observes enact a form of community surveillance of depression based on international psychiatric classification, yet mobilize a local moral economy of care. They self-consciously enact and promote a local idiom, *sneham* (“care”, “affection”, but also “unctuousness” and “grease”) in attempts to heal the depressed body with the very pharmaceuticals central to the globalization of mental health care, while repairing (as if lubricating) the social body through the admonishment of isolation and family neglect and the counseling of families. Lang argues that medicalization does not necessarily silence social inequalities and marginalization but can become productive both as a critique of familial moral economies and a tool for mobilizing care.

In her paper, “Rights as Relationships: Collaborating with Healers in Community Mental Health in Ghana”, Ursula Read examines human rights as a defining principle of global mental health conceived by international bodies, mental health leaders and advocates, as discussed above. She differentiates between the enforcement of abstract notions of rights and the relational enactment of morality. In Ghana—a key node in formal global mental health networks in Africa—the new Mental Health Act explicitly incorporates protection of the rights of persons with mental disorders. To this end, it advocates collaboration between health workers and traditional and faith healers. Through interviews and observations of interactions

between trainee community mental health workers and a renowned faith healer, Read discerns the tensions involved in translating rights in a region where many Christian healers practice physical restraint and enforced fasting for severely mentally ill patients. Community mental health workers are trained to develop collaborations with such healers, with the aim of reducing ‘human rights abuses’ and promoting psychiatric treatment. Yet as health workers and community members, they are caught in the contradictions between rights-based principles, the Christian framework they share with Pentecostal healers and the common use of forms of coercion and enforced sedation in their own clinical practice. In addition, to sanction coercive healing practices could risk damaging vital social networks of support in a resource-poor environment.

Critics of global mental health point to humanitarian crises as openings for exporting trauma-related interventions rather than supporting local collective responses. In “Mental Health System Reform in Contexts of Humanitarian Emergencies. Toward a Theory of ‘Practice-Based Evidence’”, Hanna Kienzler provides an alternative genealogy to the systematic ‘scaling up’ of evidence-based interventions in global mental health. She presents a rather more experimental and ad hoc process in which the ‘emergency imaginary’ of humanitarian crises, such as those in conflict zones, attracts donors and experts, and creates a ‘state of exception’ in which certain norms are suspended. Donors and humanitarian actors eventually move on to new emergencies, leaving mental health reforms in a state of incompleteness, presenting national actors with the challenge of transforming short-term projects into viable services. Like Lang and Read, Kienzler uncovers the complexity at work when global mental health policies and principles touch down and emerge in highly diverse contexts.

Part III, “Interrogating Global Mental Health from Subaltern Modalities of Healing”, presents counter-examples to the globalization of North American and European mental health models. In “Falling, Dying Sheep, and the Divine: Notes on Thick Therapeutics in Peri-Urban Senegal”, Anne M. Lovell and Papa Mamadou Diagne focus on a West African nation where ethno-psychiatry was pioneered in public health in the 1960s, yet which currently remains off the map of global mental health endeavors. Based on observations and ethnographic interviews with patients, carers and healers, the authors broaden the framework of responses to affliction through the notion of “thick therapeutics”. They characterize the crises triggered in psychotic disorders and epilepsy as the eruption of the uncanny into the everyday in spectacular events semantically linked to domains beyond the narrowly therapeutic. Thick therapeutics implies cross-cutting logics between domains such as kinship, the economic, political, and spiritual, generating a web of connections largely unacknowledged in global mental health. Ultimately, thick therapeutics enable the apprehension of the potential incommensurability between aspects of biomedical and psychological services exported from elsewhere and characteristics of vernacular healing. In particular, the relational and spiritual dimensions of sheep and other animals commonly exchanged when the afflicted seek local healing are

not easily made equivalent to the monetized fees for mental health and primary care services promoted by global mental health endeavors.

In “Adolescent Sex and Psyche in Brazil: Surveillance, Critique and Global Mental Health”, Dominique P. Béhague examines the epistemic shifts and new forms of expertise surrounding adolescent sexuality and pregnancy in Pelotas, Brazil, where she has conducted ethnographic research attached to a 10-year cohort study of youth. The emergence of adolescent sex-and-psyche expertise in Brazil’s schools and health clinics pre-dates the rise of global mental health. In fact, it is deeply interwoven with Brazil’s unique history of psychoanalysis, social medicine, and critical pedagogy based on Paolo Freire’s work. The Freirian principles of collective mobilization and critical consciousness, female empowerment and awareness of social determinants of health that penetrated schools, clinics, and outreach programs were replaced in the 1990s-early 2000s by a powerful discourse of aberrant impulsive sexualities, prolific fertility and behavioral agitation. Béhague’s paper interrogates the mode of critique operating through the deconstruction of global mental health’s systems of power-knowledge, to which she opposes the practical critique teen-age mothers deploy through active resistance to the surveillance of epidemiological questionnaires and institutional reprobation. Béhague illustrates the importance of transcending references to “culture”, “local” context and “contingency” while engaging power, subjugation, race and class.

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