PALGRAVE HANDBOOKS

THE PALGRAVE HANDBOOK OF SOCIOCULTURAL PERSPECTIVES ON GLOBAL MENTAL HEALTH

Edited by
Ross G. White, Sumeet Jain, David M.R. Orr, Ursula M. Read

The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health

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To the memory of Kanyi Gikonyo and Duncan Pedersen

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Situating Global Mental Health: Sociocultural Perspectives

Ross G. White, David M.R. Orr, Ursula M. Read, and Sumeet Jain

Understanding the Emergence of Global Mental Health

Dating back through the millennia, much evidence bears witness to the fascination that humankind has had with endeavouring to understand the reasons for unusual or aberrant behaviour. For example, in the fifth century BCE in Greece, Hippocrates refuted claims that 'madness' resulted from supernatural causes and suggested, instead, that natural causes were responsible. In the intervening years, there has been a waxing and waning of various explanations of madness, including humours (i.e., blood, yellow bile, black bile and phlegm), the divine, the diabolical, the biomedical, the psychological and the social. Across time, geography and cultures, different labels and systems of classification have been employed to categorize manifestations of madness.

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Equally a diverse range of reactions have been bestowed upon those experiencing madness, including the trepanning of skulls, burning at the stake, veneration, provision of asylum, moral instruction, exclusion, incarceration, restraint, compassion, exorcism, spiritual healing, persecution, psychosurgeries, medication and psychotherapy. The diversity of these reactions has been influenced by the multitude of ideologies, doctrines and ethics that have shaped peoples' lives across different contexts.

Contemporary discourses about 'mental disorders' owe much to the emergence of 'Psychiatry' as a field of medicine. In the early nineteenth century CE, a German physician named Johann Christian Reil first coined the term 'psychiatry' ('psychiatrie' in German), which was an amalgamation of Greek words meaning 'medical treatment of the soul'. The early development of psychiatry centred on the contribution of key protagonists based in Europe (e.g., Freud, Bleuler, Jung). As such, psychiatric theory and practice were strongly influenced by European societal attitudes and sensibilities. However, as psychiatrists began to travel to other parts of the world, interest grew in the potential applications that psychiatry might have in diverse cultural settings. A key example of this came in 1904 when the German psychiatrist Emile Kraepelin visited Java to determine whether the diagnosis of 'dementia praecox' (a forerunner of what was to become a diagnosis of schizophrenia) existed there. This witnessed the birth of a new field of study that Kraepelin referred to as 'comparative psychiatry' (vergleichende psychiatrie). In 1925, Kraepelin conducted comparative psychiatric presentations in Native American, African American and Latin American people in psychiatric institutions in the USA, Mexico and Cuba (Jilek 1995).

Questions regarding the incidence of mental disorders in diverse societies and the universality of psychiatric diagnoses have continued since Kraepelin's work in the early twentieth century CE. However, international comparative epidemiological studies of any size only began during the 1960s with the World Health Organization (WHO)-sponsored epidemiological studies of schizophrenia (Lovell 2014). To this day, many countries lack nationally representative epidemiological data for both low-prevalence mental disorders (such as schizophrenia) and common mental disorders (such as depression and anxiety disorders) (Baxter et al. 2013). The provision of psychiatric treatment as a part of state-sponsored health care systems has also emerged unevenly, with the bulk of investment and innovations in forms of intervention and organization taking place in high-income countries (as classified by the World Bank). When health care systems were introduced by colonial governments in the nineteenth and twentieth centuries CE, mental health was a very low

priority compared to public health and the control of infectious diseases. The few asylums constructed were concerned more with public order than treatment, and there was very limited investment in forms of community-based care (Keller 2001). Since independence, the health systems of many postcolonial governments have suffered from weak economies, fiscal deficit and the effects of structural adjustment. In such conditions, mental health care tended to be neglected (Njenga 2002).

Nonetheless, despite the limited global reach of epidemiological studies and of psychiatric interventions, a growing field of enquiry and practice emerged during this period, which came to be termed 'transcultural psychiatry'. Though this was and remains a diverse field, two notable aspects were the interests certain anthropologists had in cultural influences on mental disorders and societal responses, and the emergence of psychiatrists originating from the Global South who were trained in Europe and were attempting to apply universal diagnoses to local populations. This confluence of anthropologists and psychiatrists, some of whom had been trained in both disciplines, was strengthened after the 1950s by the beginning of large-scale migration from the former colonies to countries of Europe and North America and the growing numbers of patients from diverse cultures in psychiatric services. Academic departments and courses in transcultural psychiatry began to be established, notably at McGill in Canada and Harvard in the USA, and academic journals such as *Transcultural Psychiatry* began publication. In 1995, some of the most influential anthropologists in transcultural psychiatry based at Harvard University, including Arthur Kleinman, published a book entitled *World Mental Health: Problems and Priorities in Low-Income Countries* (Desjarlais et al. 1995). This volume set out the concerns regarding human rights, lack of treatment and rising incidence of mental disorders in terms that in many ways set the agenda for what was later to be termed 'Global Mental Health' (GMH). Six years later, the WHO brought renewed attention to mental health by making it the topic of their annual 'World Health Report' for the first time in its history (WHO 2001).

The term Global Mental Health was first coined in 2001 by the then US Surgeon General, David Satcher. Reflecting on the publication of the 2001 World Health Report (WHO 2001) and a year-long campaign by the WHO on mental health, Satcher (2001) proposed that the USA should bring mental health onto the global health (GH) agenda by 'taking a leadership role that emphasizes partnership, mutual respect, and a shared vision of improving the lives of people who have mental illness and improving the mental health system for everyone' (p. 1697). GMH was given

additional visibility through the launch of *The Movement for Global Mental Health* (MGMH). The MGMH traces its origins back to the consortium of experts that constituted The Lancet Group for GMH (2007, 2011), and who published a range of papers to highlight the need for action to build capacity for mental health services in low- and middle-income countries. The MGMH now has a membership of around 200 institutions and 10,000 individuals (http://www.globalmentalhealth.org/about). Over the last 15 years, GMH has evolved from its embryonic roots to establish itself as a field of study, debate and action, which is now latticed by diverse disciplinary, cultural and personal perspectives. This has resulted in the term 'Global Mental Health' being employed strategically in different ways, for example, as a rallying call for assembling a movement of diverse stakeholders advocating for equity in mental health provision across the globe (i.e., MGMH); a target for critical debates around the universal relevance of mental health concepts and the globalization of psychiatry; a focus of academic study (such as postgraduate programmes in GMH), and a topic of research that has precipitated dedicated funding streams (e.g., by organizations such as *Grand Challenges Canada*).

Terminology and Epistemic Frames

Patel (2014) argues that GMH initiatives are characterized by a multidisciplinary approach that harnesses together the contributions made by diverse fields of expertise. At its best, this allows for an integrated, holistic approach to mental health challenges. However, concerns have been raised that psychiatric and biomedical perspectives have exerted a disproportionately high influence in shaping the GMH agenda (Mills 2014; White and Sashidharan 2014). *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* seeks to extend understanding about GMH by drawing on diverse disciplinary perspectives, some of which have been under-represented to date. Specifically, the handbook includes contributions from people with a lived experience of mental health difficulties and academics, researchers and practitioners with backgrounds in anthropology, geography, law, history, philosophy, intercultural studies, social work, psychiatric nursing, occupational therapy, social psychology, clinical psychology and psychiatry. This brings together a broader range of epistemic frames and allows for recognition of mental health as an intrinsically complex and contested field. Such divergent epistemologies inevitably lead to different priorities in approaching the treatment of mental disorders described in this volume.

Within academic research and clinical practice, diagnostic manuals exist that provide criteria for diagnosing 'mental disorders' that are proposed to occur universally across cultures. However, there is contention about the appropriateness of applying the language of 'mental health/illness/disorders' across diverse cultural settings where aberrant psychological, emotional and/or behavioural states may not be conceptualized as being associated with either health or illness. The development of manuals for diagnosing mental disorders was predicated on the assumption that the criteria for these disorders could be universally applied across all individuals—an assumption that has been contested by those who advocate a relativist approach to understanding aberrant states that is sensitive to the beliefs and practices that particular groupings of people espouse (Summerfield 2008; Mills 2014). In recent decades, there has been a growing recognition in diagnostic manuals that certain aberrant states may be unique to particular cultural contexts. For example, the 4th edition of the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-IV; APA 1994) listed 27 distinct 'culture bound syndromes' in an appendix, which were defined as 'locality-specific patterns of aberrant [deviant] behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category' (APA 1994, p. 844). There were, however, criticisms about the restrictive and skewed way in which the terminology 'culture-bound' was deployed. Some parties criticized the inadequacy of this approach by describing the appendix as 'little more than a sop thrown to cultural psychiatrists and psychiatric anthropologists' (Kleinman and Cohen 1997, p.76). These critiques were influential in shaping the changes that were subsequently made in the 5th edition of DSM (APA 2013). Indeed, DSM-5 acknowledges that '[A]ll forms of distress are locally shaped, including the DSM disorders' (APA 2013, p.758). Section III of DSM-5 includes a *Cultural Formulation Interview* (CFI) consisting of 16 questions and 12 supplementary modules intended to elicit information about the sociocultural context in which difficulties are experienced. In addition, the notion of 'culture-bound syndromes' has been replaced in DSM-5 by three concepts: (1) cultural syndromes: 'clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts … that are recognized locally as coherent patterns of experience' (p. 758); (2) cultural idioms of distress: 'ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns' (p. 758); and (3) cultural explanations of distress or perceived causes: 'labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress' (p. 758).

The role that psychiatric diagnosis should play in GMH initiatives continues to be a matter of debate. Some parties have criticized the use of psychiatric diagnoses on the grounds that these nosological classification systems lack adequate validity and that this may be further confounded by cultural variations in the manifestation, subjective experience and prognosis of mental health issues (Summerfield 2008; Mills 2014). It has been argued that standardized approaches to classifying phenotypes of *illness* can potentially play an important role in identifying biomedical causes of *disease* (Patel 2014). However, the approach used by existing diagnostic manuals may not be fit for this purpose. Responding to concerns that existing systems for making psychiatric diagnoses do not fully accord with neuro-scientific findings, the *National Institute for Mental Health* in the USA chose to abandon these systems and adopt a new approach referred to as *Research Domain Criteria* (Insel et al. 2010, 2013). In spite of these innovations in diagnostic procedures for research purposes, in the field of practice the continued use of diagnostic manuals [principally the *International Classification of Disease—10th Edition* (ICD-10; WHO 1992)] has been defended as being 'the only reliable method currently available' (Patel 2013, s.36).

The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health seeks to be inclusive of the diverse views (and associated terminology) employed across the globe to understand and describe aberrant psychological, emotional and/or behavioural states. As such, within the volume varied terminology is used by chapter authors to describe these experiences. Frequently used examples include madness, mental health issues/problems/difficulties, mental illness/disorder and (emotional) distress. Ultimately, the handbook aims to enhance readers' understanding about the diverse ways in which mental health difficulties may be understood and approached across a variety of human situations and worldviews. This includes an appreciation of the need to develop bottom-up/grass-roots initiatives based on local realities. Because chapter contributors come from a mix of different disciplinary backgrounds, a range of epistemic frames are used across the handbook to highlight different ways of knowing, of determining what is worth knowing and of adding to the corpus of knowledge relevant to mental health. Particular emphasis is placed on understanding the role that sociocultural factors play in how mental health difficulties are experienced and responded to. This introductory chapter sets the scene by pinpointing key concepts and events relevant to the emergence of GMH and highlighting some of the relevant contemporary debates that subsequent chapters will explore in greater depth.

Global Mental Health and Social Determinants

In addition to the aforementioned association with transcultural psychiatry, the emergence of GMH has been linked to developments in the field of GH (Patel 2012, 2014).[1] Global health has been defined as: 'the area of study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide' (Koplan et al. 2009, p. 1994). Patel (2014) points out that GH initiatives are guided by three central tenets: (1) reducing disease burden, (2) increasing equity and (3) being global in its reach. The development of GH has served to propagate economic metrics that have been used to highlight the considerable impact that mental health difficulties cause globally. A key example of this was the introduction of the Disability Adjusted Life Year in the *World Development Report: Investing in Health* (Jamison et al. 1993). This metric, which measures the impact of health conditions on morbidity and mortality, led to mental health difficulties being highlighted as a considerable cause of burden in the *Global Burden of Disease study* (Murray and Lopez 1996). Results from the GBD metrics on mental health were used to strengthen the call to address mental health as a worldwide problem in the book entitled *World Mental Health: Problems and Priorities in Low-Income Countries* (Desjarlais et al. 1995). The development of GMH is thus linked to epidemiological enquiry into disease burden and the assumption that mental health difficulties and their impact are standardizable across the globe (Bemme and D'Souza 2014; Baxter et al. 2013). This in spite of the fact that mental health-related epidemiological data are absent or only partial for much of the world's population (particularly the 80% who live in low- and middle-income countries), making it inadequate for planning and policy at a global or local level (Baxter et al. 2013).

Recently, Susser and Patel (2014) have argued that GMH should be regarded as partly distinct from GH, as otherwise mental health difficulties will continue to receive lower levels of priority relative to physical illnesses (including communicable and non-communicable diseases). GMH is also vulnerable to criticisms that have been levelled at GH in recent years, particularly the risk of mental health initiatives being disengaged from environmental, political and economic factors which impact health. These factors form part of the public health concept of 'social determinants' as drivers of

[1] Readers interested in learning more about the historical context of the emergence of Global Mental Health should consult Bemme and D'Souza (2014), Lovell (2014), and Lovell and Susser (2014).

health inequalities (Marmot 2014) and which were influential in the development of the GH concept. However, social determinants are often narrowed down to proximal or 'downstream' factors such as lifestyles or family structure, with much less focus on broader 'upstream' determinants which operate on a global scale such as economic policies. For example, Richard Horton has suggested that the field of GH has 'built an echo chamber for debate that is hermetically sealed from the political reality that faces billions of people worldwide' (Horton 2014, p. 111). Specifically, Horton (2014) points out that global institutions systematically ignore the *social chaos* in which people live their lives, that is, 'the disruption, disorder, disorganisation, and decay of civil society and its institutions' (p. 111). According to Horton, social chaos can arise from three major sources: armed conflict, internal displacement and fragile economies. The narrow focus of GH may in part stem from the ways in which roles and responsibilities relating to health care have historically been designated. Professionals have tended to operate within the narrow confines of 'vertical' approaches, which have restricted their efforts to working within the competency-specific boundaries of the health sector 'silo'. Whereas health care professionals may feel sufficiently skilled to intervene in medical problems, they may feel less competent at recognizing and addressing factors related to other sectors such as education and criminal justice, let alone national and global policy. An additional complication may relate to the extent to which matters relating to health and mental health can become political issues that are susceptible to the competing political interests of different protagonists. In such circumstances, ignoring 'social chaos' may be a strategic necessity to ensure that the provision of some form of support remains possible, albeit partial. The concern here is that unresolved sources of social injustice and 'structural violence' (Farmer et al. 2006) continue to perpetuate physical and mental health difficulties and limit access to sources of support. It is hoped that the specific inclusion of mental health in the *Sustainable Development Goals* (UN 2015), and initiatives such as the *Out of the Shadows: Making Mental Health a Global Priority* launched by *The World Bank* in April 2016, will be helpful for creating momentum for addressing structural factors that may be serving to limit mental health and wellbeing.

The WHO (2014) has highlighted the need to specifically address social determinants of mental health, and recognition of the influence of social determinants on mental health has been claimed as one of the foundations of GMH (Patel 2012). Kirmayer and Pedersen (2014) argue that GMH initiatives need to place greater emphasis on forms of social inequality and injustice. Indeed, it has been suggested that:

> the hallmark of GMH is to emphasize the simultaneous need for social interventions alongside biomedical interventions as appropriate for the individual. (Patel 2014, p. 782)

However, there has not always been consensus on how a balance might be struck in addressing social, as well as medical, influences on mental health. In addition, efforts to address 'social determinants' have tended to be focused at the *micro* level of the individual and/or the community, rather than tackling wider structural determinants at a *macro* level (Das and Rao 2012). Reflecting this uncertainty, Joop de Jong has expressed concerns that the purpose of GMH is unclear because it lacks a guiding (meta-)theory (cited in Bemme and D'Souza 2012). It is perhaps debatable how much of a drawback this overarching lack of consensus is. On the one hand, it may contribute to the bogging down of GMH advances and initiatives in repetitive arguments over theoretical perspective and appropriate interventions. On the other hand, a diversity of theoretical positions may actually be a stimulating and valuable feature that continually challenges GMH as a field of study and practice to engage with the complex social realities and uncertainties in which people live.

Since the latter part of the twentieth century, mental health services in the West have increasingly professed allegiance to the 'biopsychosocial approach' (Engel 1977). The impetus for proposing this approach stemmed from a concern that the biomedical approach had left 'no room within its framework for the social, psychological, and behavioral dimensions of illness' (Engel 2004, p. 53). Whilst commentators acknowledge that the biopsychosocial approach has made an important contribution to clinical *science*, concerns have been raised about the extent to which the approach has been able to bring about meaningful change in clinical *practice* (Álvarez et al. 2012). Sadler and Hulgus (1990) highlighted that a lack of consideration of the 'practical and moral dimensions of clinical work' (p. 185) means that the *biopsychosocial* approach is largely redundant for guiding specific actions in the clinical encounter. Álvarez et al. (2012) suggested that the absence of concrete guidelines about applying the *biopsychosocial* approach in practice means that it weakens in the face of biomedical approaches. Rather than leading to a holistic, integrative way of addressing mental health difficulties, Ghaemi (2009) raises the possibility that the *biopsychosocial* approach can lead to 'cherry picking' of treatment options, whereby different professionals revert to their specialist training to decide which particular interventions to recommend. This may lead to the emergence of a monoculture of treatment in particular professional groupings. For example, Steven Sharfstein (the former president of

the American Psychiatric Association), reflecting on the dominant role that biological approaches to mental health difficulties had assumed in the USA, urged psychiatrist colleagues to:

> examine the fact that as a profession, we have allowed the biopsychosocial model to become the bio-bio-bio model. (Cited in Read 2005, p. 597)

To some extent, concerns about the risk of professional parochialism (among psychiatrists, psychologists, nurses etc.) can be offset by a multidisciplinary team approach that aims to collectively harness expertise in different forms of treatment and intervention. However, in low-income settings such approaches may be limited by restricted resources and limited diversity of professional expertise, resulting in a reliance on more easily delivered pharmaceutical interventions (Jain and Jadhav 2012).

Standardization and Evidence-Based Medicine

Since its emergence, GMH has been the target of a vocal critique, most prominently concerning a perceived dominance of biomedical approaches. Critics have suggested that GMH is a neocolonial, medical imperialist approach that serves to expand markets for psychotropic medication (Summerfield 2012; Mills 2014). Refuting such accusations, Patel (2014) points out that the bulk of interventions evaluated in GMH research have focused on psychosocial interventions. Furthermore, Patel (2014, p. 786) states that it would be 'unethical to withhold what biomedicine has to offer, simply because it was 'invented somewhere else'. Bemme and D'Souza (2014) have contended that the globalization of particular *forms* of intervention has not been a principal concern of GMH. Instead, they suggest that a key feature of GMH has been the dissemination and utilization of particular epistemologies and research methodologies for *evaluating* interventions across the globe. The emergence of the evidence-based medicine (EBM) paradigm (see Guyatt et al. 1995), and the hierarchical approach to research evidence that it espouses, has had a significant impact on shaping standardized procedures for evaluating health interventions. However, Thomas et al. (2007) have cautioned against the assumption that human behaviours and problems are amenable to investigation using the same positivist methods that are applied in the natural sciences. In keeping with this critique, EBM has also been criticized for disregarding the social nature of science and obscuring subjective elements of the human interactions that occur in the context of medicine (Goldenberg 2006).

Greenhalgh et al. (2014) identified a number of limitations in the EBM paradigm as currently practised, including a susceptibility to bias in trials, a failure to take account of multi-morbidity and a tendency to promote over-reliance on 'algorithmic rules' over reasoning and judgement. Furthermore, other commentators have suggested that 'gold standard' EBM methodologies may lack sufficient sophistication for understanding cross-cultural nuances in how emotional distress can be understood and addressed in different contexts (Summerfield 2008; Kirmayer and Pedersen 2014). Kirmayer and Swartz (2013) highlighted the need for the GMH agenda to embrace a 'pluralistic view of knowledge', which can be integrated into empirical paradigms guiding GMH-related research. More recently, the notion of mental health interventions as 'complex' interventions interacting with context to influence outcomes has led to a challenge to the gold standard of randomized controlled studies (Moore et al. 2015). Researchers have called for new methods of evaluation including the use of qualitative methodologies such as ethnography to observe such interactions and unintended effects (Kirmayer and Pedersen 2014; Kohrt et al. 2016). These have been embraced in several studies of community-based mental health interventions in low-income settings across the globe (De Silva et al. 2015). Issues related to the application of EBM to GMH are discussed by Mills and White in this volume.

The 'Treatment Gap' and Community-Based Interventions

The momentum created by the 'call to action' of MGMH coincided with the WHO launching international initiatives such as the Mental Health Gap (mhGAP) programme (WHO 2008, 2010). These programmes have proposed plans for scaling-up services to reduce the burden associated with priority psychiatric diagnoses. In recent years, there has been growing interest in the possibility of developing trans-diagnostic interventions to more generally address the experience of distress, rather than specific forms of diagnosis. This focus on 'distress' and other concepts such as 'subjective wellbeing' reflects a need to broaden the understanding about what constitutes a good outcome for individuals with a lived experience of mental health difficulties (White et al. 2016). The 'Recovery Approach' (Anthony 1993) has advocated the need for psychiatric services to move beyond focusing narrowly on reducing the severity of symptoms of mental illness, to instead move towards themes such as connectedness, hope, identity, meaning and empowerment (Leamy et al. 2011). Research has suggested that the 'Recovery Approach' may have

utility across cultural groups (Leamy et al. 2011), and there are emerging attempts to introduce innovations such as 'Recovery Colleges' in low-resource settings. The chapter by Aldersley et al. in this volume provides further reflection on the 'Recovery Approach' and the implications that this has for GMH.

Borrowing language from GH, *The Lancet Series on Global Mental Health* (2007, 2011) and the *mhGAP Action Programme* (WHO 2008) and *mhGAP Intervention Guide* (WHO 2010) draw on the notion of the need to fill the 'treatment gap' (i.e., the gap between the numbers of people assumed to be suffering from mental illness and the numbers receiving treatment). As is the case for burdensome physical health conditions (such as HIV/AIDS and malaria), the urgency for 'scaling-up' services for mental health difficulties has in part been justified on the basis of the moral obligation to act (Patel et al. 2006; Kleinman 2009). The MGMH has been engaged in concerted efforts to mobilize stakeholders and lobby for policy change to address the 'treatment gap'. Vikram Patel has stated that there is a need 'to shock governments into action', and that language should be employed strategically for this purpose (Bemme and D'Souza 2012, para. 24). For example, it is suggested that the 'treatment gap' for mental health difficulties is as high as 85% in low-income countries (Demyttenaere et al. 2004), and that urgent action needs to be taken to bridge it. However, the aforementioned concerns about the poor quality of epidemiological data relating to mental disorders in low- and middle-income countries (LMICs) (see Baxter et al. 2013) will have important implications for the accuracy of estimates of the 'treatment gap'. In addition, critics have argued that the concept of the 'treatment gap' has privileged particular forms of treatment whilst simultaneously failing to recognize the important contribution that non-allopathic[2] forms of support and healing may bring to people living across the globe (Bartlett et al. 2014; Fernando 2014). The inference is that the rhetoric of the 'treatment gap' may well shock governments into taking action, but this action may not be inclusive of the pluralistic forms of support available. Researchers have suggested that pluralism and a multiplicity of treatment options might bring potential benefits for engagement and outcome for individuals experiencing mental health difficulties in LMICs—these themes are explored in more depth in the chapter by Orr and Bindi in this volume.

Jansen et al. (2015) pointed out that the concept of the 'treatment gap' has advocated a particularly individualistic approach to scaling-up services for mental health in LMICs. Fernando (2012) suggested that the burden of

[2] The term 'allopathy' was introduced by German physician Samuel Hahnemann (1755–1843) when he conjoined the Greek words 'allos' (opposite) and 'pathos' (suffering). It is defined as the treatment of disease by conventional means (i.e. with drugs having effects opposite to the symptoms).

mental health problems experienced collectively by communities is likely to be greater than the sum of the burden on the individual members of that community, especially in the context of 'collective traumas' (see Audergon 2004; Somasundaram 2007, 2010). It is important, however, to appreciate that conceptualization of 'communities' vary across different settings, and there are also marked variations in the degree of cohesiveness in communities across the globe. Campbell and Burgess (2012) suggest that the tendency for GMH initiatives to prioritize interventions aimed at individuals has meant that the social circumstances that can foster improved health have been insufficiently addressed. Bemme and D'Souza (2014) observed that GMH initiatives have narrowly conceptualized 'community' as a method of service delivery. The rationale for community-based mental health care has been closely linked to the ideological shift towards deinstitutionalizing the care of people experiencing mental health difficulties and bringing services closer to where people live. Community care is also proposed as more cost-effective option (Das and Rao 2012; Saxena et al. 2007). Moving forward, there is a need to explore how the concept of 'community' can be promoted as a means of harnessing collective strengths and resources to promote mental wellbeing (Jansen et al. 2015). These efforts should, however, be cognizant of concerns that community action and volunteering in GH and GMH initiatives may take advantage of community workers by relying heavily on their unpaid and demanding work (Maes 2015; Kalofonos 2015). This has implications for both the sustainability and quality of care provided, particularly where there is inadequate investment in ongoing training and supervision.

The 'Global-Local' Distinction

The dichotomy that has been drawn between forms of support that reflect 'local' (i.e., specific to particular contexts) beliefs and practices, as opposed to 'global' (i.e., standardized/universalist) approaches, has been keenly debated in GMH-related discourses. Some have argued that global initiatives for mental health pose a threat to indigenous or local practices (Mills 2014; Fernando 2014). Patel (2014) has warned against the idealization of indigenous (i.e., local) practices, which can include inhumane treatments and practices. Miller (2014) has also argued that a person living in a LMIC 'deserves better than being urged to stay in (his/)her niche in some great cabinet of ethnopsychiatric curiosities' (p. 134).

Bauman (1998) highlighted the way in which what is considered to be 'local' has become organic and porous, as new and ever-evolving associations