Toward a new relationship between history and global mental health

Antic, Ana; Abarca Brown, Gabriel Antonio; Moghnieh, Lamia; Rajpal, Shilpi

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Global mental health (GMH) can benefit tremendously from critical historical analysis. The field is characterized by porous disciplinary boundaries that researchers and social actors have often crossed to engage in different aspects of mental health research, interventions, and discussion. GMH research has thus been nourished by valuable contributions from psychiatrists, psychologists, and social workers, who tailored interventions in different contexts (Collins et al., 2011; Patel, 2014; White et al., 2017) and by the insightful reflections carried out by anthropologists and sociologists (Bemme and D’souza, 2014; Béhague and Macleish, 2020; Ecks, 2016; Jain and Orr, 2016; Mills and Fernando, 2014; Rose, 2019; Summerfield, 2013). Despite the engagements of multiple actors with the history and genealogies of GMH (Lovell et al., 2019), these actors and the field itself have not paid enough attention to recent contributions in the history of psychiatry and healing, and in the anthropology of colonial and post-colonial psychiatry (Linstrum, 2016; Antić, 2021; Kilroy-Marac, 2019; Pinto, 2014; Porter, 1985). GMH actors have identified and faced various controversies and challenges such as access to institutional mental health systems, the integration of indigenous healers, the adaptation of treatments, and the role of culture in mental health. However, these are not new concerns: global psychiatry has already grappled with such problems at different points in the nineteenth and twentieth centuries. These recurrent and persistent concerns invite a deeper historical understanding of the study of mental health and treatment.

We are a group of historians, anthropologists, and practitioners who engage with the complex and messy history of global mental health—a field that at different historical moments involved cross-cultural or transcultural psychiatry, ethnopsychiatry, international mental health, and colonial psychiatry, among others. Exploring this history, which precedes and goes beyond the current Movement for Global Mental Health (Movement for GMH) (Global Mental Health Group, 2007), is our only hope for addressing these repetitive issues and critiques, and can help both practitioners and scholars to imagine new solutions for them.

1. Historicizing global mental health: recentering the history of patients, actors and expertise beyond the global north

Psychiatrists and anthropologists have often included historical analysis in global mental health research, primarily emphasizing the genealogies of global mental health (Jain and Orr, 2016; Lovell et al.,...
While many researchers value historical perspectives, theirs is a more schematic, chronological, and fragmented approach. In most of this literature, history features as a descriptive background that provides a linear and stage-by-stage narrative of the development of contemporary terminologies and institutions of global mental health. Historical research is reduced to tracing the immediate lineages of GMH, while the rest of the historical dynamics is sometimes reduced to “a prehistory of GMH” (Jain and Orr, 2016). Colonial histories of madness occupy a marginal place in these debates, often framed as a cautionary tale, a difficult (or hidden) but separate historical episode that GMH needs to avoid, and a reminder of the distant past of psycho-disciplines (Bemme and Kirmayer, 2020). Furthermore, history has been used to demonstrate an (assumed) continuity and universality of the need for mental health support across time, place, and culture (White et al., 2017). For the critics of GMH, references to history served to draw direct comparisons with colonial oppression (Summerfield, 2013).

Where do we start when we aim to historicize global mental health? Historical work on GMH and the Movement for GMH has provided important insights into the more recent and institutional history of the movement, paving the way for more historical analysis and attention to the broader and more expansive field of global mental health (Lovell et al., 2019). In anthropology, ethnographies of GMH have also provided a rich contextual understanding of its more recent practices and interventions. They generated multiple critiques of the scalability of mental health expertise, as well as nuanced analyses of the role of culture in GMH, and of political economies of illness and care. They also called attention to structural inequalities in mental health settings (Abara-Brown et al.; Bemme, 2019; Moghnieh, 2022; Read, 2015; Davis, 2018). By engaging with and broadening the scope of this literature, we invite a thicker historical approach that allows us to rethink what is global in GMH and the Movement of GMH, a question raised by several researchers (Béhague and MacLeish, 2020; Jain and Orr, 2016; Lovell et al., 2019; Bemme and Kirmayer, 2020).

A deeper historical perspective has the capacity to broaden the conversation on the making of GMH. It sketches out new relationships between social institutions, practices of care, and actors, developing new analytical constellations that have the potential to dislocate classical psychiatric, clinical and public health frames. Historical work on madness often argues for extending clinical frames of analysis to vernacular languages and literatures of illness, suffering and healing, and encourages researchers not to limit their understanding of medical encounters to ‘impact’ and ‘cure’ (Porter, 1985; Mukharji, 2011; Rajpal, 2021). In anthropology, practices such as ‘care’ and ‘recovery’ have also been central analytical concepts in the study of health and illness (Feldman and Ticktin; Kleinman and van der Geest, 2009; Bielh and Fassin, 2012; Myers, 2015). Our perspective recognizes these richer concepts of care, healing and recovery, contextualizes their historical construction and evolution, and introduces new categories, actors, and makers in the field.

One such category of actors includes patients as equal makers of knowledge on mental health. Historian Roy Porter pioneered the approach of writing the history of psychiatry from below and through patients’ voices, seeking to recover patients’ experiences and meaning-making strategies in clinical psychiatric contexts. He highlighted how both sickness and psychiatric patients’ experiences of it should be viewed as constitutive parts of whole cultural sets (Porter, 1985). This formalized psychiatric patients’ perspectives and understanding power relations between patients and psychiatrists has been at the core of recent social and cultural historical research (Kilroy-Marac, 2019; Rajpal, 2021; Sadowsky, 1999), which has also consistently emphasized the role of patients in both contesting and co-creating psychiatric concepts and care. This research on patients’ voices has developed new methodologies, interpretive frameworks, and sophisticated interdisciplinary analytic categories that can be of great value to the field of GMH and the Movement for GMH as it seeks to involve and understand service users’ experiences and perspectives (Berkenkotter, 2008; Aaslestad, 2009; Millard and Callard, 2020).

Moreover, just like historical research can help us reconceptualize the role of patients in different historical and cultural contexts, it has also consistently drawn attention to the fundamental contributions to global mental health by mental health experts from outside the Global North (Pinto, 2014; Heaton, 2013; Fringle, 2019; Antic, 2021). This insight is particularly important for the present-day field of GMH: it disrupts the idea that knowledge mainly traveled from the global north to the global south, and it outlines how psychiatrists from the decolonizing world had a vital role to play in the creation of the field of twentieth-century global psychiatry as an exceptionally diverse and dynamic profession. Finally, historical research has worked to extend the limited concept of the GMH research, by producing rich and nuanced research on the development of cross-cultural psychiatry and mental health intervention in MENA, Latin America, Eastern Europe, or Southeast Asia. By centering the history of the nineteenth and twentieth centuries in GMH research, we call for an extended and diversified understanding of mental health projects, knowledge makers, and practices on a global level. This approach places GMH in conversation with a myriad of other projects and initiatives that experimented with and negotiated the field in various historical contexts.

2. De-colonial histories: politics and power in global mental health

Our perspective centers on the formative role of colonial histories and decolonial processes in the emergence of new relationships between the global north and south, and east and west. The Movement for GMH’s understanding of global relations/differences is still informed by the concepts of civilization, development, and ‘primitivism’, which are rooted in colonial theories and medical practices. While GMH has often explicitly aligned itself with efforts to tackle the issues of global inequality and epistemic injustice (Land et al., 2011; Patel, 2014b), a thicker historical approach can help identify and overcome the latent hegemonic legacies of colonial psychiatry. This is not to say that any attempt at globalizing or standardizing mental health initiatives must be ‘colonial’ in its nature, but simply to ensure that the Movement for GMH remains aware of different ways in which colonial frameworks and hierarchies have shaped the field of global psychiatry in fundamental ways from the beginning.

An in-depth historical analysis complicates the genealogy of the field of GMH and the Movement of GMH demonstrates how strongly the practices/intellectual frameworks of colonial psychiatry influenced the post-WWII discipline of transcultural/global psychiatry (Antić, 2021). Colonial psychiatry’s evolutionary language, cultural hierarchization, and ideas about ‘civilization’ and ‘primitivism’ continued to define the proclaimed universalism of the WHO and transcultural psychiatry well into the 1980s. For example, the International Pilot Study of Schizophrenia produced a hierarchical scheme of ‘languages of emotion’, in which patients from ‘developing’ (non-Western) countries were described as lacking in capacity to differentiate between categories of negative emotions and consequently less psychologically nuanced, while their languages were termed ‘living fossils’ (Leff, 1988). Moreover, building on a long history of thinking about mental illness through the lenses of primitivism, the IPSS concluded that complex mental illnesses have better prognoses and outcomes in the ‘third world’. While we cannot discuss here the reliability of these outcomes, it is important to note that this argument was widespread among colonial psychiatrists, who believed that simple and primitive ‘native’ minds could not suffer from complex mental disorders. In current discussions about cross-cultural mental health interventions, the legacy of the IPSS is obvious in the romanticization of community and family-based care in the developing world, which is believed to offer protection from mental pathology. This belief neglects to consider that families and communities are simultaneous sites for transgression, violence, and care. Some
scholars related to the field of GMH have already critiqued such assumptions about ‘primitive’ cultures and their supposedly beneficial mental health effects (Coehen; Read and Nyame, 2019). It is only through careful historical research, however, that we can understand how these ideas were produced in the context of psychiatry’s colonial past, and how they remain embedded in those relations of political subordination and epistemic injustice, even if they are now placed in anti-colonial discourse. In a similar vein, historical research can build on the existing work and theory of primitivism in order to demonstrate how conceptualizations of primitivism in contemporary mental health research are directly linked to the psychiatric profession’s colonial histories (Lucas and Barrett, 1995).

A careful historical analysis would also mean that the field of GMH reframes some of its discussions around politics and power relations. From the very beginning, global psychiatry was fundamentally shaped by some of the most important political conflicts of the twentieth century. This field itself was formed with the emergence of colonial nations as participants and partners in the international mental health movements. However, as historians of colonialism such as Erik Linstrum have brilliantly demonstrated, some important aspects of colonial psychiatric knowledge and practice informed the new discipline, and psychological research on and mental testing of colonized populations led to the establishment of international psychiatry, intelligence testing, and cross-cultural psychometrics as disciplines. This allowed for the emergence of global mental health (Linstrum, 2016). Recent historical research also shows how the concept of a global psyche and universal humanity was formulated after the end of World War II and in direct response to the pressures of colonial conflicts (Antic, 2021; Wu).

In this reframing, it would be important to understand ‘politics’ in the broadest sense possible: not as a technocratic concept, a process of policymaking, nor as something that occasionally (and unfortunately) intrudes in an otherwise apolitical consideration of interventions, measures, and outcomes. This includes, but also goes beyond, the current technocratic discussion around poverty and global inequalities (e.g., social determinants of health (Braveman and Gottlieb, 2014; Jiménez-Molina et al., 2019; Yates-Doerr, 2020), access, evidence-based therapies, cross-cultural adaptations), and seeks to understand how such inequalities are enforced and perpetuated in different political contexts, how they are rooted in deep-seated historical patterns and relationships of subordination, and how they might be dictated by contemporary political agendas (which tend to rely on a simplified social stratification between high-income and low-income countries) (Khan et al., 2022). GMH has been criticized for depoliticizing and medicalizing structural problems (Ingleby). Deeper historical and political awareness can also help practitioners overcome this critique and become more conscious of the political contexts of their work.

In this analysis, experts, researchers, and practitioners could not possibly be seen as politically neutral. Political neutrality should not be understood as a progressive value in itself. Instead, we invite GMH actors to recognize and reflect on the influence of political ideology on their own work. This lack of political awareness and the insistence on political neutrality of mental health initiatives have been harmful in the past. For instance, the mental hygiene movement during the beginning of the twentieth century regarded the preservation of mental health as a civic responsibility that was central to the perseverance of family, community, and the nation-state. However, this movement was also centrally framed by eugenic thinking and concepts such as racial hygiene and feeble-mindedness. These eugenicist notions were in turn closely aligned with the fascist ideologies and supremacist and nationalist agendas of the time (Thompson, 2010). With this in mind and turning our attention to the current context, we should ask ourselves if the GMH movement is truly operating above politics. By reducing ‘the gap’, does it also reproduce problematic political (colonial) legacies through Western notions of personhood, culture, mind, and suffering?

This debate about the field’s political position would raise important questions about how the initiatives and actors of the Movement for GMH have understood the role of state institutions, society’s political and economic responsibilities, the relationship between individuals and society, the role of marginalized social and political groups, but also how they have approached discussions about international relations and broader global political developments. This is particularly important for psychiatry and mental health disciplines, which have, in the twentieth century, often been anchored in wider political frameworks and ideologies such as liberalism, fascism, Nazism, and socialization (Cocks, 2012; Lerner, 2003; Zaicek, 2018). Moreover, psy disciplines have regularly been integral to state-led projects of modernization, oppression, militarization, and nation-building (Lunbeck, 1994; Keller, 2007). Such a careful historical and political analysis would greatly facilitate a more nuanced and complex discussion of colonial legacies, decolonization attempts, and the persistent relevance of certain colonial-era forms of thinking in present-day discussions about cross-cultural mental health.

3. Rethinking cultural difference in mental health

Furthermore, a critical historical analysis can demonstrate culture’s multiple and heterogeneous uses as an empirical and analytical category in GMH and the Movement for GMH. This category crosses past and current debates within the field in relation to issues such as the ‘cultural barriers’ in access to mental health services; the role of culture in health/illness trajectories, and the expression of symptoms (e.g., explanatory models, idioms of distress); the relationship between health institutions and practitioners and healers; health practitioners’ competencies (e.g., cultural/structural/translational competencies); the impacts of stigma in individuals and communities; and different representations of personhood and mind; among others (Kirmayer and Swartz, 2013; Backe et al., 2021; Backe et al., 2021, 2021; Oureshi et al., 2021; Gajaria et al., 2019). It is also true that some approaches to these debates have tended to essentialize and subordinate different groups – predominantly indigenous and migrant communities – and to re-produce negative and positive stereotypes in lieu of a nuanced debate about culture. Moreover, cultural adaptations of scales and cultural competencies have sought to include different cultural experiences, yet have, in many cases, led to the reproduction of colonial ethnic taxonomies. Recent debates have significantly enriched the field in intellectual and practical terms, particularly the above-mentioned research on the anthropology and history of global mental health, and its attention to practices of culture and care. A systematic analysis of how these concepts of culture and care were formulated and changed historically, and how they were transformed and translated from colonial to postcolonial sites adds a fundamental dimension to this important literature, as the above-described example with the IPSS has demonstrated.

The value of our proposed form of historical analysis is to show how ‘culture’ as an analytic category in mental health research has been constituted in different historical contexts and time periods, and through a series of interactions between specific political, cultural, and social forces. We propose a historical approach that is attentive to how culture has been operationalized ideologically in the geographies of the global south and how it has been contingently constituted across specific historical episodes and debates. For example, rather than adopting an advocacy position on cultural versus structural competency models, some researchers have shown how the legacies of Marxism, public/collective health, and social medicine traditions of the 1960s and 1970s have shaped practitioners’ reflexivity on cultural and structural aspects and intersectionality in Chile and Brazil (Ábarca-Brown, 2023; Ortega and Rodrigues Müller, 2022). Moreover, our approach critically analyzes romanticized and simplistic definitions of culture. It also offers a possibility for historical (self-)reflection on the field of GMH as a whole.

Our perspective invites researchers to interrogate colonial legacies embedded in the category of ‘culture’ – and by extension, in the notion of ‘cultural difference.’ This is not the first time that transcultural psychiatry has had to grapple with the role and complexity of culture: in the 1970s, a number of medical anthropologists critiqued the profession’s
understanding of culture as a static and essentialized notion, and called for a more nuanced political engagement with cultural difference (this is how ‘new cross-cultural psychiatry’ was born) (Kleinman, 1967; Littlewood, 1990). A deep historical approach calls attention to such important moments and reveals many other similar initiatives and experiments with cross-cultural treatment and research beyond global institutions. One such example was the Aro village system in Nigeria, which attempted to integrate Western psychiatry and medicine with a variety of culturally specific local healing and therapeutic traditions, explored the local meanings of illness and pathology and pushed the boundaries of the WHO’s definition of psychiatric universality (Heaton, 2013). In a similar way, lesser-known East European psychiatrist Vladimir Jakovljevic attempted in the 1960s to counter the colonial legacy of psychiatry and medicine in Guinea by bringing Marxist psychiatric and psychoanalytic concepts to Guinean mental health trainees (Antic, 2021). These would be a useful well of experience and inspiration for GMH and the Movement for GMH to draw on, as well as engage with critically. Thus, we encourage avoiding an understanding of culture as an ‘apollitical’ category and instead call for a focus on how historical power relationships have shaped different systems of knowledge, practices, values, and actors in health. This will also enable a more meaningful engagement with patients’ experiences of illness and develop an inclusive and dynamic patient-centric approach that would allow for a genuinely emancipatory healing and recovery.

4. History as a source for alternative reconfigurations of illness and recovery

Yet, history can offer much more than just a critique of power relations, nor is it only about interrogating practitioners’ values and ethics. Most importantly, it does not aim to paralyze practitioners who engage in valuable mental healthcare by reminding them of historical examples of psychiatric abuse or the colonial pasts of global mental health. Quite the opposite, our historical perspective invites us to reimagine a new future for health and healing by drawing attention to alternative practices of illness and recovery in many sites around the world. A source for alternative ideas and initiatives in mental health and madness, history can foster new imagination for global mental health that goes beyond existing psychiatric frames of representations, and towards truly radical and egalitarian projects and relations.

This exercise in alternative historical imagination does not need to interfere with nor disrupt the urgency of mental health practice today; on the contrary, it is meant to improve the effectiveness of interventions. It can provide practitioners with an enriched approach to propose new solutions for long-standing clinical dilemmas (e.g., related to patient adherence or limited success of certain cultural adaptations), which could not be properly addressed previously. A historical framework can help us re-politicize mental health initiatives and global connections, in order to imagine radical alternatives that can challenge existing power relations, inequalities, and hierarchies. Such historical alternatives include the multi-faceted decolonial initiatives (many of which came from within psychiatry, such as Frantz Fanon’s experiments with institutional psychotherapy at the Blida-Joinville psychiatric hospital in Algeria, and his establishment of a psychiatric day center in Tunis (Robcis, 2021), Juan Marconi and his ‘revolution’ of community mental health programs in Chile (Montenegro, 2023), or the Fann psychiatric clinic’s integration of traditional healing practices in Dakar, Senegal (14), and anti-hierarchical reform movements and liberalization psychology, which can offer technical, conceptual and heuristic tools for practitioners to use in their practice.

As history keeps showing us, some of the core problems and challenges that GMH and the Movement of GMH are currently facing occurred with significant frequency and regularity at different points in the twentieth century. Because of this, a sustained/in-depth historical analysis will help the field avoid making the same mistakes or continuing with problematic assumptions. But it could also do much more than draw attention to possible errors: it could be an inspiring, creative exercise that highlights alternative (and forgotten) solutions, geographies, and ways of thinking - which enable the field to engage with actors, ideas, and structures outside the borders of psychiatry. It opens new horizons for understanding mental illness, healing, and its relationship to culture, social/political equality, justice, and well-being.

CRediT authorship contribution statement

Ana Antic: Center for Culture and the Mind, University of Copenhagen, Conceptualization, Methodology, Investigation, Resources, Writing – original draft, preparation, Writing – review & editing, All four authors contributed equally to preparing the article. Gabriel Abarca-Brown: Center for Culture and the Mind, University of Copenhagen, Conceptualization, Methodology, Investigation, Resources, Writing – original draft, preparation, Writing – review & editing, All four authors contributed equally to preparing the article. Lamia Moghnieh: Center for Culture and the Mind, University of Copenhagen, Conceptualization, Methodology, Investigation, Resources, Writing – original draft, preparation, Writing – review & editing, All four authors contributed equally to preparing the article.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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