This is the accepted manuscript version of a paper published in *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences*, 84, 101334. Please use the final version here for citation.

Mental Health, Normativity, and Local Knowledge in Global Perspective

Elena Popa

Abstract

Approaching mental health on a global scale with particular reference to low- and mid-income countries raises issues concerning the disregard of the local context and values and the imposition of values characteristic of the Global North. Seeking a philosophical viewpoint to surmount these problems, the present paper argues for a value-laden framework for psychiatry with the specific incorporation of value pluralism, particularly in relation to the Global South context, while also emphasizing personal values such as the choice of treatment. In sketching out this framework, the paper aims to overcome the clash between universalism and relativism about psychiatric categories by focusing on how overlaps between cultures can contribute to ontology-building. A case study analyzing ethnopsychiatric research in the context of South India will illustrate the proposed view, while also pointing out avenues for further research on the causal efficacy of local shared beliefs about mental disorder. If approaches across different traditions and theoretical frames are shown to work in treating similar ailments, causal connections appear to cut across the different ontologies. Ethnopsychiatry would play a central role in such research, namely in disclosing the variables and mechanisms at work within the local approaches.

Keywords: mental disorder, values, ontology-building, cross-cultural psychiatry, ethnopsychiatry

1. Introduction

Attempts to discuss mental health from a global perspective raise questions regarding whether psychiatric categories hold across different cultures, and insofar as such correspondence may be subject to doubt, further worries about whether a global viewpoint would inevitably exclude local means of understanding and treating mental illness. While many of these critiques have been brought forward by psychiatrists working on cross-cultural issues, anthropologists, and sociologists, there is an important philosophical aspect to the controversies: briefly put, mental health is a normative concept, and as norms require commitment to a set of values, a question arises whether a

single set of values can be applied across different cultural contexts, on a global level. More precisely, the worry is that if the norms rely on values specific to countries broadly classified as 'the Global North' and take psychological traits specific to individuals from this setting as default, the attempt to conceptualize mental health on a global level would amount to little more than a Western export.[1] In the context of psychiatry, this problem is further exacerbated by the significant cultural and social aspects involved in understanding mental illness that have been neglected by biological psychiatry. Thus, one may inquire whether the goal of improving mental health services in countries falling under the category of 'the Global South' can be discussed apart from the specific cultural and social factors.

This paper aims to provide philosophical foundations for a global perspective on mental health and illness. By looking into the issue of normativity in defining mental disorder, I explore a value-laden take on psychiatry: current criticism of the Global Mental Health movement illustrates that despite verbal commitments to the contrary, psychiatric research is underlain by a framework dominated by values specific to the Global North. Nevertheless, as I will argue, this value-laden stance can be expanded to include a plurality of values, notably values applicable to the Global South, and thus provide a global perspective as opposed to a Western-centric one (section 2). As work in ethnopsychiatry illustrates, taking into consideration local sets of values can lead to a better understanding of what approaches to treatment or prevention work in specific settings and how they interact with Western psychiatric concepts (typically, confined to biomedical psychiatry). I argue for a broader framework, that would incorporate both local values and values prevalent in a Global North setting, with focus on their overlaps. This integrating perspective is, however, open to objections stemming from the debate between universalism and relativism, namely whether such perspective is at all possible without the imposition of Global North values. Upon answering this question in the negative, critics of Global Mental Health would subsequently recommend focusing solely on local categories. I employ the partially overlapping ontologies model (as in Ludwig and Weiskopf, 2019) to bridge the universalist aim of identifying scientific categories that hold across cultures, and the goal of disclosing features specific to different cultures (section 3). While Ludwig and Weiskopf discuss categories, emphasizing that they need not be 'causally or explanatorily robust clusters of properties' (2019, p. 2), I will go on to explore certain causal features of local ontologies, particularly their relation to treating mental illness. The motivation for this is that as far as psychiatric concepts go, ontology building has a direct bearing on how mental illness is studied and treated. Within the Global South context I will highlight the importance of local knowledge: if

1 In what follows I employ the Global North – Global South distinction as it is used in the literature on Global Mental Health. While this distinction has been subject to criticism, I hope my argument in this paper will contribute to a perspective overcoming it.

cultural or social aspects determine to a certain extent what mental illness is, then there are causal links that can be used in treating or preventing it. To put it another way, local approaches to mental illness have causal efficacy. I rely on a case study on South India to illustrate the overlapping ontologies model and to emphasize such causal links: various approaches to mental illness – from Western psychiatry, to religious and traditional healing – have provided relief to the patients (section 4). The case study will also emphasize overlaps and interactions between local as well as Western psychiatric categories, and insofar as the same disorder can be approached through treatments belonging to multiple traditions, the causal connections appear to cut across ontologies. Thus, ethnopsychiatric studies are shown to help in disclosing variables relevant to the local context and in including them in psychiatric practice, as well as in explaining how the local approaches work.

2. Mental health as a global concept and normative assumptions from the Global North

The subject of mental health has gained considerable attention during the 21st century, with particular focus on mental health in low- and medium-income countries. The World Health Organization (WHO) has developed an action plan in this sense (WHO, 2013), and the Global South context is emphasized by the *Mental Health Gap Action Programme* (WHO, 2008). Despite discussion of 'culturally appropriate' approaches, as Cox and Webb (2015, p. 684) point out, the action plan relies on normative concepts of illness and disorder, as well as assumptions about social conditions specific to the Global North. Cox and Webb raise further criticism regarding the understanding of mental illness in predominantly biological terms specific to Western psychiatry and its export to the Global South.

Similar criticism is brought about in the context of the Global Mental Health movement. As the concept of Global Mental Health appears to rely on a universal understanding of mental health, critics point out that this understanding is shaped in accordance to psychiatry in the Global North and, as a consequence, it marginalizes or outright excludes traditional forms of treatment (Mills and Fernando, 2014, p. 190). As with the WHO action plan, the focus on mental illness as biological excludes social, political, or economic factors that affect people in the Global South (Mills and Fernando, 2014, p. 189). Debates around Global Mental Health have been divisive, with notable clashes between global and local categories, or universalism and relativism (Cooper 2016, p. 356).

These critiques can be traced to further problems for psychiatry in the Global North, particularly regarding cross-cultural issues. As discussed by Murphy (2015), the approach to cultural factors and mental illness has changed between the fourth and fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). DSM-IV distinguishes between

universal disorders with cultural variation in symptoms, such as depression, and 'cultural-bound syndromes', such as *ataque de nervios* experienced by Latin American individuals, that would not fit the DSM criteria for a panic attack.[2] While DSM-V dropped the category of 'culture-bound syndrome', it only discusses illnesses that occur outside the Western countries in an appendix. As pointed out by Murphy, DSM-V still takes the Western subject to be the norm: 'the assumption in mainstream psychiatry is that Western conditions are not culture-bound; they represent abnormalities in a universal human endowment' (2015, p. 100). Murphy further claims that DSM-V rests on old assumptions in psychiatry where the understanding of a universal condition takes the manifestation in the West to be the 'basic case', while 'other conditions are viewed as falling under the relevant diagnosis depending on how far they resemble the Western condition' (2015, p. 102).

These critiques highlight that Western psychiatry uses of a predominantly biomedical model. While it may be objected that social or cultural factors can be captured by the biopsychosocial approach, also present in Western psychiatry, my reply is that the biopsychosocial model remains marginal and even if it played a greater role, it would be open to similar criticism. As my analysis is philosophical, it concerns the ontological assumptions regarding the nature of mental disorder underlying these approaches as opposed to the approaches *per se*. While the symptom-based approach of the DSM remains agnostic about the etiology of mental illness, the exclusion of context information leads to a focus on biology, leaving out social factors. The elimination of the bereavement exception from the diagnosis of depressive disorder from DSM-V is illustrative of the tendency to consider symptoms outside their social context (Horwitz 2015). This is also in conflict with the biopsychosocial approach, that would emphasize etiology (Pilgrim, 2002, pp. 591-592). The prevalence of impersonal treatment methods in psychiatric practice is also in line with biomedical psychiatry and against the biopsychosocial approach (p. 591), showing that the latter is not the orthodoxy. In my view the biopsychosocial model may work better in cross-cultural setting, but it would require significant adjustment – if the psychological or social contexts are modeled on a Western setting, the question of exporting psychiatry arises again. I bring forward an argument in this sense in section 4. Finally, the Research Domain Criteria project may be an alternative to the DSM, but its applicability in global setting is only emerging (Weine et al. 2018), and analogous critiques have been raised regarding the focus on neurobiology and the neglect of environmental factors (Kirmayer and Gold, 2016). As the social and cultural aspects of mental disorder remain neglected, biomedical psychiatry appears to be the dominant model. Even if one disagrees with this assessment, my argument will also highlight issues within the biopsychosocial understanding.

2 See Kleinman (1987) on the variation of depression symptoms across cultures and Lewis-Fernández et al (2010) on the anxiety disorders and *ataque de nervios*.

The above critiques of a global understanding of mental health and illness and of Western psychiatry overall raise questions about how to approach mental health in the Global South. From the philosophical perspective I pursue in this paper, the issue of mental illness and normativity will help set up a framework. Insofar as science is dealing with facts and is aiming for descriptions of reality independent from the scientists' values or perspectives, normative scientific concepts are subject to controversy. Mental illness is one such concept – classifying something as mental illness implies a disturbance in the normal functioning of the organism; there is also an undesirable aspect to illness. Whether the concept of mental disorder can be defined on the basis of facts only, with no reference to values, has been a subject of philosophical controversy, with two main strands emerging: objectivism or naturalism attempting to construct a value-free understanding, and normativism or constructivism opting for a value-laden stance (Radden, 2019, section 8). For the purposes of this paper, my interest lies in the contrast between value-ladenness and value-freedom and less in the question of objectivity.[3] The value-laden stance helps explain how mental health is built around Western values, but, as I argue, may also be used to bring forth a more inclusive perspective. While my position here involves value-ladenness, it is not confined to normativism, but may be more compatible with so-called mixed views, such as Wakefield (1992). Wakefield's analysis of mental disorder as harmful dysfunction involves both a factual aspect, related to biology as well as a social and cultural one, referring to values: 'dysfunction is a scientific and factual term based in evolutionary biology that refers to the failure of an internal mechanism to perform a natural function for which it was designed, and harmful is a value term referring to the consequences that occur to the person because of the dysfunction and are deemed negative by sociocultural standards' (Wakefield, 1992, p. 376). Considering that biological dysfunctions can be harmful to different extents in different cultures, mental illness would be defined by reference to a set of values that may vary. For instance, after exposure to stressful events (like war or natural disasters), in cultures such as Sri Lanka not thinking about the problem (or 'letting go') is a common way of building resilience, while in the West it may be considered as a symptom of post-traumatic stress disorder (Fernando, 2012, p. 372). Thus, in order to classify a particular behavior as mental disorder, the specifics of the said culture, including values need to be taken into consideration.

Another example of an openly value-laden take is the recovery model by Thornton and Lucas (2011), arguing for a normative understanding with emphasis on the individual's concept of a meaningful life: 'the goal of recovery has to be determined through the conception of a life to be

3 Broadbent (2017) argues that the issues of objectivity and value-ladenness are logically independent, with four possible combinations between them. As he focuses on the debate between naturalism and normativism, and not on mixed (or 'weak normative') positions such as Wakefield (1992), that are closer to my position here, I only use his view to delimit my position to the question of values.

valued and hoped for by the subject concerned. Such a conception is normative or value-laden insofar as it fits, or is appropriate to or correct for the individual's self-identity' (Thornton and Lucas, 2011, p. 27). If one situates self-identity among social and cultural aspects, one can see how the notion of a meaningful life can be different for individuals within different social or cultural settings. Taking the Western subject to be the norm would lead to ignoring local conceptions of what a meaningful life may amount to, as conceptions of personal fulfillment and meaning can be different. For a more refined understanding of the psychiatric subject, knowledge of specific social or cultural conditions would be necessary. Thus, my suggestion is that the value-laden stance should be expanded such as to include values that hold beyond the Global North. In the context of mental health practice this can be achieved by emphasizing cultural competence in caring for culturally diverse populations (Brach and Fraser, 2000; Kirmayer, 2012). While cultural competence has been proposed to improve mental health outcomes for minority populations within Global North context, the expansion of value-laden framework I suggest would apply to psychiatry on a global level.

Before discussing how such an integrating perspective is possible, I will address a potential objection. The points above rely on a value-laden framework, which is common in approaches emphasizing the connection between culture and psychiatry (see, for instance, Bingham's contribution to Rashed et al., 2018), nevertheless, one may ask whether this approach would work under a naturalist viewpoint. One possible reply would point to a more general objection against naturalist approaches: they cannot completely avoid resorting to a normative aspect at one point or another in the analysis. For instance, one such account by Boorse (1997) employs a statistical definition where illness is understood in relation to a reference class (the mean for one's age and sex). It has been objected, however, that this introduces values back into the picture, albeit in a naturalized form, such as survival and reproduction (Bolton, 2008). While the debate between naturalism and normativism is beyond my purposes here, I would like to point out that merely subscribing to naturalism would not make the issue of normative claims shaped by the Global North context go away. When one speaks of mental illness in relation to different contexts, the features of the reference class may be different. This is illustrated by cases of different statistical patterns for mental illness, such as the prevalence of somatic as opposed to psychological symptoms of depression in Asia (Kleinman, 1977). Another reply to this objection would be that while one may abide by naturalism, the naturalized concept of illness may simply not be present in current psychiatry, or in mental health policies more broadly. Thus, even assuming that mental illness may be defined in a value-free way, that would not automatically rule out the imposition of Global North values in Global South contexts. On this line of argumentation, if value-freedom is indeed a

desideratum, this desideratum should also go against building global psychiatric practices around values from the Global North.

3. Universalism versus relativism? Perspectives from ethnobiology and ethnopsychiatry

In the previous section I have argued for expanding the value-laden perspective on mental illness (and, by extension, mental health) to include values from cultures beyond the Global North. In the case of value-free definitions of illness, I have suggested that the set of norms involved, should be adjusted to incorporate the relevant differences. Nevertheless, thinking of mental health on a global scale through a framework integrating widely varying sets of values may bring about the question whether reaching a coherent understanding is possible. To put it another way, one may end up with completely distinct psychiatric categories according to the values taken to be part of the frame of inquiry. More broadly, this potential objection relates to the clash between universal psychiatric categories and local concepts. Recent discussions of cross-cultural issues in psychiatry show the debate to be inconclusive: in current psychiatry it is 'premature to argue that all psychopathology is local, and also premature to announce the success of the universalist conception of mental illness' (Murphy, 2015, p. 108). This remark can be read in the light of the univeralist ambitions of Western psychiatry discussed above clashing with theoretical stances taken in fields such as cultural psychiatry and anthropology that support a view focusing on local categories. In this section I first explore the philosophical tenets underlying the field of ethnopsychiatry and conclude that exclusive focus on local categories is also unsatisfactory. I then proceed to argue that if supplied with a distinct model of ontology-building, ethnopsychiatric research can contribute to the global view sketched out above, particularly in disclosing the role of local context and values, thus informing understandings of mental health and illness beyond the perspective of the Western subject. In articulating this ontological background I use the partially overlapping ontologies model (Ludwig and Weiskopf, 2019) with additional emphasis on the causal efficacy of local approaches in treating mental disorder to be discussed in relation to a case study in section 4.

Disclosing the theoretical assumptions underlying ethnopsychiatry requires an investigation of the historical development of the field. I will do so by contrast with ethnobiology, to highlight the clash between universalism and relativism arising in both cases, and emphasize the political factors that rendered relativism important from the onset for psychiatry, which are still relevant to current global approaches to mental health. Concerning ethnobiology, Ludwig (2018) notes a trajectory shifting from a metaphysics of convergence in the 1960s and 1970s that focused on the correspondence between folk classifications and biological ones, to an emphasis on local categories. In the case of ethnobiology, the central factors supporting convergence metaphysics are identified

by Ludwig as ‘the cognitive revolution’, and its search for universal cognitive structures, and ‘the modern evolutionary synthesis’. The decline of universalist views is linked to increasing interest in research that particularly targets local categories, most notably illustrated by the field of ‘traditional ecological knowledge’ (TEK), but also to political issues, such as the neglect of knowledge that falls outside the universalist scope (Nadasdy, 1999). While a discussion of different forms of ecological knowledge is beyond the scope of this paper, the similarities to questions of universalism versus local categories in psychiatry should be noted. A universalist perspective may look at the same disorder (say, depression) and its different manifestations across cultures (say, depression experienced through somatic symptoms, as discussed by Kleinman, 1977). However, this approach may run the risk of neglecting the psychiatric conditions falling under the category of ‘culture-bound syndrome’, or employing means of treatment specific to Western culture while overlooking local interventions. A look at historical aspects of ethnopsychiatry will show how such tensions have been present since the emergence of the field, thus leading to a focus on local concepts and relativism.

A historical perspective on ethnospychiatry would involve an investigation of the legacy of colonialism. Colonial psychiatry relied on an assumed superiority of the European civilization, and institutions such as psychiatric asylums were not solely meant to care for the ill, but also to aid colonial rule (see Keller, 2001 for a review focusing on the British and the French empires). The beginnings of ethnopsychiatry can be traced to French psychiatrists treating North African migrant workers following World War II (Fassin and Rechtsman, 2005). Both colonial psychiatry as well as emerging studies on mental illness outside the European context emphasized difference, thus singling out non-European patients as ‘the others’. The assumptions of difference as inferiority were challenged as part of the struggle against colonialism. Nevertheless, ethnopsychiatry of the 1960s and 1970s still emphasized difference, albeit in a distinct sense: ‘ethnomedicine and ethnopsychiatry were fueled by the ambition to avoid the imposition of Eurocentric psychological and psychiatric categories in populations from the non-Western world. But, by attributing specific ethno-specific features and mechanisms to particular communities and to “the colonized” it ran the danger of essentializing and reifying earlier ideas of racial characteristics and “character”’ (Ernst, 2017, p. 212). Kirmayer (2007) further illustrates this in relation to Fanon’s (1982) work in the context of Algeria.

Regarding the field of ethnopsychiatry, a change in scope can be noted from Devereux’s (1961) pioneering account of folk theories of mental illness among Native Americans described by Gaines (1992) as ‘old’ ethnopsychiatry having ‘as its focus mental derangements as locally understood, treated, managed, and classified’ (Gaines, 1992, p. 4) and a wider reaching ‘new’

ethnopsychiatry. The ‘old’ sense runs in contrast with cross-cultural psychiatry: because cross-cultural psychiatry looks for local manifestations of Western psychiatric categories, it is prone to ignore the differences, and in this sense it can be seen as taking a Western-centric universalist stance. As illustrated by Kleinman (1987, p. 448), the International Pilot Study of Schizophrenia by WHO (1973) focused on individuals exhibiting symptoms similar with Western patients, while ignoring differences. Ethnopsychiatry would address this shortcoming by focusing on mental illness from local perspectives. In introducing a collection of articles comprising ethnopsychiatric studies as well as broader anthropological analyses as part of the ‘new’ ethnopsychiatry, Gaines holds that ‘all forms of psychiatry, whether formal or informal, professional or personal, are equally ethnopsychiatries’ (1992, p. 5). The view of ethnopsychiatry as folk psychiatry, as well as the recognition of local aspects underlying scientific approaches to psychiatry fall in line with a perspective that emphasizes local concepts, and thus amounts to a rejection of universalism. The cross-cultural issues in psychiatry are dealt with in different ways by ethnopsychiatry and cross-cultural psychiatry: the former emphasizes local concepts, while the latter has universalist ambitions but risks employing Western-centric categories. This paper seeks to bring the two closer together, beyond the universalism-relativism clash: admitting that there are common aspects to mental illness, as well as cultural differences need not commit one to a kind of universalism that ignores the local context or to relativism.

The historical background above highlights the tension between universalist and relativist stances. While for ethnobiology a shift from the former to the latter is noted, ethnopsychiatry appears to have started from relativist premises. Although beyond the purposes of this paper, the different trajectories and the question of relativism can be explained by reference to the time when political questions became important. In the case of ethnobiology and ecological knowledge political issues gained prominence in the 1980s and 1990s, whereas they seem to have been present all along in the case of psychiatry, namely in the clash between colonial psychiatry and views critical of the Western-centric perspective. This background further stresses the question whether one can speak of mental health from a global perspective, or simply of multiple psychiatries with concepts of mental health specific to the respective cultures. If there is no common ground between the two, the solution of including local values in understanding mental illness and health proposed above would leave one with as many concepts of health and illness as there are cultures. Thus, an answer to the dilemma cannot be found within the theoretical assumptions underlying ethnopsychiatry. To overcome this worry, I will argue for a perspective where broad features applying to Western psychiatry intertwine with local aspects, by extending the framework of partially overlapping ontologies by Ludwig and Weiskopf (2019) to ethnopsychiatry.

The model by Ludwig and Weiskopf seeks to avoid the drawbacks of both universalism and relativism – namely the oversimplification of complex issues which may involve local variants by the former, and the issue of incommensurable worldviews resulting from the latter. As earlier I suggested that a framework including the values of the relevant cultures be adopted for global reaching psychiatric concerns, my proposal is in line with analyzing overlaps 'through the influence of local concerns and purposes in ontology building' (Ludwig and Weiskopf, 2019, p. 4). This claim, made at an epistemic level, brings together the concepts of 'anthropic categories' (Weiskopf, 2018) and 'bottleneck categories' (Franklin-Hall, 2015) – the former to designate categories serving different human purposes, the later to highlight that common categories may arise even across widely varying interests. The model by Ludwig and Weiskopf further explores the role values play in building ontologies by singling out four determining factors: material, cognitive, cultural, and political (2019, pp. 7-8). This model of ontology building is applicable in the context of psychiatric categories as follows:

a) the *material* would refer to the search for biological phenomena linked to mental illness, such as the chemistry of the brain;
b) the *cognitive* would bring forward common ways of understanding mental illness. Insofar as cognitive processes with universal applicability can be found, as emphasized by the 'cognitive revolution' there may be universal grounds for understanding certain features of mental illness. For instance, Boyer's (2011) discussion of principles of intuitive psychology being tacitly used across distinct cultures, and his explanation of disorders in these terms may show significant overlaps in cross-cultural understandings of mental disorder;
c) the *cultural* would include psychiatric categories arising within particular cultures, or systems of beliefs. Ethnopsychiatric studies especially would disclose connections to local knowledge systems and context;
d) the *political* would take into consideration local understandings and ways of addressing mental illness and their underlying values, in a 'preservation of ontological difference' (Ludwig and Weiskopf, 2019, p. 7) as opposed to marginalizing or replacing them.

These considerations regarding ontology also help shed more light on the discussion of mental illness as a normative concept. On a reading in line with Ludwig and Weiskopf's view on biological categories that matches Wakefield's concept of mental disorder as harmful dysfunction, the biological or cognitive variables may come down to a set of facts constituting mental disorder, while cultural and political factors also play a role, and it is here where values become relevant. It should be noted, however, that the fact/value distinction does not necessarily overlap with the universal/culture-bound one. Thus, on an alternative reading, values would be involved in knowing

biological or cognitive aspects, while there may be value-free social facts.[4] These could be accounted for from a value-laden take on psychiatry, for instance Sadler (2013, p. 764) discusses ontological values as presuppositions about what it is, and the material and cognitive aspects can comprise assumptions about human nature. Thus, the model would accommodate both 'weak' and 'strong' normativism about mental disorder. Regarding the proposed framework, the model of overlapping ontologies shows that including local factors does not amount to an entirely divergent worldview: cognitive or biological factors uniform across cultures can be present, while variation in biological factors, such as different symptoms, can also be accommodated as cultural aspects are also considered. Another strength of this model is that it can extend beyond the scope of cross-cultural psychiatric concepts. Given controversies regarding the emphasis of biology and the neglect of social or psychological factors in the study of mental illness (Bentall, 2004), a model incorporating social and cultural factors would accommodate understanding mental illness in a way that does not exclude them. As critiques of global mental health emphasize the risk of imposing a biological approach while discarding local knowledge, using the model above would emphasize the role of psychological, social or political factors without falling into relativism.

Thus far I have highlighted the need for an understanding of mental illness, and more broadly of normative considerations underlying psychiatry, that avoid the imposition of Global North values or the psychology of the Western individual. While the theoretical assumptions behind ethnopsychiatry do not suffice to address this worry, as focus on local categories exclusively may undermine the attempt to think about mental health at a global level, I have suggested the incorporation of local concerns and values from the framework of partially overlapping ontologies. This model, particularly through its cultural and political components, can include contributions from ethnopsychiatry to inform approaches to mental illness especially in Global South context. As I have suggested that a global understanding of mental health can be grounded in the ontological considerations above, I will now investigate how these ontological considerations can contribute to the questions raised in the beginning, with regard to approaching mental illness at a global level. In addition to the model by Ludwig and Weiskopf, I am also going to consider causal connections involving psychiatric concepts, particularly in relation to treatment. As defining mental illness in a certain way influences how it is studied (say, by defining it as biological versus psychological) and also how it is treated (say, through medication versus psychotherapy), ontological claims presuppose certain causal relations to hold.[5] For the remainder of this paper, I use a case study to

4 I am grateful to an anonymous referee for this point.

5 I am presenting these factors by opposition to portray the tension between the biomedical and biopsychosocial approaches to mental illness. I do not hold that they are exclusive, but that they appear that way given the current state of psychiatry.

illustrate the claims above, as well as to explore the causal relations encompassing ontological categories built around local concerns. The discussion of causality will help highlight two points. Firstly, emphasizing the causal efficacy of shared beliefs about mental disorder would make a stronger case for incorporating them in a global account of mental disorder with objectivist goals. I make this point by analogy with the debate concerning critical realism in the social sciences where causal efficacy may count as a criterion for entities such as social structure to be considered real as opposed to mere theoretical constructions (see Bhaskar, 1989; Lewis, 2000). Likewise, if local beliefs about health and illness are causally efficacious, they are more than constructs specific to a given culture, and can effectively be used in approaching mental disorder. This is shown in ethnopsychiatric studies such as the ones to be explored in section 4, disclosing that in places where competing treatment approaches are available patients resort to healing methods outside of their culture or religion, and find relief. Secondly, the discussion of causality will help bring the philosophical considerations closer to the question of the role of local knowledge: ethnopsychiatric research may explain whether and how different understandings of mental illness work in causal interactions such as treatment or prevention.

4. Traditional treatments of mental disorder, recovery, and pluralism in the context of South India

This section will analyze the case of recovery from mental illness through traditional and religious healing in the context of South India as a way of illustrating the view above, while exploring further issues regarding causal connections involving local categories. This will highlight the role of ethnopsychiatric research, namely in investigating local practices and approaches and explaining their connection to positive treatment outcomes. In the context of a global perspective on mental health these contributions would support local approaches and pluralism.

My discussion focuses on two studies on South India analyzing the effects of traditional methods in treating mental illness. Raguram et al. (2002) discuss improvement in psychotic patients following admission to a Hindu temple in Tamil Nadu. Halliburton (2004) analyzes personal reports on mental health as well as family members' assessment of patients seeking treatment in Western psychiatric institutions, ayurvedic practitioners, or religious sites in Kerala. These findings can be read against the backdrop of higher rates of recovery from psychosis for patients in the Global South noted in several WHO studies (see Sartorius et al., 1986; Sartorius et al., 1996).

Raguram et al. (2002) used the brief psychiatric rating scale for assessing the state of patients admitted to the temple, noting a decrease in symptoms by almost 20% at the end of their stay, which is close to treatment outcomes under medication (Raguram et al., 2002, p. 39). The

patients are admitted to the temple with a family member to take care of their daily needs, and are encouraged to take place in the daily activities in the temple. The authors point out that as the temple is not run by a higher Hindu caste, no specific healing rituals are used, with patients only taking part in morning prayers (p. 40). The local belief is that 'it is the experience of residing in the temple for a period of time, rather than therapy provided by a healer, that brings relief from mental illnesses' (Raguram et al., 2002, p. 40). The authors provide a broader explanation of recovery in terms of patients finding the temple as a refuge, and insofar as this option is no longer available to patients in the Global North, this could potentially explain the higher recovery rates.

Halliburton (2004) brings forth an explanation of the discrepancy between recovery rates between the Global North and the Global South through the availability of multiple treatments in the latter setting. This does not rule out the previous findings by Raguram et al., but rather places them in a broader perspective. Halliburton compares interviews from patients using three different types of treatment – allopathic, ayurvedic, and religious (including a Hindu temple, a mosque, and a church). The allopathic treatment includes biomedical approaches, while the ayurvedic and religious treatments rely on different understandings of mental illness. In Ayurveda, mental illness is also defined through biology, although through a distinct system: 'psychopathology is defined according to ayurvedic etiology which is based on ascertaining disorders in underlying bodily and mental processes known as dosas and identifying information about environment, diet, behavior, psychosocial context, and personality type' (Halliburton, 2004, p. 90). The treatments include medication, special diets, counseling.[6] Regarding religious healing, Halliburton mentions that the Beemapalli mosque includes 'prayer and ritual performances and a space where [patients] can act out their behaviors without judgment or scorn' (p. 92). Similar practices were noted at a Hindu temple and Catholic church admitting patients suffering from mental disorders. Halliburton notes that 'people improve, at least to some degree, with all of these therapies' (2004, p. 88). At the same time, he points out cases where people noted no effect of a choice of treatment and subsequent relief upon trying a different one (both positive and negative reports were given for all three options).

There are several points to highlight in connection to these studies. Firstly, a connection between religious beliefs and understanding mental illness is noted. The connection between local understandings of mental illness and religious beliefs is captured by Nichter's (1981) concept of 'idioms of distress': afflictions such as spirit possession can be viewed as expressions of the individual experiencing mental health issues. From a broader perspective, the connection between psychiatric disorders, patients' religious beliefs, and recovery illustrates a contrast between local practices and Western psychiatry. As pointed out by Fernando (2010), among the central differences

6 See Obeyesekere (1977) for a detailed description of Ayurveda.

between psychiatric practices in Western culture and indigenous cultures across Asia, Africa, and North America is that while in the former psychiatry is practiced as a specialized discipline, within the latter it is not separated from broader religious and philosophical perspectives. In connection to the question of values above, it can be noted that from the perspective of such systems, a picture of scientific knowledge as distinct from social or religious values may not be achievable. Thus, help seeking and particular treatments involve approaches that can be explained in biological terms, but they also include people's commitment to a set of values. Interestingly, the overlaps may be between values more than beliefs as such. If people seek help from, say, religious institutions they are not affiliated with, and thus do not necessarily share the core religious beliefs of the community, the overlap can be explained in terms of common values.

Secondly, analyzing the case of psychiatric pluralism in the context of South India, Halliburton goes on to claim that the results 'lead us to question whether a healing system as a system, independent of the tendencies and preferences of individual patients (as well as their families and communities), can be evaluated as being "effective," and suggest that the only thing we may be confident of is that some therapies work for some people and some work for others' (2004, p. 89). This is an illustration of how values underlie the very definition of what counts as a treatment option. Interestingly, values are not confined to those of the community, and individual values and choices of treatment are emphasized. In more recent work, Halliburton points to aesthetic values that come down to the individuals' perspective: 'a therapy that feels good might have some advantages over a therapy that is more painful or abrasive, especially for problems of mental illness' (2016, p. 19). In terms of the framework of partially overlapping ontologies in the previous section, this shows how in a pluralistic approach to psychiatric treatment distinct sets of values operate together – values specific to the Global North may hold regarding allopathic treatment, while Ayurveda and religious healing rely on different sets of local values. One further thing to emphasize here is that the cultural or religious values do not necessarily determine individual choices – as Halliburton (2004) reports, some Hindu patients sought treatment at the Beemapalli mosque and reported feeling better, while a Muslim patient reported not trusting the faith healing. In broader South Asian context this is explained by the following remark by Thara and Padmavati: 'the choice of the modality of treatment goes beyond the boundaries of religious faith. Ritualistic behaviours and their symbolic meanings are readily accepted and have a social sanction' (2010, p. 538). Thus, the availability of several treatment options the choice of which is determined by cultural, social, but also individual values shows several views on mental health and illness as well as value sets coming together. Partial overlaps can be noted, as in cases where patients using local idioms of distress opt for allopathic treatment, or when complaints such as spirit

possession reveal symptoms that can also be classified according to Western psychiatry. Moreover, there are studies focusing on how Western psychiatric concepts, such as depression, are reframed within ayurvedic psychiatry (Lang and Jansen, 2013).

In connection to the points made so far, these studies show how taking into consideration cultural factors – such as religious beliefs, or social relations, but also individual choices - can contribute to recovery. Thus, a normative concept of mental health along the lines of Thornton and Lucas (2011) would work insofar as a conception of a meaningful life is connected to the culture one belongs to, but need not strictly follow it – the example of treatment seeking not necessarily tracing religious affiliation is illustrative in this sense; the same would hold for patients that decided to change the treatment upon noting what they would perceive as not significant enough improvement. Regarding partially overlapping ontologies, ethnopsychiatric studies such as those discussed above reveal cultural and social factors that affect understandings of mental health and illness, while also playing a role in recovery. The common complaints between Western psychiatric conditions and local or religious understandings of mental disorder mark the overlaps. Similarly, the successful use of therapeutic practices belonging to one tradition to treat disorders classified according to a different one, such as the use of Ayurveda to treat depression, is indicative of these overlaps. The ontologies of ayurvedic and biomedical approaches to depression would overlap insofar as they would consider depression to have biological causes. Nevertheless, the explanations would refer to different biological entities, and corresponding treatments. Thus, it would be difficult to account for a treatment that does not connect to the chemistry of the brain on the biomedical approach, for instance. Nevertheless, the presence of both perspectives is apparent in what Halliburton (2016) singles out as a pragmatic perspective, people go to different places seeking treatment for the same ailments.

Coming back to the four factors discussed by Ludwig and Weiskopf (2019), in the context of the study above, they would work as follows:

(a) the *material* – there is a biological dimension to mental illness to be investigated not only by biomedical psychiatry, but also in Ayurveda;

(b) the *cognitive* – some of the treatments provided at the temple, as well as the temple functioning as a place of refuge would broadly fit into psychotherapeutic practices. In terms of cognitive categories that hold across psychiatric theories, the efficiency of psychotherapy and related practices in the case of religious healing can be spelled out in terms of ‘folk psychology’ (Bruner, 1990; Binder et al., 2010). A further illustration of this point is Nichter’s (2003) analysis of a case of the ‘Gulf Syndrome’ – upon returning to India migrant workers would seek admission and checkups in nursing homes for vague health complaints

as a way of dealing with their psychological distress. The nursing homes would also function as places of refuge;

(c) the *cultural* – the case study shows how various interpretations and approaches to mental illness can coexist and even interact: religious understandings such as spirit possession, or explanations in terms of humors in Ayurveda;

(d) the *political* – the context of the case study reveals coexisting practices in a plurality of approaches to mental illness. Beside illustrating the benefits of providing patients with the autonomy of choosing the treatments they find more pleasant, these studies also reflect a sharp contrast with cases where local ways of approaching mental illness are threatened by what Davar and Lohokare deem 'the so-called "modern" mental health institutions' (2009, p. 66).

In relation to the discussion in section 2, an objection may be raised concerning whether the findings highlighted in the case study could also fit within the explanatory patterns of Global North psychiatry. In reply, I point out that the biomedical model would be too narrow to account for the effectiveness of religious rituals, relevant social mechanisms, or the psychological effects of spending time in a place of respite. While the employment of biological explanations would be a common point with Ayurveda, the two systems have different ontologies that could not be explained solely from the biomedical perspective. Alternatively, the biopsychosocial approach can incorporate psychological and social aspects involved in religious healing and consider the context. Nevertheless, given the earlier discussion of values, the question is whether assumptions modeled on the psychology of Western individuals could fit the relevant cultural patterns. Particularly, in Western psychiatry mental illness is understood apart from religious beliefs, but in the context of different cultures the two may be difficult to disentangle. Thus, while the biopsychosocial approach would work better in terms of handling social or cultural factors, its use would be limited if values relevant to the context are not taken into consideration. A further issue would be the conflict between say, biological explanations from biomedicine and Ayurveda. The advantage of the partially overlapping ontologies model is the emphasis of both places of overlap – say, common social or biological patterns – and divergences due to different theoretical backgrounds for treatments such as Ayurveda, or religious healing. Thus, while the biopsychosocial model can explain the findings to a limited extent (as long as there is overlap with corresponding Western ontologies, but the differences remain unaccounted for), the partially overlapping ontologies model can account for pluralism, as well as the possibility to shift between options. As there are overlaps between these systems, the initial understanding and an alternative approach would not be incommensurable (say, treating demonic possession with medication).

The last point helps address another possible objection, regarding whether the overlapping ontologies model is not undermined by cases of conflicting ontological claims. This could hold for biomedical psychiatry and Ayurveda, as in the example above, or local approaches, say religious healing according to different co-existing traditions. The case study shows that there is at least a pragmatic way of choosing between systems and ontologies – people choose the treatments they perceive as working, and can change options upon unsatisfactory results. More broadly, the value-laden model can explain choices: for instance, Halliburton refers to people's preference for approaches they perceive as less invasive, in this sense one could opt for religious healing or psychotherapy if one wants to avoid side effects of medication. The choice here is underlain by personal values, and, as described above, people do make such choices.

The case study shows traditional approaches to make a difference to patient recovery, and this is important insofar as it can inform discussions of mental health at a global level – ethnopsychiatry does not merely describe local concepts, but it can show that they work. Within the broader context of the philosophy of science, a further question would be how to account for such causal patterns. Due to the multiple levels involved,, investigating this would go beyond the purposes of the paper, nevertheless, potential further research could consider interventionist model to show *whether* the approaches yield desired results (Kendler and Campbell, 2009), or a mechanism approach (Kendler et al., 2011) explaining *how* these approaches work. The latter option would emphasize the local conditions, which can be disclosed by ethnopsychiatric studies.

While more research is needed on establishing the causal efficacy of local shared beliefs about mental disorder, and in spelling it out in terms of current approaches to causation in the philosophy of science, the picture I have described shows that the connection between local treatments and recovery, as well as the interactions between local psychiatric categories and biomedical psychiatry can be singled out in causal terms: the example of the recovery rate would meet a probabilistic criterion for causality, but more evidence to rule out accidental correlations is needed. Above I have suggested that two of the leading models, the interventionist and the mechanistic one, could work in this case and further investigations on the matter can take ethnopsychiatric work as a departure point in the search for causal connections.

5. Conclusions

In this article I have explored how the framework for investigating mental health from a global perspective can be expanded to include values characteristic of Global South context as an alternative to exporting Western psychiatry. In sketching out this framework I have addressed the pressing issue regarding whether such integrating perspective is possible, and consequently whether

commitment to culturally appropriate approaches can go beyond a mere verbal level. I have used the overlapping ontologies model to integrate universalist psychiatric concerns with local contexts. Ethnopsychiatry in particular can provide the material for constructing such ontologies. In analyzing ethnopsychiatric studies in the context of South India I have explored possible causal connections between treatment and recovery working within different theoretical approaches to mental illness, ranging from biomedical psychiatry to religious healing. While further research is needed in this sense, a clearer statement of causal connections can be provided by joint ethnopsychiatric and philosophical investigations, and the results of such research could inform global approaches with regards to the relevant local aspects.

Further research possible within this framework would include singling out the causal connection between local treatment approaches and recovery. Moreover, studies on practices analogous to psychotherapy and descriptions in terms of intuitive or folk psychology could also reveal common ground between local psychological interventions and recovery from mental disorder. Thus, a better understanding of mental health on a global level would benefit from philosophy of science and ethnopsychiatry working together.

Acknowledgments

I would like to thank the two anonymous referees for comments that helped strengthen this paper. I am also grateful to Tiffany Cone and Maria Temmes for helpful comments on an early version of this article.

References

Bentall, R. P. (2004). *Madness explained: Psychosis and human nature*. Penguin UK.

Bhaskar, R. (1989). *The Possibility of Naturalism: A Philosophical Critique of the Contemporary Human Sciences*. 2nd edition (1st edition, 1979). Hemel Hempstead: Harvester Wheatsheaf.

Binder, P. E., Holgersen, H., & Nielsen, G. H. S. (2010). What is a “good outcome” in psychotherapy? A qualitative exploration of former patients' point of view. *Psychotherapy Research*, *20*(3), 285-294.

Bolton D. (2008). *What is Mental Disorder? An Essay in Philosophy, Science, and Values*. Oxford University Press.

Boorse, C. (1997). A Rebuttal on Health. In *What Is Disease?*, J. M. Humber and R. F. Almeder (eds.), Totowa, NJ: Humana Press, 1–134.

Boyer, P. (2011). Intuitive expectations and the detection of mental disorder: A cognitive background to folk-psychiatries. *Philosophical Psychology*, *24*(1), 95-118.

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research Review*, 57(Suppl. 1), 181e217.

Broadbent, A. (2017). Health as a Secondary Property. *The British journal for the philosophy of science*, *70*(2), 609-627.

Bruner, J. (1990). Acts of meaning. Cambridge, Mass.: Harvard University Press.

Cooper, S. (2016). Global mental health and its critics: moving beyond the impasse, *Critical Public Health*, 26:4, 355-358,

Cox, N., & Webb, L. (2015). Poles apart: does the export of mental health expertise from the Global North to the Global South represent a neutral relocation of knowledge and practice?. *Sociology of health & illness*, *37*(5), 683-697.

Davar, B. V., & Lohokare, M. (2009). Recovering from psychosocial traumas: The place of dargahs in Maharashtra. *Economic and political weekly*, 60-67.

Devereux, G. (1961). Mohave ethnopsychiatry and suicide: The psychiatric knowledge and the psychic disturbances of an Indian tribe. *Bureau of American Ethnology Bulletin*.

Ernst, W. (2017). Histories of madness in South Asia. In *The Routledge History of Madness and Mental Health* (pp. 210-228). Routledge.

Fanon, F. (1982). *Black Skin, White Masks*. New York: Grove Press (Translation of *Peau noire, masques blancs*, Seuil, 1952).

Fassin, D. & Rechtman, R. (2005). An anthropological hybrid: the pragmatic arrangement of universalism and culturalism in French mental health. *Transcultural Psychiatry*, 42(3), 347–366.

Fernando, G. (2012) Bloodied but unbowed: resilience examined in a South Asian community, *American Journal of Orthopsychiatry*, 82, 3, 367– 75.

Fernando, S. (2010). *Mental health, race and culture*. Macmillan International Higher Education.

Franklin-Hall, L. R. (2015). Natural kinds as categorical bottlenecks. *Philosophical Studies*, 172(4), 925– 948.

Gaines, A. D. (Ed.). (1992). *Ethnopsychiatry: The cultural construction of professional and folk psychiatries*. SUNY Press.

Halliburton, M. (2004). Finding a fit: psychiatric pluralism in South India and its implications for WHO studies of mental disorder. *Transcultural psychiatry*, *41*(1), 80-98.

Halliburton, M. (2016). *Mudpacks and prozac: Experiencing ayurvedic, biomedical, and religious healing*. Routledge.

Horwitz, A. V. (2015). The DSM-5 and the continuing transformation of normal sadness into depressive disorder. *Emotion review*, 7(3), 209-215

Keller, R. C. (2001). Madness and colonialism: psychiatry in the British and French empires, 1800–1962. *Journal of Social History*, 35, 295–326.

Kendler, K. S., & Campbell, J. (2009). Interventionist causal models in psychiatry: repositioning the mind–body problem. *Psychological medicine*, *39*(6), 881-887.

Kendler, K. S., Zachar, P., & Craver, C. (2011). What kinds of things are psychiatric disorders?. *Psychological medicine*, *41*(6), 1143-1150.

Kirmayer, L. J. (2007). Cultural psychiatry in historical perspective. *Textbook of cultural psychiatry*, 3-19.

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social science & medicine*, *75*(2), 249-256.

Kirmayer, L. J., & Gold, I. (2016). Re-socializing psychiatry: Critical neuroscience and the limits of reductionism. In S. Choudhury, & J. Slaby (Eds.), *Critical neuroscience: A handbook of the social and cultural contexts of neuroscience*. Chichester, UK: John Wiley & Sons, 307-330.

Kleinman, A. M. (1977). Depression, somatization and the "new cross-cultural psychiatry". *Social Science & Medicine (1967)*, *11*(1), 3-9.

Kleinman, A. (1987). Anthropology and psychiatry. The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, 151, 447–454.

Lang, C., & Jansen, E. (2013). Appropriating depression: biomedicalizing Ayurvedic psychiatry in Kerala, India. *Medical anthropology*, *32*(1), 25-45.

Lewis-Fernández, R., Hinton, D. E., Laria, A. J., Patterson, E. H., Hofmann, S. G., Craske, M. G., Stein, D. J., Asnaani, A., & Liao, B. (2010). Culture and the anxiety disorders: Recommendations for DSM-V. *Depression and Anxiety*, 27, 212–229.

Lewis, P. (2000). Realism, causality and the problem of social structure. *Journal for the theory of Social Behaviour*, *30*(3), 249-268.

Ludwig, D., & Weiskopf, D. A. (2019). Ethnoontology: Ways of world building across cultures. *Philosophy Compass*, e12621.

Ludwig, D. (2018). Revamping the metaphysics of Ethnobiological classification. *Current Anthropology*, *59*(4), 415-438.

Mills, C., & Fernando, S. (2014). Globalising Mental Health or Pathologising the Global South? Mapping the Ethics, Theory and Practice of Global Mental Health. *Disability and the Global South*, *1*(2), 188-202.

Murphy, D. (2015). "Deviant Deviance": Cultural Diversity in DSM-5. In *The DSM-5 in Perspective* (pp. 97-110). Springer, Dordrecht.

Nadasdy, P. (1999). The politics of TEK: power and the ‘integration’ of knowledge. *Arctic Anthropology* 36 (1): 1–18.

Nichter, M. (1981). Idioms of distress: Alternatives in the expression of psycho-social distress: A case from South India. *Culture, Medicine and Psychiatry*, 5, 379–408.

Nichter, M. (2003). The social relations of therapy management. In *New horizons in medical anthropology* (pp. 95-124). Routledge.

Obeyesekere, G. (1977). The theory and practice of psychological medicine in the Ayurvedic tradition. *Culture, Medicine and Psychiatry*, *1*(2), 155-181.

Pilgrim, D. (2002). The biopsychosocial model in Anglo-American psychiatry: Past, present and future?. *Journal of Mental Health*, *11*(6), 585-594.

Radden, J. (2019). Mental Disorder (Illness). *The Stanford Encyclopedia of Philosophy* (Summer 2019 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/sum2019/entries/mental-disorder/>.

Raguram, R., Venkateswaran, A., Ramakrishna, J., & Weiss, M. G. (2002). Traditional community resources for mental health: A report of temple healing from India. *British Medical Journal*, 325, 38–40

Rashed, M. A., Bingham, R., Poole, N. A., Sanati, A., & van Staden, W. (2018). Debate: The concept of culture has outlived its usefulness for psychiatry. *BJPsych bulletin*, *42*(2), 72-76.

Sadler, J. Z. (2013). Values in psychiatric diagnosis and classification. In *The Oxford handbook of philosophy and psychiatry*, 253-778.

Sartorius, N., Gulbinat, W., Harrison, G., Laska, E., & Siegel, C. (1996). Long-term follow-up of schizophrenia in 16 countries. *Social Psychiatry and Psychiatric Epidemiology*, 31, 249–258.

Sartorius, N., Jablensky, A., Korten, A., Ernberg, G., Anker, M., Cooper, J. E., & Day, R. (1986). Early manifestations and first-contact incidence of schizophrenia in different cultures. *Psychological Medicine*, 16, 909–928.

Thara, R., & Padmavati, R. (2010). Social psychiatry in India. *Principles of social psychiatry*, 531.

Thornton, T., & Lucas, P. (2011). On the very idea of a recovery model for mental health. *Journal of Medical Ethics*, *37*(1), 24-28.

Wakefield, J. C. (1992). The concept of mental disorder: on the boundary between biological facts and social values. *American Psychologist*, *47*(3), 373.

Weine, S. M., Langenecker, S., & Arenliu, A. (2018). Global mental health and the National Institute of Mental Health Research Domain Criteria. *International Journal of Social Psychiatry*, *64*(5), 436-442.

Weiskopf, D. A. (2018). Anthropic concepts. *Noûs*, vv(ii), xx.

World Health Organization (WHO)(1973) International Pilot Study of Schizophrenia. Geneva: World Health Organization.

World Health Organization (WHO) (2008) *Mental Health Gap Action Programme (mhGaP): Scaling Up Care for Mental, Neurological and Substance Abuse Disorders*. Geneva: World Health Organization.

World Health Organization (WHO) (2013) *Mental Health Action Plan 2013–2020*. Geneva: World Health Organization.