Edited by William Sax and Claudia Lang

The Movement for Global Mental Health

Critical Views from South and Southeast Asia

The Movement for Global Mental Health

Social Studies in Asian Medicine

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Views from South Asia and Beyond[1]

William S. Sax and Claudia Lang

Abstract

Although the contributors to this volume are sympathetic to many of the goals of the Movement for Global Mental Health, we are also of the view that its agenda at the time of publication is based upon a number of problematic assumptions, that it may serve unacknowledged interests, and that in some respects it might even have harmful consequences. In the introduction we focus on the problematic assumptions that "mental disorders" can clearly be identified; that they are primarily of biological origin; that the world is currently facing an "epidemic" of mental disorders; that the most appropriate treatments for them normally involve psychopharmaceutical drugs; and that local or indigenous therapies are of little interest or importance. We also question the value of "scaling up" mental health services, as advocated by the Movement for Global Mental Health, and conclude by summarising the structure of the book, with brief comments on the various essays.

Keywords: Movement for Global Mental Health, treatment gap, treatment difference

Global mental health is something that everyone supports: Who does not want everyone on the planet to be mentally well? But what does it mean to be mentally healthy, or mentally ill? What concepts of "mind", "health", and "illness" are applied, by whom, and with what authority? What visions of global mental health have been articulated, and by

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1   Thanks to Stefan Ecks and Laurence Kirmayer for their comments on earlier versions of this introduction.

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whom? Must one choose between them, and if so, how? In recent years, one particular vision of global mental health has come to dominate the field, and its answers to these questions have become increasingly influential. The Movement for Global Mental Health (henceforth MGMH) is a worldwide assemblage of psychiatrists, psychologists, government agencies, medical doctors, public health professionals, health policy makers, private foundations, medical journals, and others "committed to collective actions that aim to close the treatment gap for people living with mental disorders worldwide, based on two fundamental principles: evidence on effective treatments and the human rights of people with mental disorders" (Patel et al. 2011). It rose to prominence in 2008 following a series of articles in one of the world's leading medical journals that culminated in a call "to scale up the coverage of services for mental disorders in all countries, but especially in low-income and middle-income countries" (Chisholm et al. 2007, 1241; for the genealogies of global mental health cf. Ecks 2016 and this volume; Lovell et al. 2019). The MGMH has no rigid hierarchical structure, and this allows it to respond to its critics quickly, flexibly, and (in our view) usually productively. The protean quality of MGMH also means that any attempt to characterise it risks immediate obsolescence.

We do not doubt that virtually all of those involved in the MGMH are committed to relieving the suffering associated with what are called "mental disorders", and ensuring equal access to mental health resources on a global level. But the contributors to this volume are also of the view that the MGMH's agenda at the time of publication is based upon a number of problematic assumptions, that it may serve unacknowledged interests, and that in some respects it might even have harmful consequences.[2] And because the MGMH has become so influential, we feel that it is important to subject these assumptions to critical scrutiny.

Problematic Assumptions

These problematic assumptions are numerous, and appear regularly in the movement's literature. In some of their recent publications, leading figures in

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2   We have had some difficulty in deciding whether we should define the topic of this introduction as "Global Mental Health", or as the "Movement for Global Mental Health", where the latter is a subset of the former, and whose active core consists of a smaller group with a slightly more precise agenda.

the MGMH have critically re-examined and partially revised some of them. This is an example of the MGMH's dynamic, protean nature, as mentioned above. We applaud the MGMH's willingness to engage in self-criticism, and want to suggest ways in which this might be carried much further. In order to do so, we will focus in this introduction on the following problematic assumptions: the idea that "mental disorders" can clearly be identified; that they are primarily of biological origin; that the world is currently facing an "epidemic" of mental disorders; that the most appropriate treatments for them normally involve psychopharmaceutical drugs; and that local or indigenous therapies are of little interest or importance. We will take a close look at each of these assumptions, which are sometimes explicit and sometimes implicit, but are in either case pervasive in the literature associated with the MGMH.

Let us begin with the idea that "mental disorders" are clearly identifiable. This is simply not true. One can only say that psychiatry is and always has been characterised by a fundamental *lack* of agreement about the classification of mental disorders, their causes, and the best ways to treat them. (See below for our analysis of the reasons why.) Psychiatric thinking about these topics was dominated for a long time by psychoanalytic approaches, but these failed to deliver on their grandiose promises so that, beginning in the 1980s and culminating in the 2010s, psychiatry came to be dominated by materialist approaches like neuropsychiatry and genetics. But these, too, have failed to lead to any striking advances in the understanding and/or treatment of mental disorders, and there are signs that the biopsychiatric consensus is breaking down (Harrington 2019). Periodic statements by the MGMH that mental diseases are well understood – in one of their most recent publications, they write of "the convergence of evidence from diverse scientific disciplines on the nature and causes of mental health problems" (Patel et al. 2018, 1) – may therefore be read as unjustifiably optimistic assessments intended to shore up support for their program. Or they can simply be regarded as false and misleading.

Athough the MGMH makes use of a variety of disciplines, including clinical psychology and social work, and increasingly includes self-identified "service users" or "people with psychosocial disabilities", it is first and foremost a vehicle for the introduction of a comprehensive programme of mental health care based upon contemporary biomedical models and therapies, and ultimately under the direction of psychiatrists. But how, exactly, should one define the mental disorders to which such models and therapies respond? As a standard-bearer for international psychiatry, the MGMH faces the same intrinsic challenge as its apex discipline – namely,

that the signs and symptoms of mental disorders are overwhelmingly behavioural and not physical, making them exceedingly difficult to measure and quantify. Psychiatry has a fundamental problem with validity,[3] because the illnesses with which it is concerned rarely have physical markers, and this complicates all of its branches: psychiatric aetiology, nosology, and therapy. As Canguilhem might have put it, those suffering from mental disorders rarely have "lesions" that can be measured, dissected, and analysed; nor are there visible aetiological agents like bacteria or viruses. Biomedicine is very good at counting and measuring such things, and its continuing refinement of the techniques of measurement has contributed much to the production of its so-called "miracles". But although many psychiatrists in the twentieth century believed that one could dissect the brain and "see" the biological causes of mental illness, and even though many psychiatrists in our own century continue to believe in similarly material (genetic or neurological) causes, such beliefs have always turned out to be largely illusory: The lesions cannot be found, much less measured, and this creates problems for psychiatry. As Wittgenstein might have put it, making a psychiatric taxonomy is like trying "to classify clouds by their shape".[4] Ian Hacking (2007) describes mental disorders as "moving targets", assembled at different scales and grounded in multiple social, historical, and political contexts.

For example, the disease entities in clinical psychiatry's "bible", the *Diagnostic and Statistical Manual* (henceforth DSM), and its international sister, the *International Classification of Diseases*, are often of contingent historical origin, with no common aetiological theory to link them (Bowker and Star 2000). In their book *Making us Crazy*, Kutchins and Kirk (2003) argued that the DSM is the result of the industry's internal lobbying for financial gain; that it contains much racial and gender bias; and that it persists as a necessary step in the remuneration of health professionals and drug companies (cf. Harrington 2019, 267-68). The absence of agreement within psychiatry on fundamental questions of aetiology explains why the DSM V and ICD-10 came to rely on what is called the "phenomenological approach", focusing on symptoms and contexts rather than aetiology. Few of the disorders listed in these manuals have measurable physical correlates, and most consist of collections of symptoms, so that they might better be

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3   "Validity" refers to the degree to which a concept "correspond[s] to external reality" (Aragona 2015). See the very useful discussions of validity in psychiatry by Jablensky (2016) and Zachar (2012).

4   This observation was made by the neuropsychiatrist Jablensky (2016), referring Wittgenstein's (1975) remark that "the classifications made by philosophers and psychologists are as if one were to classify clouds by their shape."

labelled "syndromes", rather than "disorders" (Jablensky 2016). But definitions of both symptoms and syndromes change over time, according to broader collective judgments about what kinds of behaviour – and what kinds of mental suffering – are acceptable or unacceptable. As Jablensky, a leading cross-cultural psychiatric epidemiologist, puts it,

> The present diagnostic manuals, ICD and DSM, are classifications of current diagnostic concepts, and not of "natural kinds", such as people or diseases. There is little evidence that most recognized mental disorders, including the psychoses, are separated by natural boundaries. (ibid., 30; cf. Hacking 2013)

The second problematic assumption characteristic of the MGHM is that mental disorders have a material cause. Like the assumption that mental disorders can be easily identified, this idea is omnipresent in psychiatry. Because mental disorders have few measurable physical symptoms, psychiatry relies more heavily on interpretation and clinical judgment than other medical disciplines do, and thus it is often regarded as one of the least scientific branches of medicine. Many psychiatric researchers try to overcome this problem by defining the psyche and its disorders in material terms, in an (in our view, highly problematic) attempt to facilitate their quantification. This explains the ongoing, frantic search for genetic markers and neurological causes of mental disorders, which would effectively constitute the psychiatric version of Canguilhem's "lesions" (1991). If only the material causes of mental disorders could (finally!) be identified, then the disorders themselves would be more susceptible to treatment (presumably by means of psychopharmaceuticals), and the medical profession would (finally!) acknowledge psychiatry as a properly scientific discipline. But in our view, the very idea that (presumably disease-specific) drugs will be discovered, which produce their effects by reversing the particular brain abnormalities that give rise to symptoms (in more colloquial terms, drugs that "rectify a biochemical imbalance in the brain") is, as Moncrieff (2008) has convincingly shown, a myth. The relationship between neurochemical processes in the brain and psychiatric symptoms and treatments remains an unsolved puzzle, and that is why the pharmaceutical industry has largely abandoned research in psychiatry, resulting in a dearth of new psychopharmaceuticals (Dumit 2018).

A good example of psychiatrists' determination to find material causes of mental disorders is provided by the repudiation of the DSM-V, shortly before its publication, by Thomas Insel, who was then head of the US National

Institute for Mental Health (the primary funder of research in the field).[5] Insel justified his actions with the argument that the DSM concerned itself only with symptoms, whereas he wanted "causation", by which he meant neuropsychiatry (Insel 2014).

Both the dogged insistence on material explanations for mental disorders, and the increasing neglect of research into social explanations for them, is difficult to explain, since the results of neuropsychiatric and genetic research have, to date, been quite disappointing (Kendler 2013; Harrington 2019). Although some forms of mental disorder can be strongly correlated with particular processes in the brain, a correlation is not a cause. The *causes* of mental disorders are likely to be found in some combination of biological (genetic, neurological) risk factors and the particular conditions of a person's life (e.g. poverty, abuse, stress, personal tragedy, etc.). In fact, there is little evidence that behavioural disorders are caused by genetic problems or chemical disturbances in the brain, but much hard evidence of the damage done by psychopharmaceuticals used for therapeutic purposes (Moncrieff 2009). Nevertheless, the default position of contemporary psychiatry is to look for pharmaceutical solutions to behavioural disorders, and in the final analysis this is traceable to the widespread assumption that such disorders have neurological or physiological causes.

Here it must be acknowledged that leading voices in the MGMH have acknowledged these criticisms, and claim to favour a more holistic, multi-disciplinary approach to mental health than previous ones. For example, a recently published report of the Lancet Commission on Global Mental Health and Sustainable Development admits the inadequacy of "biomedically defined mental disorders" (Patel et al. 2018, 11). The report begins by noting sympathetically a set of critiques very similar to those articulated in this volume.

> [T]he biomedical framing of the treatment gap has attracted criticism from some scholars and activists championing a cultural perspective and representing people with the lived experience of mental disorders. These voices fear that a biomedical emphasis will take priority over indigenous traditions of healing and recovery, medicalise social suffering, and promote a western psychiatric framework dominated by pharmaceutical interventions. (ibid., 8)

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5   Insel's research on communication and social attachment amongst rodents (and later, primates) had somehow qualified him for this post. Before resigning to work for Google.com, he slashed funding for research into the social causes of mental illness, in order to focus on neuropsychiatry.

In response to such criticisms, the report specifically acknowledges the "social determinants of mental health" (ibid., 14), and articulates an approach to mental health and illness in terms of the interactions among biology, inherited genetic causes, and "environment" in both its social and physical dimensions (ibid., 18 ff.). We applaud this recognition of the complex aetiology of mental illness by the MGMH, and hope that it continues. But this will not be easy, since psychiatry is the apex discipline within the MGMH, and its very location within biomedicine predisposes psychiatrists toward materialist/neurological paradigms, even in the absence of good evidence for them. This is clearly shown by a passage on "deep phenotyping" immediately following (and in our view, at odds with) the enthusiastic words regarding "the convergent approach to mental health" quoted above.

> Deep phenotyping involves the collection of observable physical and behavioural traits of an individual down to the molecular level. When anchored by a carefully constructed clinical profile, the resulting multilevel biomarker set *could* provide more precise understanding of the causes of disease, and *could* eventually produce a more accurate way to describe and classify mental health conditions than current diagnostic classification systems. In the future, deep phenotyping *could* enable precision mental health care – for example, treatments *could* be targeted on the basis of the underlying disease mechanisms, such as depression linked to immune dysfunction. (ibid., 11; emphasis ours)

Old Habits Die Hard

A third problematic assumption characteristic of the MGMH is that we are faced with a "global epidemic" of mental illness. The foundational literature of the MGMH often invokes two highly publicised studies (Desjarlais et al. 1995; WHO 2001) purporting to show that the global burden of mental disorders is significant and growing. Based upon these and similar studies, some scholars refer to a worldwide "epidemic" of mental illness; others argue that the so-called epidemic is, to a significant extent, the effect of a new metric that has come to dominate the field of health economics in recent decades: the DALY or Disability Adjusted Life Years. This measure was first used in the 1995 World Mental Health report (Desjarlais et al. 1995), and then in the 1996 Global Burden of Disease report, and purportedly revealed an "unseen burden of psychiatric disease" that had hitherto gone unperceived (Murray and Lopez 1996, 21; cf. Bemme and D'Souza 2014; Lovell et al. 2019;

also Ecks's and Das and Rao's contributions to this volume).[6] Technically, the DALY need not be a measure of productivity but only of healthy years lost by a person who is ill or disabled. Practically however, it is very often used in conjunction with "age-weighting" to distinguish between the maximally productive years of young adults and the less productive years of children or the elderly. In this sense it is a textbook example of what Foucault calls "biopower", since it measures lost economic productivity rather than human suffering. According to Li, use of the DALY persists because "the power structure of global health has changed from the political to the economic and biomedical, and power (and money) have become concentrated in the hands of a few individuals" (2014, 1; cf. also Mahajan).[7] But even if we were to accept the claim that the statistics represent a real increase in mental suffering worldwide, this would not necessarily imply that therapies and interventions to address it should be uncritically imported from the West (Mills 2014; Mills and Fernando 2014). Movements like the MGMH and organisations like the WHO are intent on medicating the symptoms of non-Western others so that they can be more economically productive, but might it not be even more important to help them address the social determinants of mental suffering, which may include such things as inequality, prejudice, and violence?

Beginning with the assumption that European definitions of mental health and illness are universal, those in the MGMH have, in the past, made the further, equally problematic assumption that mental disorders are best treated by psychiatrists or those working under their direction. And since there are precious few psychiatrists or other mental health professionals in South Asia, people there (as well as in other regions that are culturally and geographically distant from Europe and North America) are said to suffer from the "treatment gap", a phrase that is constantly invoked in the MGMH literature. By contrast, the contributors to this volume take the view that South Asians have abundant resources for maintaining mental health, so that it would be better to speak of a "treatment difference" than a "treatment

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6   Anne Harrington argues that the explosion in the incidence of depression is due to the collapsing of previous distinctions into one grand category of depression when applying the widely used HAM-D scale to measure it (2019, 203-04).

7   Something similar may be happening in the MGMH's advocacy of a "balanced-care model" that is differentially applied depending on whether the location is wealthy or not, viz., "The balanced care model is an evidence-based, systematic but flexible approach to planning treatment and care for people with mental disorders" (Patel et al. 2018, 158), and argues that the provision of mental health services should distinguish between low-income, medium-income, and high-income country settings (ibid., 176).

gap". The problem is that such resources are rarely "seen" by advocates of global mental health, and when they are, they are either dismissed or, even worse, denigrated as inhumane, because they do not correspond to Western psychiatric models. This is confirmed in a recent publication by leading figures in the MGMH. They begin by significantly moderating their claims regarding the efficacy of psychopharmaceuticals:

> The effect sizes for psychological treatments typically range from moderate to large, and sideeffects are relatively rare. The strength of evidence for psychological therapies is at least as strong as for other treatment methods. Furthermore, when headtohead comparisons of efficacy have been done between pharmacological and psychological therapies (notably for mood, anxiety, and traumarelated disorders) no consistent evidence has been reported for the superiority of either in terms of attaining remission; additionally, psychological therapies seem to have a greater enduring effect than pharmacological therapies. (Patel et al. 2018, 21)

Furthermore, as an alternative to psychopharmaceuticals they enthusiastically advocate a large number of psychological therapies, citing numerous studies pointing to their efficacy. They emphasise the need to localise psycho-social treatment modalities, and suggest that the content of therapies needs substantial modification to incorporate local metaphors and beliefs, and to combine psychological skills building components with social work components. The tasks should also be adapted to ensure acceptability for people with limited literacy (e.g., completing homework in sessions). (ibid., 25).

But nearly all of the therapies mentioned originate within the disciplines of psychology and psychiatry, and none is "indigenous" in the strict sense. The overarching assumption has not changed: namely, that psychiatrists and psychologists from the resource-rich "countries of the North" (formerly known as the First World) know what is best for those living in the resource-poor "countries of the South" (formerly known as the Third and Fourth Worlds); and that the latter must be trained, cajoled, perhaps even forced to recognise this. The language in the passages cited above provides the clue: local ideas consist of "metaphors and beliefs" rather than facts or knowledge, and those suffering from mental disorders must be made to comply with the psychiatric regime by "completing their homework".

In this way, a reflexive and self-confirming loop is created and reiterated over and over in the publications and policies of the MGMH: Mental disorders are defined primarily in terms of Western psychiatric nosology, for which

only biomedical, or biomedically-approved, therapies are considered. It is true that activists in the MGMH often claim that their movement is not about exporting Western therapies, but rather involves providing (and eventually up-scaling) "packages of care" developed in the countries of the Global South in a situation of scarcity (of professional psychiatric and psychological services). But these packages always place the psychiatrist at the apex of the system, and none of them include the most prominent practices and forms of treatment in such countries: namely traditional medicine, ritual, and religious healing (see Sax, this volume). The single exception in South Asia is yoga, which is deeply ironic, since recent scholarship has shown that modern postural yoga is not traditional at all, but rather a twentieth-century invention, jointly produced by Western doctors and Indian spiritual entrepreneurs (Alter 2004).

This is indeed the crux of the issue. For most of the contributors to this volume, the very definitions of terms like "mind", "mental", "mental health", "mental illness" and so on are highly variable, both culturally and historically. Moreover, language has its own powerful agency such that, for example, people who are told over and over that they are mentally ill finally come to experience themselves that way (cf. Hacking 2002), whereas at an earlier time or in a different culture some of them might have experienced themselves as "holy" or simply "different". The agency of language is even more powerful when it is associated with authoritative figures like doctors and psychiatrists (or priests and shamans) (Kirmayer 1987). The difference between "scientific" and "traditional" understandings of mental illness is very great: in effect, they represent different ontologies, and one wonders if they can ever be truly integrated, although, as Lang shows in this volume, there are increasing efforts to do so. The publications of the MGMH strongly suggest that in their view, this integration should take place, but can only do so within an epistemic hierarchy in which "religion" and "tradition" are subordinated to "science", which adjudicates all questions of truth. And how could it be otherwise? To critically examine the collusion of science and biomedicine with modern, neoliberal capital-ism (see below), or to open the door to non-scientific theories of causation, would threaten the economic, political, and scientific foundations of "modern mental health care", and cannot be seriously contemplated. To put it in other words, advocates of the MGHM do not take alterity seriously: Ontological differences are re-interpreted as "metaphorical", and the therapist is urged to learn the native metaphors, not in order to broaden his/her interpretive horizons, but merely in order to implement the therapy more effectively.

According to the proponents of the MGMH, there are two main problems in implementing mental health. First is the stigma associated with mental illness (a stigma that is, by the way, strongly associated with psychiatry and the labelling of psychological alterity as a "disease", but generally absent from traditional understandings), and second is the fact that the intended beneficiaries do not seek psychiatric help for their problems, because they have different explanatory models (Patel et al. 2018, 25). Such models must therefore be eliminated or transformed in order to provide modern, biomedically-approved therapy and in our view, this rejection of non-psychiatric ontologies of suffering is a form of epistemic violence.

> In many communities, the widely varying explanatory models of mental health and disorder (e.g., that they are equivalent to social suffering or are the result of moral weakness, or spiritual or religious misfortune) lead to low levels of self-recognition or detection by health workers. Innovative strategies for educating health workers and communities that integrate biomedical and contextually appropriate understandings and messages improve detection of common mental disorders and enhance demand for health care (ibid., 25).

With its vision focused narrowly on psychiatry, the MGMH fails to take seriously the idea that ontologies and experiences of mental health and illness might vary significantly between (and within) cultures, and that "mental health resources" include traditional approaches to mental suffering, and not just techniques developed in the West. Take schizophrenia, for example: Certainly there have been many times and places in human history where it has been neither recognised nor named. Indeed, it only came to be regarded as a universal disease with a stable cross-cultural epidemiology after the 1966 International Pilot Study of Schizophrenia (Lovell 2014). The essay by Hornbacher in this volume is relevant here, as it points not only to the important role played by anthropologists Mead and Bateson, and their research in Bali, in the historical production of "schizophrenia" as a universal psychiatric disease category, but also to more general philosophical problems associated with the history of the term.

Are not the symptoms psychiatrists associate with schizophrenia sometimes considered to indicate a special, even valued state of mind? Are there non-biomedical models of mental health and illness where the category "schizophrenia" does not fit? And are such models not associated with kinds of therapy that are more culturally appropriate than those employed by psychiatrists? Is it not worth seriously considering the possibility that in some

cases, such therapies might be more effective than psychopharmaceuticals? Anthropologists have identified numerous internally coherent models of mental health and illness amongst the world's cultures (two good examples are Laderman 1993 and Tambiah 1990, chap. V), but as Stefan Ecks points out in his essay in this volume, such questions have simply been erased from the agenda of the MGMH. Perhaps they are simply too difficult.

All human cultures, including those in Europe and North America, use ritual and religion to heal or mitigate mental suffering, but such techniques are almost never taken seriously by those in the MGMH – not because there is no evidence of their efficacy, but rather because religion and ritual are assumed to be fundamentally at odds with the modern, scientific episteme (Sax 2010, 2014, 2015; Quack and Sax 2010). Meditation and related practices are popular components of health programmes in schools, prisons, businesses and government agencies, and they are increasingly subject to scientific trials of various sorts, but similar studies of ritual healing are practically non-existent. We suspect that this is largely because methodology and class reinforce each other in determining research protocols: While it is indeed possible to measure the effects of meditation on those middle- and upper-class persons who practice it, it is much more difficult, perhaps even impossible, to obtain similar measurements of traditional forms of ritual healing with their ecstatic trances, bloody sacrifices, and oracular diagnoses (though see Snodgrass et al. 2017a and 2017b.). To find out what people actually do when they suffer "mental illness" outside the laboratory or clinic, one would have to observe them, rather than subjecting them to artificial experimental environments. In other words, one would have to proceed like an ethnographer rather than an experimental psychologist. However, such radically empirical methods are unfamiliar or unacceptable for most researchers. Moreover, the health authorities are more likely to criminalise such activities than to investigate them (Sood 2016). The best known example from South Asia was the so-called "Erwadi tragedy" of 2001, where pilgrims chained to trees and other structures near a South Indian Sufi shrine famous for mental healing perished in a fire, resulting in a series of attempts to criminalise ritual and religious healing throughout India. There is no doubt that the fire was a terrible tragedy, and that it pointed to the need for fire safety regulations in such places. But there have been tragic fires in mental hospitals, too (Barry and Kramer 2013) and these have not led to calls for the state to criminalise them.

As many of the articles in this volume make clear, South Asians do in fact have access to a variety of resources for maintaining or improving their mental health. In this sense there is not so much a "treatment gap" as

there is a "treatment difference", and it may even be that the existence of a great variety of non-medical forms of therapy contributes to a high level of mental health for regions outside of Europe and North America. Relevant here are a series of robust, "gold standard" epidemiological studies by the World Health Organization, which have consistently shown that Nigerians and Indians have better rates of recovery from severe mental illness than Europeans and Americans (Hopper and Wanderling 2000; Sartorius et al., 1986). Although there is continuing debate about what these studies really show, one persuasive view is that their overarching lesson is about the importance of social bonds for recovery (Jablensky and Sartorius 2008).[8]

Although we have, in this introduction, questioned the universality of the disease categories focused upon by this well-known series of studies, still, the results give us pause. They document a markedly higher reduction of psychiatric symptoms and mental suffering in regions where psychiatry is difficult to access, than in regions where it is readily available, and this suggests that psychiatry is not necessarily the key to relieving mental disorders. At the very least it would make sense, as Halliburton (2016) argues, for those in the MGMH to first ask what they might learn from non-Europeans' approaches to mental health before rushing in with psychiatry, pharmaceuticals, and other exogenous therapies in order to "save" them. But because of the presumed universality and superiority of biomedical psychiatry, this is simply not done. Perhaps the Nigerians' and Indians' higher recovery rates have partly to do with the "treatment difference"; that is, with the fact that they live in medically plural societies, where there are numerous alternatives to psychiatry with its drug-based therapy. Unfortunately, such a hypothesis cannot be tested, since the studies did not control for which therapies were used: Some test subjects used biomedicine, others used traditional healing, still others used nothing. Nevertheless, it strikes us as highly problematic that rather than focusing on why the non-Europeans' scores are so high, the MGMH seeks instead to provide them with an exogenous disciplines – psychiatry with its armoury of drugs, and a form of counselling loosely based on cognitive behavioural therapy – both of which originate in a region with a comparatively poor record for recovery from severe mental illness.

In order to understand and evaluate non-medical techniques for promoting mental health, health professionals would have to take them seriously. They would have to *learn from* local people rather than simply indoctrinating them. But in practice, such traditions are of little or no interest to most

8   Thanks to Laurence Kirmayer for pointing this out in a personal communication.

health researchers, who regard them as unscientific and even dangerous. Neither can they be "seen" by Ministries of Health, which are not interested in them and therefore collect little or no information about them.[9] And although they are not entirely absent from the MGMH literature, they are still difficult to find there, and are certainly subordinated to psychiatry. As a result, we think it is fair to say that the MGMH necessarily rejects pluralism – the deliberate encouraging of a variety of models and approaches – with respect to mental health and illness. Instead, it carries forward what Mills (2014) calls the neocolonial "psychiatrization of the majority world" – what others criticise as a top-down, imperial project exporting Western illness categories and treatments that would ultimately replace diverse cultural environments for interpreting mental health (Watters 2010; Summerfield 2013; Mills and Fernando 2014).

And what, precisely, might be learned from these local traditions? Some of the essays in this volume provide answers to this question. Lang discusses a form of psychiatry based on Ayurveda, India's dominant indigenous medical system (cf. Halliburton 2009; Langford 2002). Ayurvedic psychiatry is a highly dynamic field that draws upon a truly ancient tradition based on classic texts, which it combines with vernacular practices and globalised psychiatric knowledge so as to know and treat distressed embodied minds. Halliburton shows how South Indian psychiatric hospitals and rehabilitation centres used "love" to aid the healing process, Mukherjee shows how the MGHM is as blind to forms of group possession as it is to any forms of non-individualised suffering. Sax and Mukherjee each write about Muslim religious healing of mental suffering, which is widespread in Europe as well as South Asia (Sax 2013). Elsewhere, Ecks (2013) has explored how, in India, non-biomedical forms of healing like Ayurveda and homeopathy are redefining notions of what it means to be mentally ill, and shown how Indian psychiatrists, finding themselves in an extremely pluralistic context, adapt their prescribing practices to local expectations. Critics suggest that global mental health discourses and initiatives have conceptualised "community" much too narrowly, merely as a method of service delivery, and that a subtler conception might help to employ resources more effectively (Campbell and Burgess 2012; Das and Rao 2012). In the same vein, Jansen et al. "propose that 'community' should be promoted as a means of harnessing collective strengths and resources to help promote mental well-being" (2015, 1). Rather than conceiving of communities as targets of psychiatric interventions, it

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9   Cf. Ecks and Basu's 2014 discussion of "strategic ignorance" in relation to GMH strategies of "task-shifting".

might be better to think of "community" whether local, transnational or digital as another aspect of the "treatment difference"; that is, as a mental health resource, providing active participants in the therapeutic process.

A final problematic assumption is suggested by the very name of the Movement for Global Mental Health, which implicitly distinguishes mental from physical health. This dualism of mind and body may be simplistic, but it is certainly pervasive, having been institutionalised in the world's medical schools and health ministries. It is true that many MGMH programmes seek to resist this distinction by arguing that mental health is part of general health and well-being and by locating mental health treatment within primary health care, and it is also true that the comorbidity (i.e. the close relationship) of psychiatric and somatic symptoms is well known to mental health care workers everywhere. But none of these assumptions and practices implies a redefinition of the relation between mind and body, only a re-administration of it. And this should not surprise us, since there does seem to be something universal about the distinction between mind and body. Indeed, we are suspicious of the oft-repeated assertion that this "dualism" is peculiarly Western, or that it is not found in Asian or other non-Western medical systems. On the contrary, all the South Asian medical systems with which we are familiar distinguish between a locus of thought and consciousness on the one hand, and the human body on the other (Langford 2002; Lang this volume). But such distinctions are made differently in the various systems, and are never precisely parallel to those found in modern psychiatry and medicine, and in our view, any therapeutic regime should at least be aware of the differences among them. Ideally, each system should be willing to learn from the other. Perhaps a greater awareness of the ways that physical injury or disease can lead to mental disorder (and vice versa) would be useful for local healers, and one wonders whether a serious investigation of non-psychiatric therapies might fruitfully lead us away from the contemporary reduction of mind to brain.

In sum, the MGMH has in recent years begun to question some of its earlier assumptions that we regard as highly problematic; for example, that mental illness is better explained in terms of neurology than as a result of social factors like poverty, prejudice, stigma, pressures of consumerism, addiction, family breakdown, relationship difficulties, unemployment, etc.; and that the default modality of treatment is the administration of psychopharmaceuticals. In recent publications, both of these assumptions have been revised, and we heartily applaud these refinements and improvements. Nevertheless, a significant number of problematic assumptions continue to inform the agenda of the MGMH: that the paradigms of biomedical

psychiatry are universally true, and unquestionably superior to those of non-biomedical systems; that non-biomedical resources for mental health are scarcely worth being investigated; and that the world faces an "epidemic" of "mental illness". We do not claim that all of these assumptions are false; we do however think that it is important to acknowledge their existence, and to note how profoundly they influence the agenda of the MGMH.

Unacknowledged Interests

In addition to these unexamined assumptions, the MGMH may well be unduly influenced by a number of unacknowledged interests. One of these is the pharmaceutical industry. Harrington for example argues that the dominance of biological psychiatry has to do with the fact that by the late 1980s, "a critical mass of clinicians and researchers had aligned their professional interests with the commercial interests of the pharmaceutical industry" (2019, 249). A forerunner program of the MGMH, the Nations for Mental Health, was partly funded by two large pharmaceutical companies (World Health Organization 2002). Earlier agendas of the MGMH (e.g. Patel et al. 2011) focused much more heavily on the use of psychopharmaceuticals. Such pharmaceuticalisation creates markets for the pharmaceutical industry, either by depoliticising and silencing social inequality, marginalisation, and suffering or by providing an idiom of critique and a powerful tool for mobilising care and social inclusion (Kitanaka 2012; Lang 2019). But not only are funding and financing streams difficult to track (cf. Erikson 2015); the pharma industry's interests are rather ambiguous and difficult to characterise. "Big Pharma" has been unable to develop any new, reliable drugs for quite some time (Dumit 2018; Harrington 2019). Perhaps this has something to do with the fact that the social environment really does play an important role in the aetiology of what is called "mental illness", which cannot be reduced to "brain disease". Kirmayer and Gold ask if such research has been largely unsuccessful because of its valorisation of the brain and with it the creation of a psychiatric discipline that is both "mindless and uncultured" (2012, 308). In India the "Big Pharma" companies' patents have mostly expired, and the market for psychopharmaceuticals is predominantly generic, so that such companies doesn't have much of an interest in them. The result is that nowadays it is the smaller regional companies that push psychopharmaceuticals, often by means of what is called "outreach" or "patient education" (Ecks 2018; cf. Applebaum 2015).

Psychiatric training in India overemphasises the role of psychopharmaceuticals, so that pharmaceutical representatives have an enormous influence on South Asian doctors' prescribing patterns. Moreover, to the extent that psychopharmaceutical interventions moderate the symptoms of mental disorders, they are truly needed by poor people in South Asia and elsewhere, who may well respond quite positively to the "psychopharmaceuticalisation" of their mental health. The reason is simple: if the poorest don't work, then they don't eat (and nor do their children). That is why drugs that relieve their symptoms, thus allowing them to work, are likely to be enthusiastically received, even if the duration and dosage of those drugs is observed only in the breach (Han 2012; Barua and Pandav 2011; Ecks and Basu 2014). This is one of the many ways in which the worldwide system of consumer capitalism creates its modern subjects.

Another way involves the use of digital technology for diagnosis and treatment. Despite the growing literature pointing to the deleterious effects of modern communications technology on mental health, the members of the Lancet commission on global mental health and sustainable development (Fairburn and Patel 2016; Patel et al. 2018) have an unbridled enthusiasm for it. Traditional healing methods may be ignored by the MGMH, but there is an exaggerated faith in the capacity of technological "fixes" to address mental health problems. Such fixes are much more business-friendly than social interventions, and the medicalisation of mental health promoted by the MGMH serves the interests of those manufacturing software for mental health apps, tablets and mobile phones for health workers etc. Despite our intuition that the physical presence of the therapist is important for mental health therapy, and the growing evidence that social media is strongly associated with mental pathology (Hunt et al. 2018; Kross et al. 2013; Steers et al. 2014; Twenge et al. 2017), the MGMH seeks (at least partly) to abolish the former and replace it with the latter:

> The nonspecialist healthcare provider should ideally work within a collaborative care framework with access to a specialist provider who can be remotely located, participates in training, oversees quality, and provides guidance or referral options for complex clinical presentations [...] Several innovative strategies can facilitate dissemination of psychosocial therapies. First, a major bottleneck to task sharing is the reliance on traditional facetoface methods for training and on experts for supervision. These barriers are being addressed through online training. [...] Technology applications include mobile and online programmes for illness self-management and relapse prevention, SMS text messaging for promoting

medication and treatment adherence, and smartphone applications for tracking and monitoring symptoms (e.g., moodgym, Living Life, and 7 cups). Opportunities could also be available to track highrisk situations with wearable sensors or smartphonebased location, time, or activity data and to send realtime alerts to patients or designated caregivers. Additionally, social media offers peertopeer networking combined with individually tailored therapeutic interventions. Telepsychiatry applications such as online videoconferencing can allow patients to connect with mental health providers for clinical consultations for diagnosis, followup care, or longterm support. Websites and mobile applications can also be used to deliver evidencebased treatments (e.g., those to reduce alcohol consumption, or cognitive behavioural therapies) [...] (Patel et al. 2018, 22)

MGMH proponents advocate the use of digital technologies as technical fixes to manage the presumed gaps in training, diagnosing, treating and governing mental health. Here they are in line not only with the emphasis on technological fixes in global health more generally (Li 2011; Geissler 2013) but also with the increasingly use of online technologies and techniques for managing mental distress (Fullagar et al. 2017; Lupton 2017; Ruckenstein and Schüll 2017) that paradoxically decentre the hegemony of the psychiatrist by expanding the psy-ing gaze beyond the clinic. Not only must the ontological assumptions of the suffering subjects be brought into line with those of the psychiatrists and psychologists or their digital proxy, they must also be trained to conform to a modern, neoliberal and consumerist model of rational agency that makes extensive use of commercially-available technology. And all of this takes place against the background of the psy-experts with their disciplinary powers as agents of the state. Why else would these kinds of consumer-led initiatives be praised as "effective under some circumstances in reducing compulsory admission to psychiatric hospital" (Patel et al. 2018, 22)?

Harmful Consequences

In addition to the unexamined assumptions discussed above, and along with the danger of serving unacknowledged interests, we also think that the implementation of the agenda of the MGMH may run the risk of causing harm.

In its earlier versions (e.g. Patel and Prince 2012) the MGMH assumed that the aetiology of mental disorders could best be accounted for by theories of

biological causation, so that psychopharmaceuticals were the "default" mode treatment. These paired assumptions allowed those in the MGMH to make two – not necessarily consistent – claims at once. First of all, they could make a moral case for the introduction of pharmaceuticals, claiming that sceptics effectively block the human rights of those suffering from mental disorders. Second, they could at the same time prevent a serious discussion of the moral and ethical problems faced by psychiatry. There are several prominent examples of how such rhetoric was employed, perhaps the most notorious being the photograph accompanying an article by Insel, Patel, and other leading advocates of GMH in the 7 July 2011 issue of *Nature* magazine, entitled "Grand Challenges in Global Mental Health". The photo is of a small girl chained to a tree, and this image is meant to represent the traditional healing of mental disorders, as if this had to do primarily with repression rather than the relief of suffering. But what about the well-known concept of chemical incarceration (Fabris 2011)? Is a heavily sedated patient in a psychiatric ward more free than the pilgrim Sax met at the healing shrine of Balaji in north India, who had to walk slowly because of the chains on his feet, which he said were there "for his own safety"? What about the reported violations of human rights in Indian mental hospitals (National Human Rights Commission 2012)? Perhaps most disturbing are the recurring tropes used to justify certain types of human rights violations by psychiatrists in India, for example, the idea that Indians, like people from the Global South generally, are childlike and need the patronizing care of the psychiatrist. Nandy calls this "a homology between childhood and the state of being colonized" (ibid., 97). The final article in this volume, by "Anonymous", gives a highly personal account of such an experience from the point of view of a victim.

By defining mental disorders as forms of brain disease, these earlier discussions placed neuropsychological models at the centre of the paradigm, and relegated discussion of the sociocultural causation of mental disorders to second place. This had the effect of "depoliticising" mental suffering by failing to address various forms of social structural inequality and violence that contribute to it. One glaring example is farmers' suicides in India. Despite clear evidence that the "epidemic" of farmer suicides is caused by political economic factors, the Indian state looked frantically for genetic causes (Arya 2007 cited in Aggarwal 2008, 291; Mills 2014, 37), thus managing to avoid grappling with the difficult political issues involved. And although many psychiatric studies acknowledge the role of political economic factors in farmer suicides, they tend to limit the role of psychiatry to the mitigation of the resulting suffering, not the elimination of its causes, for example by

focusing on restricting the availability of pesticides (a common means of suicide) rather than confronting the multinational companies whose agricultural policies led to the suicides in the first place. Such a depoliticisation of mental illness has happened elsewhere as well: Scheper-Hughes for example showed how hunger in one region of Brazil "became so normalized that it was no longer a sign of nutritional deprivation but a mental pathology – 'del deliriumirio de foe', hunger madness – to be managed by tranquilizers and sleeping pills imported from the United States" (1992, 41). Here too, the essay by "Anonymous" seeks to show how contemporary psychiatry in India is deeply gendered, with women risking the imputation of mental illness if they fail to conform to the roles expected of them.

Leading figures in the MGHM have, however, significantly revised this approach in more recent discussions of the aetiology of mental disorders. Exemplary are the discussion of the social determinants of depression by Patel et al. (2009) and Patel and Thornicroft (2009), and of the "social determinants of mental health" found in Patel et al. 2018, which includes a lengthy and persuasive section on how poverty, gender inequality, forms of racism and other social factors contribute to mental illness. Once again, we enthusiastically support this acknowledgement of the complexity of causal factors in the arising of mental suffering, which is not only consistent with the best scientific evidence, but also helps to relocate the causes of mental illness where they belong: in the interplay between "biology" and "society".

"Scaling Up"

Like global health more generally, the MGMH promotes research on the effectiveness of its interventions, and this is linked to the "scalability" of its projects (Adams 2016). Testing interventions in randomised control trials (RCTs) and scaling up these "evidence-based" interventions in low-resource setting have been central activities for the MGMH since its beginnings. In 2009 for example, Patel, Goel, and Desai (2009) called for "[s]caling up services for mental and neurological disorders in low-resource settings." The authors acknowledged several times that there was little evidence for the efficacy of Western psychotherapy at the scale of the Indian village where they were working, and particularly with the "technically simple and affordable treatments delivered by non-specialist health workers" that they advocated. They also accepted "the need for evidence to assess the impact of scaled-up interventions." But this did not lead them to re-think their programme; instead, they simply pushed ahead with a plan to create a large

number of parallel units with identical operative assumptions, so that these could be "scaled up" when necessary, in the form of "a basic, evidence-based package of services for core mental disorders." In the meantime, numerous research projects by NGOs that are part of the MGMH network have (no surprise here!) been able to generate the required evidence based on randomised trials for the claimed efficacy of different kinds of psychosocial and other interventions that the MGMH hopes to "scale up" (e.g. Dias et al. 2019; Patel et al. 2010). Proponents of the MGMH attempt to combine the standardisation inherent in attempts to "scale up" with localisation by means of what Bemme (2019) calls "contingent universals" – that is, processes of constant learning and change in local contexts. But we contend that even if they do manage some sort of combination of this kind, their understanding of local context is limited and includes neither larger structural processes nor already existing forms of treatment and care.

Plans to "scale up" global mental health services have more recently been linked to the Sustainable Development Goals agenda: Patel et al. write that their goal "is to reframe global mental health within the paradigm of sustainable development" (2018, 4), and conclude their review by systematically linking mental health to each of the SDGs. At the end of the article they summarise their points: mental health is a global public good; the unique outcome of biological, environmental and developmental factors across the life course; a fundamental human right; and an essential part of health care requiring public and policy action, especially the scaling up of mental health assessment and treatment plans. All of this requires, so they argue, a comprehensive global monitoring system (ibid., 9).

Here lies yet another unforeseen, but potentially problematic, result of the MGMH agenda. As anthropologist Anna Tsing has pointed out,

> (s)calability is, indeed, a triumph of precision design, not just in computers but in business, development, the "conquest" of nature, and, more generally, world making. It is a form of design that has a long history of dividing winners and losers. Yet it disguises such divisions by blocking our ability to notice the heterogeneity of the world; by its design, scalability allows us to see only uniform blocks, ready for further expansion. (2012, 505)

Tsing is worried about "the exclusion of biological and cultural diversity from scalable designs" and she writes that:

> most modern science demands scalability, the ability to make one's research framework apply to greater scales without budging the frame

> […] Scalability is possible only if project elements do not form transforma-
> tive relationships that might change the project as elements are added.
> But transformative relationships are the medium for the emergence of
> diversity. Scalability projects banish meaningful diversity, which is to
> say, diversity that might change things. (ibid., 522).

"Scaling up" can only occur when the specifically creative aspects of social
life are deliberately ignored or defined as irrelevant. One might say that those
who promote scaling-up projects repress this creativity in order to empower
themselves. Tsing argues that the kind of knowledge produced at the macro
scale cannot see nonscalability, because of the constitutive scalability of its
own practices.[10] According to Tsing, the problems of diversity, and of living
together with others, require other modes of knowledge.

Perhaps this is also true of therapy for mental disorders. On the macro
scale, an assemblage of psychiatrists, universities, clinics, journals, hospitals,
experiments, and professional associations works to ensure that practices
relating to the diagnosis and treatment of mental disorders are standardised,
and that their efficacy is evaluated according to universal criteria, purified
of their social and historical context: a classic example of what Latour calls
"the work of purification". As is the case for global health more generally
(Reubi 2018), such activity tends to be regulated in terms of neoliberal
assumptions and managerial techniques (see e.g. Patel et al. 2018), which are
quite compatible with modern technology, re-education (replacing religious
paradigms with "scientific" ones), and comprehensive monitoring systems
to ensure compliance, but particularly unsuitable for traditional systems of
healing, whose efficacy has hardly been studied, but most probably lies in its
context-sensitivity, its cultural appropriateness, and its political economic
embeddedness (for example, traditional healers often refuse cash payment).

Meanwhile, at the "micro" end of the spectrum are thousands of isolated
traditions of ritual healing that attempt, through myriad techniques and a
veritable Babel of idioms, to re-integrate afflicted persons with their families,
communities, and cosmologies. They do so in terms of specific contexts,
which are, by definition, local and small scale. Most traditional healing is
what Tsing calls "nonscalable"; it resists the normalising practices of the
state and of biomedicine – and so it must, or else lose the very context-
sensitivity that defines it. The MGMH is blind to these local traditions
everywhere, not just in South Asia, and one of the purposes of this volume
is to remind us of this, while at the same time also suggesting that these

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10   This is what Sax has referred to elsewhere (2014) as "structural blindness".

locally-embedded traditions may in some cases provide reasonable local alternatives to psychiatry with its predominantly psychopharmaceutical therapies, and its lay counselling based on models developed in Europe and North America.

For whatever reasons, schizophrenia, depression, and other common mental disorders are no longer limited to the industrialised, capitalist "West". Instead, they are increasingly global idioms in which people express their (and their family members') troubles, for which neuroscientists develop methods of measuring and testing, about which journalists write and report, and concerning which governments develop programmes and policies. The whole process is a perfect example of what Hacking (2007) calls the "looping effect", a kind of extra-linguistic iteration where a new disease is invented, research reconfirms its existence, people begin to receive the corresponding diagnoses, more research is done, papers published, and diagnoses made, until finally people have internalised an illness category to which they previously had no access.

Perhaps, with this volume, we can set in motion a few "loops" of our own, by suggesting that "mind" cannot be reduced to "brain", that the experience of mental health and illness is located in particular historical and cultural contexts, that effective therapies for mental suffering sometimes arise in such contexts, and that a truly pluralistic model of mental health care, in which many alternatives are available, is something worth pursuing.

Structure of the Book

In this book we have attempted to assemble a number of voices from South and Southeast Asia, each of which take a critical look at the MGMH. The volume's strength lies in its multivocality, with voices from anthropology, history, public health, psychiatry, and service users. Plurality is more important to the editors than doctrinal homogeneity, and we do not agree with every voice expressed in this volume. Following this introduction are two essays focusing on historical themes. In "Mental Ills for All: Genealogies of Global Mental Health", anthropologist Stefan Ecks writes about the recent History of the Movement for Global Mental Health and its three "pillars": economics, epidemiology, and the "scaling up" of mental health services. In "Schizoid Balinese? Anthropology's Double Bind: Radical Alterity and Its Consequences for Schizophrenia", anthropologist Annette Hornbacher reviews the many conceptual and empirical problems with the disease entity "schizophrenia", and also tells the story – unknown until now – of

the influence of Gregory Bateson's joint fieldwork with Margaret Mead in Bali on his famous "Double Bind" theory of schizophrenic aetiology. The research was funded by the American "Committee for Research in Dementia Praecox" in the 1930s, and might be seen as one of the earliest forays in Global Mental Health. The second section of the book has three articles critiquing the Movement for Global Mental Health. In "Misdiagnosis: Global Mental Health, Social Determinants of Health and Beyond", psychiatrist Anindya Das and public health physician Mohan Rao use the "social determinants of health" approach to argue that the MGMH has taken insufficient account of economic and political realities of India, and that it embodies a thoroughly Western discourse that is not appropriate to India. In "Jinns and the Proletarian Mumin Subject: Exploring the Limits of Global Mental Health in Bangladesh", historian Projit Bihari Mukharji analyses cases of "mass possession" that illustrate the "ontopolitical confrontation between mental health professionals" on the one hand, and local models of explanation in relation to "fundamental assumptions regarding the nature of the suffering subject" on the other.

The third section of the book explores alternatives to modern psychiatry with its drug-based therapies, and challenges the MGMH's notion of a treatment gap. In "The House of Love and the Mental Hospital: Zones of Care and Recovery in South India", anthropologist Murphy Halliburton provides an inspiring ethnography of one particular clinic in South India, and discusses the "role of love and family involvement" in mental health care, suggesting that this local, enhanced version of psychiatry provides an alternative to conventional care. In "Ayurvedic Psychiatry and the Moral Physiology of Depression in Kerala", anthropologist Claudia Lang discusses in detail one of the many "highly dynamic indigenous medical fields addressing mental health problems" that are typically ignored by proponents of global mental health. She is however optimistic that such local forms of medical knowledge might still be included in MGMH's agenda, as recent publications (e.g. Patel et al. 2018) testify. In "Global Mental Therapy", anthropologist William Sax asks why it is that even though, worldwide and throughout history, rituals are the most common treatment for mental distress, they are nevertheless systematically ignored by MGMH. He also makes some tentative suggestions about how rituals "work" to address mental disorders. The book concludes with two separate Afterwords. In the first of these, Johannes Quack focuses on the themes of "love" and "justice" that appear throughout the volume, and shows that they address different, though related, concerns. He also urges the contributors to think more carefully about what they might learn from psychiatrists about mental health. In the second Afterword, "Anonymous"

offers a poetic memoir of her treatment in a psychiatric institution in India. She recounts her efforts to make sense of her institutionalisation, and challenges the MGMH with a feminist critique of psychiatry.

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About the Authors

William S. ("Bo") Sax studied at Banaras Hindu University, the University of Wisconsin, and the University of Washington (Seattle), and the University of Chicago, where he earned his PhD in Anthropology in 1987. From 1987 to 1989 he was lecturer in Anthropology at Harvard University, and post-doctoral fellow in the Harvard Academy. After that, he taught Hinduism in the Department of Philosophy and Religious studies at the University of Canterbury in Christchurch, New Zealand, for eleven years. In 2000 he took up the Chair of Anthropology at the South Asia Institute in Heidelberg. He has published extensively on pilgrimage, gender, theatre, aesthetics, ritual healing, and medical anthropology. His major works (all published by Oxford University Press, New York) include *Mountain Goddess: Gender and Politics in a Central Himalayan Pilgrimage* (1991); *The Gods at Play: Lila in South Asia* (1995); *Dancing the Self: Personhood and Performance in the Pandav Lila of Garhwal* (2002); *God of Justice: Ritual Healing and Social Justice in the Central Himalayas* (2008); *The Problem of Ritual Efficacy* (with Johannes Quack and Jan Weinhold, 2010); and *The Law of Possession: Ritual, Healing, and the Secular State* (with Heléne Basu, 2015). He is currently working on a book about archaic polities in the Western Himalayas, tentatively entitled *In the Valley of the Kauravas: From Subject to Citizen in the Western Himalayas*. His 1991 book *Mountain Goddess* has been translated into Hindi under the title *Himalaya ki Nanda Devi* (Dehra Dun: Wimsar).

Claudia Lang is an associate professor (Heisenberg) of anthropology at University of Leipzig and research partner at the Max-Planck-Institute of Anthropology in Halle. Before, she was a postdoc at the ERC project "GLOBHELATH: From International Public Health to Global Health" in Paris, France. She works on the anthropology of health in India and has published on various topics, including traditional medicine, mental health, psychiatry, religion and ritual, health governance, and subjectivities. She is currently working on the digitization and proliferation of mental health and global psy in India's megacities, and on memories, traces, and genealogies of primary health care in Kerala. Her most recent publications include *Depression in Kerala: Ayurveda and Mental Health Care in India's 21st century* (2018) and a co-edited special issue of *Culture, Medicine and Psychiatry*, "Genealogies and Anthropologies of Global Mental Health" (2019).