

GLOBHEALTH Mental Health Workshop:
Historical and ethnographic perspectives on the emergence of global mental health

June 12-15, 2017
Venue: Villa Finaly, Florence, Italy

Organizers: Anne M. Lovell, Claudia Lang, Ursula Read

This workshop brings together historians and anthropologists to analyze the processes through which psychiatric disorders have come to occupy a major place within the global health agenda and how the activities and interventions of global mental health networks today translate into practical knowledge in particular contexts.

In the period following World War II, tropical diseases and worldwide infectious disease epidemics dominated the nascent World Health Organization's agenda and international aid efforts. Early interest in mental illness outside the global North largely constituted a sort of "epidemiological primitivism". The emerging discipline of transcultural psychiatry examined culturally variant expressions of aberrant behavior in so-called 'simpler' societies, from which was culled the construct of 'Culture-Bound Syndromes' which still holds currency today. The colonial legacy of the asylum remained intact in much of the developing world, although scattered "developing-developed world" encounters in Africa and Asia focused on the potential of local healers, family care, and the 'psychiatric village'. Much of this history and what was at stake for whom has yet to be uncovered.

By the early 1960s, the development of an international psychiatric epidemiology at the WHO and the subsequent schizophrenia and other epidemiological studies provided a language and an institutional visibility through which psychiatry could become incorporated into international health policies and practices. Yet despite such international research and the marketing of pharmaceuticals as targeting specific mental disorders, mental health ranked low among WHO's priorities. In a decolonizing world, a more pragmatic stream of knowledge-production centered on adapting psychiatric treatment to the contexts of "developing countries", through low-cost innovations such as the invention of traditional healers as collaborators and the delivery of treatment through primary health care. These approaches reflected the rejection of institutional care and a view of the 'community' as a "natural" locus of support. In some regions biomedical psychiatry and psychoanalysis encountered pre-existing medical traditions. However, the productive friction engendered and the involvement of psychiatrists and scientists from the global South in the production of knowledge and policy internationally remain understudied.

In the 1990s the advent of a new metrics - the Global Burden of Disease - propelled mental disorders to the top of international disease rankings with depression, in particular, ranked among the leading causes of the collective 'disease burden'. This visibility, alongside the epidemic view of mental illness, the expansion of psychiatric diagnoses, and public awareness campaigns, generated new sites for intervention and expanded markets for psycho-pharmaceuticals. At the same time, the notion of 'well-being' has become linked to the language of the economy and generated new forms of 'self-care'. More generally the era of 'global health' since the 1990s is characterized by shifts in goals, perspectives and organizational actors. With the increasing influence of the World Bank, mental health has become absorbed into a broader concern with improving health as an economic good through scalable, cost-effective and evidence-based interventions. The primary provider of health care has shifted from the state to multilateral

government and public-private partnerships and public funding is giving way to corporate philanthropy and donor aid. Domains of expertise formerly limited to scientific and administrative experts now legitimate non-governmental organizations and civil society groups as actors in mental health policy, funding, and service delivery.

Across these three hypothesized periods, experimentality at the intersection of North and South has contributed to the construction of psychiatric knowledge, with differential impacts on psychiatric traditions in the global North and on modernizing forms of older traditions such as Ayurveda and Chinese medicine. Each of these periods is also traversed by the problematics of psychiatric classification and debates regarding the best approach to treatment. Within global disease metrics, psychiatric categories are taken as if they have stable referents, despite ongoing critiques. Likewise, concerns are expressed regarding the standardization of treatment, the increasing medicalization of emotional life, and a disregard for structural context. The vision of 'community mental health' has scarcely been fulfilled, hampered by the weakness of health systems in many parts of the globe, as well as insufficient interrogation of what 'community' might mean in different settings, particularly in contexts of urbanization, rising migration, family dispersal, and increasing pressures on household budgets. More recently, efforts to apply a rights-based agenda have promoted new forms of solidarity as persons with 'psychosocial disabilities', as well as reinvigorated longstanding controversies over involuntary psychiatric treatment.

The present century has witnessed the materialization of something called 'global mental health', defined by shared practices, principles, tools, and models of biomedical and psychosocial treatment. Yet the multi-directional movement of actors, knowledge, tools, therapeutics and models of practice redefines positions and hierarchies, peripheries and centers, expertise and patient-hood, creating resistance and critique as much as homogenizing difference. We aim to explore and analyse the processes through which mental health is made visible over time in diverse settings, and the translations, improvisations, hybridisations and rejections which reshape global mental health as it travels.

This workshop welcomes papers exploring these themes, including:

- (a) historical processes, what was at stake, for whom, and with what outcomes;
- (b) intersections of colonialism and post-colonialism with the regimes of international health and global mental health
- (c) the relationship of psychiatric epidemiologies or "epidemiological styles of thought" and new health metrics to these processes;
- (d) materialization of regimes of psychiatric knowledge and practice in different localities, regions and virtual spaces, and processes and practices of hybridization, improvisation, translation and resistance.
- (e) specific therapeutics and systems of mental health care delivery, including the pharmaceuticalization of treatment, different uses of "traditional" therapeutics, the objects of standardization, the actors of mental health (patients, clinicians, nurses, social workers, volunteers, peer workers etc.)
- (f) the economies of global mental health (moral economies, constructions of cost-effectiveness, scalability)
- (g) the changing status of the person (moral, empirical, psychological) under the different regimes of mental health governance

PROGRAMME

Monday 12th June

19.00 Arrival and evening reception

Tuesday 13th June

9-9.30 Introduction

9.30-13.00

Session 1: From international health and development to global mental health: historical perspectives

Discussant: Christoph Gradmann, University of Oslo, Norway, and Cermes3, France

09.30-10.00

Harry Yi-Jui Wu, University of Hong Kong, People's Republic of China

Common ground between Geneva and developing countries in WHO's first social psychiatry project

10.00-10.15 Q&A

10.15-10.45

Megan Vaughan, University College London, U.K.

Globalizing the psyche? Psychological counselling in eastern Africa.

10.45-11.00 Q&A

11.00-11.30 Break

11.30-12.00

Matthew Heaton, Virginia Tech, U.S.A.

Decentering global mental health history: Nigeria, India, and the WHO's International Pilot Study of Schizophrenia

12.00-12.15 Q&A

12.15-13.00 Plenary discussion

13.00-14.00 Lunch

14:00-18:00

Session 2: Knowledge production, global health metrics and models, epidemiologies

Discussant: Tine Hanrieder, WZB Berlin Social Science Centre, Germany

14.00-14.30

Dörte Bemme, McGill University, Canada

Contingent universals: On the use of theory of change in Global Mental Health

14.30-14.45 Q&A

14.45-15.15

Nicolas Henckes, Cermes3, France

Schizophrenia research as a global social movement: a framework for analysis

15.15-15.30 Q&A

15.30-16.00 Break

16.00-16.30

Mohan Rao, Jawarharlal Nehru University, India

If wishes were horses: mental health in India

16.30-16.45 Q&A

16.45- 17.15

Claudia Lang, Cermes3, France

Inspecting mental health: Depression, surveillance and care in Kerala, South India

17.15-17.30 Q&A

17.30-18.00 Plenary discussion

20.00 Dinner

Wednesday 14th June

09:00-13:00

Session 3: Transformations of therapeutics

Discussant: Caroline Meier zu Biesen, Freie Universität Berlin, Germany

9.00-9.30

Sara Cooper, University of Capetown, South Africa

Preparing the maternity care environment for mental health care task-shifting in South Africa: The 'Secret History' method and the development of an ethos of care

9.30-9.45 Q&A

9.45-10.15

Anubha Sood, Southern Methodist University, U.S.A.

Hurting the body to heal the mind? The case of the Balaji temple in North India

10.15-10.30 Q&A

10.30-11.00 Break

11.00-11.30

Dominique Béhague, Vanderbilt University, U.S.A./Kings College London, U.K.

Tbreeding and untbreading: trajectories of conflict, politics and social justice in Pelotas, Brazil

11.30-11.45 Q&A

11.45-12.15

Anne Lovell and Papa Mamadou Diagne, Cermes3, France

Thick therapeutics: Madness and moral economies of healing under globalizing regimes in Senegal

12.15-13.00 Plenary discussion

13.00-14.00 Lunch

14:00-16:45

Session 4: Human rights, community and sovereignty

Discussant: Jean-Paul Gaudillière, Cermes3, France

14.00-14.30

Ursula Read, Cermes3, France

Rights as relationships: Negotiating human rights and moral complexity within community mental health in Ghana

14.30-14.45 Q&A

14.45-15.15

Roberto Beneduce, Franz Fanon Center, Turin, Italy

What remains of ethnopsychiatry? Health, healing, and sovereignty against the background of global psychiatric diagnosis

15.15-15.30 Q&A

15.30-16.00 Break

16.00-16.30

Hanna Kienzler, King's College London, U.K.

Humanitarian crisis as opportunity for mental health system reforms

16.30-16.45 Q&A

16.45-17.30 Plenary discussion

17.30-18.30 Round table

Facilitator: Laurent Pordié, Cermes3, France

20.00 Dinner

Thursday 15th June

Departure

Abstracts

Common ground between Geneva and developing countries in WHO's first social psychiatry project

Harry Yi-Jui Wu, Assistant Professor in Medical Humanities, University of Hong Kong

In this paper I interrogate the space in which the exchange of knowledge, the sharing of methods, and the formation of collaborative research were enabled between the WHO and its member states. I first provide short examples in which knowledge transfer occurred between the WHO and its Latin America and African collaborators. As a case in point, I further discuss a series of large-scale epidemiological studies on mental disorders which were conducted by the research team of National Taiwan University Hospital in the early postwar years, regarding their purpose, significance, and legacy within Taiwan and in the international social psychiatry projects led by the WHO. I analyze the active and passive roles these studies played in the context of postwar decolonization and the milieu of scientific internationalism in the new world order created by the United Nations and its specialized agencies. As influenced by the survey-based Japanese ethnological studies developed in the first half of the 20th century and designed for the purpose of building discipline after WWII, the psychiatric epidemiological research conducted in Taiwan not only reflected the vision of the international scientific communities to “deracialize” the human sciences but also fulfilled the pursuit of knowledge by the WHO ideology of “world citizenship”. The approach of cultural determinism not only matched the then dominant neo-Freudian theories of psychopathology, which moved away from the bequest of biodeterminism from colonial psychiatry, but also laid the foundation for the universal profiles of mental disorders, which the WHO mental health experts attempted to establish.

Responding to existing historical accounts commenting on projects conducted by the WHO, I also offer a conceptual framework to rethink the relationship between Geneva and its target developing countries. The tie between the WHO and its member states not only exemplifies the “trading zone” explained by science historians vis-à-vis the collaboration among scientists of various cultures and languages, as mobilized by the exchange of thoughts and methods, but also reflects the “dreamscape” propagated by STS scholars, after which developing countries shaped their identities as postwar modern states with sociotechnological imageries exercised beyond the WHO's ideological framework centered in Geneva. Such effort of national self-fashioning and administrative pilgrimage enabled scientists from the WHO's member states to participate in international scientific collaborative projects. WHO's projects could not have been conducted without a world that was mutually imagined by its headquarters and member states. At the end of the presentation the author also comments on the achievements and fallacies of this short-lived optimism.

Globalizing the psyche? Psychological counselling in eastern Africa.

Megan Vaughan, Professor of African History and Health, University College London

This paper examines the recent spread and popularity of psychological counselling techniques and training in eastern Africa. It traces the multiple roots of this phenomenon across the region to forms of Christianity and their attendant concepts of self and self-care, to conflict and displacement, human rights discourse, to the HIV/AIDS epidemic, as well as to the impact of self-consciously ‘modern’ forms of subjectivity. Largely de-linked from more formal (and chronically under-funded) mental health services, this bricolage of theories and techniques, though often sponsored by external agencies, has taken root in the region and has been adopted and adapted by local practitioners, some of whom actively seek to ‘Africanise’ and appropriate them.

Decentering Global Mental Health History: Nigeria, India, and the WHO's International Pilot Study of Schizophrenia

Matthew M. Heaton, Associate Professor, Department of History, Virginia Tech

The cultural critique of global mental health in many ways condenses to a binary in which a “global” psychiatric theory and practice rooted in “western” beliefs conflicts with “local” theories and practices, usually in “non-western” environments. Much of the power of this narrative derives from an implicit understanding of the history of the movement toward global mental health as originating in a “western” center and flowing outward to a “non-western” periphery essentially as a colonial legacy. However, it is also possible and necessary to see the historical trajectory toward global mental health as comprising non-western, post-colonial genealogies. Citing brief examples from Nigeria and India, this paper will demonstrate the ways that psychiatrists of indigenous background in each country engaged in local production of psychiatric knowledge in pursuit of anti-colonial, nationalist, and developmentalist agendas in the 1950s and 1960s. Research centers in both countries later contributed to the WHO's International Pilot Study of Schizophrenia, the gold standard of the time for cross-cultural psychiatric epidemiology. Recognition that knowledge produced in post-colonial socio-political contexts influenced the establishment of global norms helps us begin decentering narratives proclaiming the Eurocentric genesis of the international processes that begot the global mental health movement.

Contingent universals: On the use of theory of change in Global Mental Health

Doerte Bemme, PhD student, Department of Anthropology, McGill University

The movement for Global Mental Health (GMH) is a multi-disciplinary assemblage striving to treat ‘mental health’ on a global scale through evidence-based interventions. While relying heavily on standardized epidemiology to advocate for mental health in the policy arena, GMH's treatment models and clinical trials often employ flexible and iterative research designs that square the demands of globally comparable data production with the contingencies of situated knowledge and health systems. Drawing on empirical fieldwork within a multi-country mental health research consortium, this presentation attends to the ways a participatory framework called “Theory of Change” (ToC) operationalizes (and perhaps reformulates) the paradox between universality and contingency in practice. “Theory of change” workshops reverse-engineer a desirable outcome by inviting a number of stakeholders to collectively define the process and steps required to achieve it. The resulting “ToC maps” can vary greatly from country to country, yet they create the language, conceptual skeleton and, importantly, new spaces of indeterminacy, through which knowledge emerges, flows, and temporarily hardens for the sake of global comparison. By paying attention to ToC as a space and practice that is neither “global” nor “local” I seek to trouble the common narrative of how universal categories, metrics and modes of accounting come up against “local” realities “on the ground”.

Schizophrenia research as a global social movement: a framework for analysis

Nicolas Henckes, CNRS Associate Researcher, Centre de Recherche Médecine, Sciences, Santé, Santé Mentale et Société (CERMES3), Paris

This paper is an attempt at mapping the history of schizophrenia research in the second half of the twentieth century as a global social movement. Its argument is that this research, as a social movement, contributed to shape the concept of schizophrenia in the very same ways in which the asylum movement had done in the period before. If schizophrenia was from the beginning a global concept, one that circulated across boundaries in different social and cultural milieus, its understanding used to be local by nature. Schizophrenia targeted patients who were first defined

by their embroilment in local circuits of chronicization built in and around asylums. After 1950 the conjunction of deinstitutionalization and a booming research industry mapped schizophrenia onto a series of new networks which extended well beyond the walls of psychiatric institutions to cut across the limits of national communities. Psychopharmaceutical research, genetics, epidemiological and psychosocial research all contributed to the creation of not only concepts, instruments and techniques, but also of interconnected research collectives with connections to the industry, the clinics and the politics. As a result this research endeavors not only changed the nature of the phenomena that were labelled schizophrenia but also the very sort of persons who were afflicted with the disorder. As both agents of research and subjects of the multiple protocols which regulated this research, both labelers and labelled, both patients and clinicians-researchers emerged as new figures. Relying on a situated analysis approach (Clarke 2005), the paper will delineate a framework for mapping these transformations.

If wishes were horses: Mental health in India

Mohan Rao, Professor, Centre of Social Medicine and Community Health, Jawarharlal Nehru University

The Government of India has recently passed the Mental Health Care Bill, 2017. This Bill is indicative of the political will towards provision of mental health care, woefully poor today, to the population of the country. It also represents *zeit geist*, a response to the global mental health movement. This paper critically examines the assumptions underlying these recent moves, and argues that efforts at provision of mental health is not possible given the utter neglect of public health services in the country. With a collapsing public health, with increasing inequalities in the country, the medicalising of distress does not represent a step forward.

Inspecting mental health: Depression, surveillance and care in Kerala, South India

Claudia Lang, Postdoctoral Fellow, Centre de Recherche Médecine, Sciences, Santé, Santé Mentale et Société (CERMES3), Paris

With the publication of the Global Burden of Disease studies of the last two decades, depression has become one of the major global health concerns, in spite of major critiques that question the universality, medicalization and ontology of depression as a medical entity. The South Indian state of Kerala sees itself as a society in distress, suffering from unprecedented rates of depression. The rise of depression and suicide is often related to a discontent around modern transformations and the flipside of what is called (today with increasing sarcasm) the “Kerala model of development”. Solutions are sought in the form of psychosocial engineering or governmentality capable of producing mentally resilient subjects able to face the multiple crises of Kerala’s increasingly neoliberal society.

Integrating mental health into primary health care in line with WHO’s programs and guidelines and India’s efforts to promote community mental health since the 1950s is part of the District Mental Health Program (DMHP). Kerala’s primary health care not only comprises general physicians but is based on a variety of multi-purpose and community health workers. As part of the DMHP in Thiruvananthapuram district, community and multi-purpose health workers are trained in identifying possible mental health problems, referring them to the Primary Health Centers for diagnosis and psycho-pharmaceutical treatment, and giving basic psychosocial counseling. Based on an ethnographic reading of the ‘Mental Health for All’ program in a rural community in Southern Kerala, I explore how the emergence and globalization of depression as a major public health concern and the agenda of integrating mental health into primary health care translate into local programs and practices of inspection, surveillance and care.

Preparing the maternity care environment for mental health care task-shifting in South Africa: The ‘Secret History’ method and the development of an ethos of care

Sara Cooper¹, Simone Honikman², Sally Field²

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The burden of maternal mental illness and associated ‘treatment gaps’ within low-and-middle-income countries, including South Africa, have gained renewed attention as an important global public health concern. There is growing consensus that addressing this situation requires the scale-up of maternal mental health care through a ‘task-shifting’ approach, whereby services are delivered by nurses within routine Primary Health Care (PHC) settings. There are, however, concerns that this model of care is too often being applied in a ‘one-size-fits-all’ manner, with little attention to the local contexts of PHC environments. In South African PHC maternity settings, nurses’ abuse of patients and associated poor quality of care is ubiquitous, a situation which current mental health task-shifting initiatives face the danger of exacerbating. This was the vantage point that the Perinatal Mental Health Project developed its Secret History method, as a critical pedagogical intervention for maternity care nurses in South Africa. The method seeks to better prepare the maternity care environment for task-shifting initiatives by introducing nurses to a powerful, counter ideology of empathic care.

This paper provides an in-depth account of the theoretical underpinnings and practical application of the method. Before this, we first offer an analysis of the complex socio-structural factors underpinning nurses’ mistreatment of patients in South Africa, and how formal nursing education and current ‘top-up’ mental health training are failing to tackle, and even perpetuating this situation. This provides a lens through which the Secret History method can be understood, and the complex dynamics of power and oppressions it seeks to address. We demonstrate how the method draws on Boal’s Theatre of the Oppressed, and associated education principles of Paulo Freire, to provide a space for nurses to become aware of, interrogate and reimagine dysfunctional nurse-patient relations within the maternity care setting. Grounded in a pedagogy of participatory, dialogical and embodied learning, the method goes against the grain of traditional nursing education and training by capacitating nurses in the more interpersonal or ‘being with’ components of care. Ultimately, we argue that efforts such as the Secret History method could go a long way in ensuring that current mental task-shifting strategies in South Africa are more democratic, responsive and ultimately humane.

Hurting the body to heal the mind? The case of the Balaji temple in North India

Anubha Sood, Southern Methodist University

How do practices that involve inflicting voluntary pain to the body become therapeutic for alleviating psychological ailments? And how may these practices be engaged within a dominant global mental health discourse that espouses Western psychiatric understandings and human rights as indisputable tenets of mental health practice? Based on ethnographic research with female attendees in the Hindu healing temple of Bālaji – a site popular across North India for treating spirit afflictions that manifest as mental illnesses – this paper explores the logic and effects of methodical engagement with pain as a therapeutic modality. I illustrate how the therapeutic value of painful bodily practices in Bālaji lies in the cultural understanding of the body as a fundamental site of self-transformation, and how these practices are gradually dying in the wake of India’s adoption of the global mental health policy discourse in the twenty-first century.

Threading and unthreading: trajectories of conflict, politics and social justice in Pelotas, Brazil

Dominique P. Béhague, Associate Professor of Medicine, Health and Society, Vanderbilt University & Senior Lecturer, Kings College London

What constitutes the clinic? How can we come to know the clinic and the sciences that co-constitute it without resorting to an overly teleological and episteme-oriented understanding of expertise? These questions are particularly timely in Brazil, where over the last 15 to 20 years, psychiatrists' long-standing commitments to psychodynamic approaches and Marxist-inspired social medicine have been challenged by the rise of biological and behaviorist models in psychiatry. Thinking with -- and against -- a form of analysis that explains this shifting landscape with reference to the recent globalization of biopsychiatric knowledge-forms, my research situates the clinic historically and politically through long-term and comparative ethnography. In my fieldwork, I followed a group of 96 young people from a range of economic and social backgrounds for more than 10 years, from their 15th birthdays into adulthood. As I watched them grow up, flowing in and out of clinics and psycho-pedagogic initiatives in schools, I witnessed distinct life-trajectories and clinical forms co-materialize. In some of these, conflict, politics and the demand for social justice took clinical center-stage and nurtured a clinical-ontological form of becoming that interrupted long-standing inter-generational cycles of institutionalized violence and discrimination. Relative to the systems of oppression within which psychiatry has historically been intertwined -- and indeed *because of* this intertwining -- this clinic thus (also) engenders a unique form of psychiatric productivity that, in the absence of a historic perspective, might otherwise remain invisible and under-theorized.

Thick therapeutics: Madness and moral economies of healing under globalizing regimes in Senegal

Anne M. Lovell and Papa Mamadou Diagne, Centre de Recherche Médecine, Sciences, Santé, Santé Mentale et Société (CERMES3), Paris

The uncanny eruption of seizures or psychotic states constitutes a triple crisis – psychic, social and moral – for the family nexus. It questions the taken-for-grantedness of the everyday and ultimately disrupts the domestic economy. In Senegal, bio-medicalization and psychiatrization introduced by development programs and humanitarian NGOs add additional, though not necessarily alternative, possibilities to the recourse to “wolof medicine” (the local designation for a range of religious and healing practices to which families turn, whose practitioners include Islamic healers, herbalists, itinerant Hausa, and charismatic spiritual figures). To explore the effect of global mental health practices on this triple crisis, interviews with patients, carers, mental health practitioners, administrators and “wolof healers” were conducted in two, contrasting cities: a peri-urban area that also serves as a “dormitory” city for Dakar, the capital; and a predominantly mouride holy city.

The possibility of seeking help depends on the strength of interactions and solidarities within and without the family nexus. Ultimately, it is less the globalization of mental health than globalization's spatial and relational dispersion of family networks that shapes the therapeutics of crisis. Therapeutic trajectories underscore latent and imbricated moral economies, regardless of the efficacy or pragmatics of different therapeutic possibilities. If a greater heterogeneity and dilution of practices characterize the management of crises compared to earlier periods (Zempleni 1968, Fassin 1993), an incommensurability separates “wolof medicine” and global mental health. Within wolof medicine, this incommensurability is reinforced by the symbolics of the exchange of animals, similar to Ferguson's (1985, 1994) “bovine mystique”, versus the mostly utilitarian nature of paying for psychiatric treatment.

Rights as relationships: Negotiating human rights and moral complexity within community mental health in Ghana

Ursula M Read, Postdoctoral Fellow, Centre de Recherche Médecine, Sciences, Santé, Santé Mentale et Société (CERMES3), Paris

This paper will discuss the interactions of community mental health workers with traditional and faith healers in Ghana in the context of international concerns regarding human rights abuses and mental health innovations developed through partnerships between government and various actors in global mental health, including the World Health Organization, international donors and researchers, and NGOs. These actors envision legislative reform and the expansion of community care as working to protect the human rights of people with mental illness through establishing processes of oversight and collaboration. Despite the passage of a new mental health act in Ghana which explicitly prohibits involuntary treatment within ‘non-orthodox’ facilities and commits to protection of the rights of persons with mental disorders, traditional and faith healers (particularly Pentecostal pastors who operate ‘prayer camps’) remain popular resources for treatment and practices of mechanical restraint commonplace.

With the expansion of community mental health services, mental health workers increasingly visit such healers as part of ‘community outreach’ activities and advocate the use of psychopharmaceuticals as a humane alternative to calm violent or disruptive behaviours. However, in interactions with healers they avoid confrontation and the use of legal enforcement, seeking rather to support healers’ activities through, for example, improving the infrastructure of their facilities. These forms of collaboration may be questioned by international agencies as collusion with perpetrators of human rights abuses. Drawing on ethnographic research with mental health workers, people with severe mental illness, family carers, and traditional and Pentecostal healers this paper suggests rather that through such forms of engagement mental health workers seek to engender sentiments of reciprocity within a shared moral landscape and avoid rupturing relationships with healers and families whose support is crucial, particularly given the lack of resources within public health and social welfare. The paper describes how mental health workers engage in forms of ethical, moral and theological reasoning to interrogate the tension between the spiritual authority of healers and their professional duty of care. Such forms of ethical reflection problematize the secular vision of individual rights as freedom and self-determination, as advocated within the ‘empowerment’ discourse of global mental health and disability rights, recognising rather that rights are embedded in relationships within which moral complexities around freedom, responsibility and obligation in the care of people with serious mental illness are negotiated and performed.

What remains of ethnopsychiatry? Health, healing, and sovereignty against the background of global psychiatric diagnosis

Roberto Beneduce, Associate Professor, University of Turin, Department of Cultures, Politics, and Society

This paper, based on research conducted in Mali and southern Cameroon, briefly investigates three interconnected aspects. The first considers the legitimacy of the concept of ‘traditional medicine’ itself, in light of the dynamics of incessant change transforming its symbols, techniques and epistemology. I propose to consider traditional medicine as a ‘formation’, to stress the complex, at times chaotic, characteristics of these processes, as well as the political nature of its social grammar. The second aspect involves an analysis of the bureaucratization and professionalization of traditional medicine, and the paradoxes of the programs encouraging cooperation between biomedicine and traditional medicine. Against this background, these considerations propose a third issue: the relationship between Global Mental Health and the

hegemonic Western psychiatric diagnosis “apparatus” (Foucault; Hacking; Summerfield). My aim is to discuss these issues on the basis of a critical ethnopsychiatry primarily addressed to think of ‘healing practices’ in terms of political sovereignty and subaltern knowledge (de Martino, Fanon).

Humanitarian crisis as opportunity for mental health system reforms

Hanna Kienzler, Lecturer, Department of Global Health & Social Medicine, King’s College London

It has been suggested that humanitarian crises interventions offer the international aid community a unique opportunity to reorganize and reform mental health systems by shifting hospital-based care to community-based services. Reports make apparent that such reforms place particular emphasis on the enhancement of government driven policies, human resources and training, programming and services, research and program monitoring, and finances. It is further highlighted that these activities follow “enlightened”, more “humanistic” and “evidence-based” approaches to mental health policies, service development and treatment for persons with mental health problems.

In this presentation I argue that the World Health Organization and its allies in fact used humanitarian crises situations in the 1990s and early 2000s as laboratories for developing and trying out first mental health system reform activities before creating the now well-known Mental Health Gap Action Programme (mhGAP) in 2008. Contrary to what is often assumed, these initial trials were not based on solid research or systematic situational analyses, but rather developed through learning by doing with no blue print to follow. I will substantiate this argument through case studies based on long-term ethnographic research conducted in Kosovo and the occupied Palestinian territory among national and international NOGs, ministries of health, and health practitioners and administrators. Attention will be paid to (a) the emergence of new models of mental health care at the intersection of global health agendas and humanitarian and mental health aid; (b) processes through which short-term crisis interventions were transformed into long-term mental health and psychosocial interventions; and (c) how these developments eventually led to systemic transformations with rather indecisive outcomes. Thereby, I aim to contribute an alternative history to the pool of existing stories about the emergence of global mental health.