Culture, Politics and Global Mental Health

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This paper critically examines some of the assumptions and politics which underlie the global mental health (GMH) movement; and explores the issue of cultural awareness within western psychiatric thinking and practice. The way distress is labelled has a range of consequences for the individual, their family and society, as well as those who may control or negotiate the descriptors used, the actions taken as a result of these and the resources subsequently allocated. This paper will examine if these are the most useful principles, and if so, who might be the main beneficiaries of these. The importance of context, international, national and health politics, in addition to wealth and power differentials cannot be ignored in the way that the global mental health debate is constructed. Diagnostic classification systems, such as the Diagnostic Statistical Manual (DSM) and the International Statistical Classification of Diseases and Related *Health* Problems (ICD), are not neutral documents as is frequently assumed but carry a range of assumptions and represent a number of interest groups. Different cultural constructions, explanatory health beliefs, idioms and local ways of dealing with distress often appear to be seen as additional layers of meaning within the current debate, rather than as the central organising concepts they are for many people. Yet the transfer of western psychiatric ideas and the uncritical generalisation of them around the world (even if made with the best of intentions) can undermine the rich traditions and cultural heritage of many low- and middle-income countries (LMICs) and could be viewed as a form of neo-colonialism. There are many angles to this debate, including the use of language and the fact that some cultures have concepts and long traditions around 'mental health' which are different from those used in 'the west'. The paper will use the diagnostic category Post Traumatic Stress Disorder (PTSD) as an example to illustrate many of the points made.

Keywords: Culture, politics, global mental health, distress, labelling, power, trauma

The Nature and Labelling of Distress

In 2008, the World Health Organization launched what it termed the Mental Health Gap Action programme (mhGAP) initiative, which was aimed at working towards 'scaling up' mental health services in low- and middle-income countries (LMICs) to match their availability in high income countries (HICs) (WHO, 2008). Global Mental Health (GMH)

has been described as an 'Area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide' (Patel & Prince, 2010:1976). Whilst few people would disagree with these aims, differences arise in regard to definitions, understandings and constructions of mental health, and questions arise as to who has the power and authority to decide on what good mental health is. These are complex, disputed and highly politicized areas (Summerfield, 2012; Fernando, 2014.). For example, a study by Patel & Sumathipala (2001) reviewed international representation in six leading psychiatric journals and found that only six per cent of articles were published from areas of the world where ninety percent of the population lives, i.e. that the vast majority of research papers come from the West. Since, in general, people working in HICs are more likely to have the resources and facilities to conduct research and study, the voices of those from LMICs may be effectively silenced or at least significantly curtailed. Thus much of the published research is likely to have been conducted on a rather skewed sample or, at the very least, to have been conducted by those schooled in a western biomedical model.

There is no doubt that people all around the world suffer emotional distress, but whether or when this is best labelled as an individual mental health disorder, or whether individual psychiatric help (based on a model developed in the West) should be offered as the best solution appears open to question. The point at which emotional distress becomes a psychiatric illness is a highly complex and contested issue even within psychiatric theories developed in the West; where a range of explanatory models are held on the issue of underlying reasons for 'mental illnesses'. These explanations range from those that position 'distress' as 'illness' in terms of biological markers and causes, to those put forward by 'critical' psychiatrists and psychologists who might see distress as a normal response to 'toxic' life conditions, or as a normal reaction to abnormal events or difficult life circumstances. Some critical psychiatrists and psychologists take issue with the constructions and philosophical assumptions used in defining and categorising human problems attributing them to problems of 'mental health' or, as psychiatry does to 'disorders' (Bentall, 2010; Boyle, 2002; Ingleby, 1981), while some would argue for a combination of the biological and experiential.

Explanations relating to the constructions and models of mental health/illness are complex even at the national or regional level, before the international/global level is considered. There are a plethora of reasons given, and models held, relating to causation, 'symptoms exhibited', treatment and outcomes. This is before we even start to consider the role of culture, varied explanatory health beliefs, idioms of distress, and ways of dealing with these which may vary across cultures (Bracken, 1999; Summerfield, 2001; White, 2013). Unfortunately culture has frequently been viewed as something which is associated with the 'other'; groups that are seen as 'non-western' (Sashidharan, 2001; Tribe 2007). This ethnocentric perspective has been noted by Patel et al (2000:3), who write - 'An individual

practitioner may strive admirably to understand the contribution of their client's culture to the conversation created between them ……, but will rarely give the same scrutiny to the role of their own culturally-determined belief system'. The issue of defining mental health cross culturally is even more complicated and controversial (Kirmayer, 2012; Vaillant, 2012).

A possible form of medical imperialism?

The GMH movement additionally runs the risk of leading to a homogenization of services which fail to account for cultural diversity, different explanatory models, and traditional ways of dealing with distress, thus narrowing the options available to people seeking help. For example, Patel, et al. (2011:1442), in seeking to establish a 'global norm' for mental health, argue that this norm (developed by those in HICs) would lead to some 'treatments' being viewed as 'irrational and inappropriate'. This might mean that treatments traditional to non-western cultures, which may be the treatment of choice for many people, would become unavailable; this is a cause for concern and could be viewed as a form of medical imperialism or neo-colonialism.

Models of help and treatment used in HICs may not always be the best ones: they do not have the monopoly on good care and a number of studies have shown that people residing in LMICs have better recovery rates in certain circumstances, possibly because of the variety of treatments/models available to them (Castillo, 2003; Hopper & Wanderling, 2000; Jablensky et al., 1992). In addition the GMH movement has frequently failed to recognise the implicit assumptions and biases contained within psychiatry in HICs (White, 2013). The uncritical imposition in LMICs of a biomedical model developed in HICs and the uncritical use of western diagnostic manuals which contain a range of cultural and historical assumptions, raises a series of issues that will be discussed within this paper.

Diagnostic manuals and the dominant western biomedical model

It is often assumed that the diagnostic manuals developed and used in the West are impartial scientific metrics. However, the Diagnostic and Statistical Manual (DSM) and the International Statistical Classification of Diseases and Related ***Health*** Problems (ICD) are not neutral documents, they carry a range of assumptions which reflect a western biomedical model and represent a range of interest groups, many of which are located in HICs. The DSM came into being to enable patients from the USA to obtain treatment through their private individually funded health care system, thus it inevitably reflects the dominant North American biomedical model and the implicit cultural and historical assumptions of a particular HIC. For, if a set of concerns/behaviours/'symptoms' are not recognised by the

editors of the DSM, then patients in the USA are unable to claim assistance/treatment for it.

Within the USA, DSM is a highly politicised manual, with a range of groups wishing to ensure that their interests are represented. It also has a range of critics: Strakowski (2011:2) (the editor of the Society of Biological Psychiatry newsletter and someone it might be assumed would support the biomedical model and the DSM) writes - ' ..In the absence of research demonstrating that new definitions meaningfully advance the utility of our diagnoses, our credibility with the public and our medical colleagues is challenged with each DSM revision.' Cooksey & Brown (1998) argue that over reliance on the DSM and ignoring social and cultural contextual factors may lead to patients being misunderstood and their concerns ignored. Summerfield (2002:248) - writing about the manuals used to diagnose mental illness developed in the USA and Europe - claims that the 'Diagnostic Statistical Manual (DSM) and International Classifications of Diseases (ICD) are not, as some imagine, atheoretical and purely descriptive nosologies with universal validity. They are western cultural documents, carrying ontological notions of what constitutes a real disorder, epistemological ideas about what counts as scientific evidence, and methodological ideas as to how research should be conducted'.

In addition, diagnostic categories may on occasions be translated into simple checklists as part of surveys used to calculate prevalence rates of western diagnosable 'mental disorders' (Horwitz & Wakefield, 2006). As these survey tools frequently allow no probing or discussion of contextual factors, they may inadvertently medicalize a range of behaviours and socio-economic conditions, such as poverty. Psychometric measures for depression may mean that a person is feeling sad, but is not clinically depressed or ill. If questionnaires/psychometric measures are used, these have frequently been developed and validated on western populations and should not be used outside this group if the results are to be meaningful.

Thus the de-contextualisation and cultural relativism of the DSM may come to be applied uncritically, globally. The British Psychological Society (2012) Report to DSM-V expressed concerns about the risks of over diagnosis of mental illness, as well as the related concern of the over use of psychiatric medication which can have harmful side effects. This is discussed in relation to the diagnosis of trauma later in this paper.

Some advocates of the GMH movement appear to recognise cultural differences, although this appears to frequently refer merely to a slight variation in the outward expression of what is viewed as the same underlying physiological cause. For example, one response by some proponents of GMH is to 'educate' people about mental health. The author is aware of examples of western trainers working in LMICs reporting having to 'educate the population about western models of mental health' rather than the other way round, thereby dismissing other cultural perspectives as being based on a lack of 'relevant education'. This is

particularly striking given that service user groups are increasingly seen (in theory at least) in HICs as an important group to be consulted in the provision of mental health services but this same courtesy is not always extended to people from LMICs (see PANUSP, in this volume). If we take a more holistic or wider social constructionist position, we may conclude, with McNamee and Gergen (1992:1), that: 'We not only bear languages that furnish the rationale for our looking, but also vocabularies of description and explanation for what is observed. Thus, we confront life situations with codes in hand, fore-structures of understanding which themselves suggest how we are to sort the problematic from the precious.'

Diagnostic manuals as culturally constructed artefacts

Perceptions of mental illness are not fixed or sacrosanct but flexible as social and cultural mores are constantly developing and changing. Mental ill-health may be defined by societal, cultural and religious norms, and certain types of behaviour in one society may be seen as unacceptable in another. For example homosexuality was seen as a psychiatric condition in the USA and most of Europe approximately forty years ago (and was only removed from DSM in 1973) to a position where gay marriage or civil partnerships are viewed by many societies as quite acceptable, whilst other societies see same sex relationships as anathema (see Suffling, et al. in this volume). So, socio-cultural context plays an important part in defining the labelling of behaviour as a psychiatric condition/disorder and recommending appropriate 'treatment'.

In addition, patriarchal societies have frequently been implicitly sexist in their theorising and positioning about the roles and behaviour of women and their mental health, defining more restrictive roles and behaviour compared to those viewed as available and acceptable to men (Miller, 1990; Tindall et al., 2010). Whilst single mothers have frequently been labelled as being 'morally deficient', immature or blame worthy, the fathers of these children seemed to be ascribed no responsibility or blame (Handler, et al. 2007). So the values held by the most powerful or dominant groups in a society or on the world stage (in this case the GMH movement) may also play a role in defining what behaviour may be labelled as unacceptable, 'abnormal' or indicative of mental ill health. The example of trauma and PTSD will be used as an example in this chapter

Poverty, structural inequalities, mental health and power

The role of poverty is documented as a predisposing factor for mental ill health (Belle, 1990; Saraceno & Barbui, 1997) and people living in LMICs are more likely to be living in poverty as defined by internationally used criteria. It is important not to conflate a state of poverty and possible associated feelings of hopelessness, helplessness or impotence with a label of

clinical depression or poor mental health. Diagnosing and treating with anti-depressants may do little to deal with the structural inequalities and poverty which may be making people feel sad; an intervention based on poverty reduction might perhaps be more beneficial. However, admittedly, there may be an interactive relationship on some occasions between poverty and depression.

Many theorists have noted the link between poverty and mental health, in a range of LMICs, including Jamaica (Hickling, 2009); Mexico (Berenzon et al., 2009) and parts of East Africa (Kigozi and Ssebunnya, 2009). They suggest that poor economic conditions can lead to poor mental health and well-being and that the costs associated with mental illness can lead to deterioration in economic conditions. Hickling (2009) argues, perhaps rather optimistically and as many development and humanitarian workers have argued for a long time, that this relationship could helpfully be recognised and addressed by relevant organisations, governments and by the international community thereby helping to minimise mental ill health and distress. There appears to be little doubt that programmes which aim to alleviate poverty and increase access to education might also prove helpful in reducing the risk of mental ill health. Context and physical conditions are important parts of the mental health equation, rather than merely additional factors. Hickling (2009) also notes the adverse effects of colonialism, which contains an important message for parts of the GMH movement, who might be accused of practicing a form of neo-colonialism in the ways that certain knowledge bases, associated economic powerbases and resources are privileged over others.

Appropriate models or does one size fit all?

There is no doubt that the objective of good mental health and access to relevant resources across the world is an excellent one, but what is equally important is that the context and issues of culture and tradition are viewed as central rather than as additional or 'exotic' variables. It is also important that a one size fits all model is not imposed by powerful nations and funding bodies which may lead to the imposition of a particular explanatory model of intervention and convenience in terms of international (but probably largely western) research, but which fail to account for local perspectives or what communities actively state that they want (Weerackody & Fernando, 2011). Kirmayer & Minas (2005), writing about the future of cultural psychiatry note how what is called 'evidence based practice' can actually be used to serve particular interest groups, and to set a research agenda which further minimises the importance of local traditions. If money was given without restrictions on how it was to be spent and what types of mental health services communities would choose to develop, it is possible a very different and varied provision might emerge.

The politics of global mental health, health pluralism and culture

Some writers have suggested that the way forward is for LMICs is to incorporate elements of culture into a western biomedical model, so that a form of health pluralism results. However the emphasis in much of this work seems to be on western training being the dominant model, with non-western ideas only being incorporated minimally rather than as an equal partnership, with each cultural health tradition having things to learn from the others (Summerfield, 2012; see White and Sashidharan, this volume).

Those advocating western models may assume, or be ascribed, power due to socio-political positioning and access to financing, resources and information or distribution channels. The people advocating these may also have access to resources which enable a body of literature or research to be developed. Assumptions may be made about the generalisability of these findings and research to other countries which have different health models and requirements.

The importance of politics, context and wealth and power differentials cannot be ignored in the way that the global (mental) health debate is constructed. Where it is ignored it can lead to a minimisation or destruction of traditional perspectives and systems - many of which may have been in operation for years (see Davar, this volume). The silencing of community voices and views, and training the populations of LMICs in western mental health, can be damaging and ubiquitous (Fernando, 2010; Summerfield, 2012). There is no doubt that good mental health and well-being are important for people all over the world. This paper makes a plea for listening to a range of voices and cultures and for avoiding a monotheistic notion of mental health and ways of dealing with distress.

Meaning-Making and Global Mental Health

What seems to be most important is to consider the meaning of any emotional distress or adverse effects on mental health to the individual and, where relevant, the family and communities of which they may form a part. Some authors have related this to someone's ability to carry out their duties (Ely & Denney 1987); others emphasise the need to sustain relationships or to function effectively; and still others believe that trying to understand behaviour without knowing the cultural, linguistic and philosophical models used in the society that the person belongs to is an inappropriate and flawed endeavour (Kleinman & Good, 1986). Rather than thinking about modifying western models to incorporate other cultural viewpoints, as stated earlier, culture needs to be viewed as a central explanatory and organising concept, not as a variable to be accommodated or managed. Many of the psychometric and other measures used have never been validated on the populations under study, which means that there are a series of methodological concerns that undermine many of the arguments made.

It is perhaps interesting to note that Williams et al. (2006), writing about Britain, found that people from Black and Minority Ethnic (BME) groups continue not to access mainstream psychological services for a variety of reasons. Whilst we cannot un-critically generalise from this, it does give rise for concern that services which are felt to be inappropriate wherever they are located in the world may not be used. Thus the link between imposing services developed in the West onto LMICs raises a number of professional and ethical questions. Patel (2001:250) claims in relation to global mental health that 'Its driving philosophy is equity, i.e. justice and fairness in the distribution of health in society'. Whilst this is a laudable aim, it appears that the distribution may be on the terms of the West, with western models appearing to be the dominant force. As stated earlier, the diagnosis of Post traumatic Disorder (PTSD), including complex post trauma (CPTSD) and Disorder after extreme stress not otherwise specified (DESNOS), will be used as an example to show how some of the issues relating to global mental health and psychiatric diagnosis when applied unthinkingly across cultures raise a number of serious concerns.

The Politics of Trauma

The politics of the diagnosis and treatment of trauma are complex and politicised across the world (see Rind et al, 1998; Rind et al. 2001; Lerch, 1999; and the US congress report, 1999, resolution 107). For example, Rind et al. (1998) conducted a meta-analysis of 59 studies on the long-term effects of child sexual abuse, which showed that the survivors of child sexual abuse were as well adjusted as their non-abused peers. They explained that they were not taking any moral position on the findings, but merely reporting them, noting a distinction between something being wrong and it causing harm. The paper was widely attacked as the findings were at variance with widely-held opinion in the USA, despite the fact that the paper had gone through a rigorous pre-publication peer review. The US senate went as far as tabling a resolution condemning the article as flawed (US House of Representatives (1999) resolution 107). Members of the mental health community took a range of positions on the paper, some of which might be said to have been influenced by their personal views and political expediency rather than merely the data. This led Hunt (1999), who has written about the ways various interest groups have worked to control aspects of the agenda within social and behavioural research, to call, perhaps optimistically, for a partition between science and politics.

Therefore, the issue of trauma diagnosis and treatment is often linked to wider political issues and is highly relevant to global mental health issues and politics as discussed next. Sometimes being viewed or 'diagnosed' as a traumatised individual or community (particularly in situations such as a civil war or in relation to an asylum claim) may also be linked to reparation, compensation or blame, and may be highly functional for the individual

at the time (Tribe, 2013). The issue of who the media, or a society or sub-group within it, presents as 'traumatised and worthy of help' may be linked to socio-political or cultural positioning and values. Psychology and psychiatry are not neutral sciences but contain a range of assumptions and western medical systems of diagnosing and labelling mental ill health, which global mental health needs to consider.

As stated earlier, the uncritical imposition of western ideas through a lens of global mental health as a unitary category can undermine rich sources of healing found within a culture. This can be further compounded when no consideration is given to issues such as different world views, explanatory health beliefs, idioms of distress, and how language and culture may be interwoven. The work of the social constructionists (for example McNamee and Gergen, 1992) illustrates how language and culture are co-constructed, making evident the importance of considering these in clinical work.

Different world views may not be transferable across cultures and languages, and may require active consideration and attention. This is particularly the case when issues such as constructions of mental health and ideas relating to treatment and help-seeking are at stake. It appears that some of the proponents of GMH have failed to account for a range of models and cultures. The quote below drawn from an autobiographical account illustrates something of this:

> Simon was sitting right behind him in the dock, laughing in the face of death, but in many respects he wasn't there at all. He could not speak for himself and was not expected to. He spoke through an interpreter, in images, poetry, and metaphors that did not translate easily, and would have meant nothing to whites, nothing at all. The interpreter simply rendered them into serviceable English, into words and ideas white men could understand (Malan, 1990:199).

This quote demonstrates some aspects of the difficulties associated with making assumptions about the generalisability of language and culture, and the fact that languages help construct reality. We need to remain aware of this in clinical practice and note that ideas generated in the West may not have the global applicability that has been assumed by some theorists (Owusu-Bempah et al., 2000). The next section of this paper will consider other aspects of mental health practice, more specifically the type and unit of engagement, and detail their relevance to the global mental health debate.

Individual therapy versus Community engagement

The notion of collective trauma advocated by Somasundaram (2007), a Sri Lankan psychiatrist who has worked in Cambodia (as well as Sri Lanka), emphasises the effects of

trauma at the individual, family and community level rather than just as an individualised psychiatric condition. His approach is based on the community as the unit of engagement rather than the individual, on building community coping structures and resilience and cultural knowledge and tradition as opposed to, or in addition to, individual therapy (Tribe, 2004; Weerackody & Fernando, 2011). His work appears to have a useful contribution to make towards the global mental health debate.

Community engagement in mental health brings many benefits, including, minimising a model of individual psychopathology which can inadvertently stigmatise individuals and may not help a community to heal. Community engagement or focus can also concentrate on prevention rather than treatment, and perhaps assist or intervene helpfully before acute problems have developed. Most importantly, it can address problems that are identified by community members and help build local capacity based on local needs rather than on top-down centralised views and systems (Fernando, 2010). Community engagement can also help the development of appropriate support structures and provide a normalising function for community members who have been through traumatic events. Community engagement containing a thorough consultation and active collaboration which really listens to the views of people rather than a pseudo- consultation, if well planned can be cost effective and flexible. A community focus may also be resource-effective, less stigmatising, more accessible and appropriate. For this reason, the National Institute for Health and Clinical Excellence (NICE) UK have stated that community participation and engagement should be at the heart of health and social care services and have developed guidance on Community Engagement to Improve Health (NICE guidance, 2008).

Yet, there may also be some disadvantages with a community focus. For example, it may be seen as challenging the status quo and the way mental health services have run in the past. In addition, the voices of the dominant or more vociferous members of a community can silence the voices of a minority. Evaluation may be seen as less straightforward and complicated in view of the large range of possible intervening variables or factors. Issues of access may also require further thought, and issues of confidentiality may be complex (Lane and Tribe, 2010). The move to work in partnership with communities is being realised in many parts of mental health provision, for example, the Section of Community Psychology established within the British Psychological Society (2010:1) states 'Values which include those of inclusivity, social justice and improvement of health and well-being…Those who base their work through non-individual intervention'.

It may be instructive to consider afresh how we might minimise psychological distress in any country. Does the best solution consist of a focus on individual treatment after diagnosis using a categorisation developed in the West which contains a number of cultural and socio-political assumptions and is heavily politicised? Or is a different focus preferable? The focus in the West has largely been on treatment rather than prevention.

All of the factors previously discussed may lead us to question the proposition that global mental health is a single unitary concept; perhaps it is just an umbrella term under which a range of positions may be held. In any case, we need to think carefully about what we mean by the term 'global mental health'. What seems important is that individual countries and cultures have an active role in continuing to define their own ways of considering mental health and well-being, including health pluralism without one particular western system being imposed upon them. This is to recognise a multi-layered or diverse range of explanatory health beliefs, and a concomitant wide range of coping strategies or help-seeking behaviours, as well as a varied range of designated healers.

In conclusion, the current focus on global mental health should have provided an opportunity for us all to reflect and consider what is being done to enhance mental health and wellbeing around the world. The motivation of the global mental health movement in desiring equity and access to good mental health for all is an extremely important one. How this might be obtained and what it means needs to be debated further. The imposition of a neo-colonialist perspective which assumes that 'west is best' is unhelpful and fails to acknowledge the rich traditions and knowledge developed around the world. The nature and labelling of distress within psychiatry, psychology and the DSM are still contested. The importance of politics, context, culture and the associated wealth and power differentials which exist, appear to have been largely ignored in the way that the global mental health debate is constructed by some of its current proponents. It seems vital that if the objective of good global mental health is to be achieved, equal partnerships need to be established which are led by people from the relevant countries, and their views and systems of dealing with mental health are shared around the world. That variety and diversity is encouraged seems vital, rather than a western model imposed by rich institutions or funders which may lead to a reductionism and over simplification of a complex area. In addition it may inadvertently undermine the rich cultural mental health traditions and systems which may also be the preferred choice of the population. Who controls or negotiates the descriptors used in defining mental health and the subsequent actions taken and the resources allocated is a political and professional challenge. There may be incentives for the replication of western models by international funders, drug companies or universities in the West and recipients of budgets or grants, as this requires no change in the status quo.

Improving mental health across the globe is important but much thought and careful consideration should be given on how best this is done given the vast inequalities and different needs of people globally. It would be disastrous for everyone if all that happens is that western models of 'mental health' and 'illness' are replicated throughout the world and that traditions of the West are imposed globally.

References

Belle, D. (1990). Poverty and women's mental health. *American Psychologist,* 453, 385-38.

Bentall, R. (2010). *Doctoring the Mind: Why psychiatric treatments fail*. London: Penguin.

Berenzon, S., Lara, M.A., Medina-Mora, M.E. (2009). Inequity and poverty: everyday emotional disturbances and mental disorders in the Mexican urban population. *International Psychiatry,* 6(2), 32-33.

Boyle, M. (2002). 2nd edition. *Schizophrenia: A scientific Delusion?* London: Routledge

Bracken, P. (1999). Hidden agendas: Deconstructing Post Traumatic Stress Disorder. In P.J. Bracken, & C. Petty (Eds.), *Rethinking the Trauma Of War.* London: Free Association Books.

British Psychological Society (2012). Response to DSM 5: The future of psychiatric diagnosis (2012 Final Consultation). British Psychological Society response to American Psychiatric Association. [Online] Available at: apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202012%20 [Accessed: 1 February 2014)

Castillo, R. J. (2003). Trance, functional psychosis, and culture. *Psychiatry: Interpersonal and Biological Processes*, 66, 9-21.

Cooksey, E.C., Brown, P. (1998). Spinning on its Axes: DSM and the Social Construction of Psychiatric Diagnosis. *International Journal of Health Services, 28(3), 525-554.*

Ely, P. and Denney, D. (1987). *Social Work in a multiracial society*. London: Gower.

Fernando, S. (2010). *Mental Health, Race and Culture* (3rd edn.) Basingstoke and New York: Palgrave Macmillan.

Fernando, S. (2014). *Mental Health Worldwide: Culture, Globalization and Development.* Basingstoke: Palgrave Macmillan.

Handler, J.F., Hasenfeld, Y. (2007). *Blame Welfare, Ignore Poverty and Inequality*. Cambridge: Cambridge University Press.

Hickling, F.W. (2009). The high cost of poverty: mental health perspectives from the Caribbean Diaspora. *International Psychiatry, 6(2), 29-31.*

Hopper, K., Wanderling, J. (2000). Revisiting the developed versus developing country distinction in course and outcome in schizophrenia: results from ISoS, the WHO collaborative follow up project. *Schizophrenia Bulletin*, 26, 835-846.

Horwitz, A.V., Wakefield, J.C. (2006). The epidemic in mental illness: clinical fact or survey artifact? *Contexts, 5, 19-23.*

Hunt, M. M. (1999). *The New Know Nothings: The Political Foes of the Scientific Study of Human Nature.* New Brunswick, New Jersey. Transaction Books.

Ingleby, D. (Ed.) (1981). *Critical Psychiatry: The Politics of Mental Health.* Harmondsworth: Penguin

Jablensky,A., Sartorius N., Ernberg, G. et al. (1992). Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organization ten-country study. *Psychological Medicine Monographs,* Supplement, 20, 1-97.

Kigozi, F., Ssebunnya, J. (2009) Chronic poverty, wars and mental health: the East African perspective. *International Psychiatry, 6,2, 31- 32*

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

Kirmayer, L.J., Minas, I.H. (2000) The future of Cultural Psychiatry: An international perspective. *Canadian Journal of Psychiatry*, 45, 438-466.

Kleinman, A., Good, B.J. (Eds.) (1986). *Culture and Depression: Studies in the Anthropology and Cross –Cultural psychiatry of affect and disorder.* California: University of California Press.

Lane, P., Tribe, R. (2010). Following NICE 2008: A practical guide for health professionals: Community engagement with local black and minority ethnic (BME) community groups. *Diversity, Health & Care,* 7(2),105-14.

Lerch, I. (1999). Letter from the Chair of the American Association of the Advancement of Scientific Freedom Committee responsible to Richard Mc Carty executive director of Scientific American Psychological association (reprinted Nov/Dec 1999*). Science Agenda, 12(6), 2-3.*

Malan, R. (1990). *My Traitor's Heart*. A South African Exile Returns to Face His Country, His Tribe, and His Conscience. New York: Grove Press.

McNamee S., Gergen, K. (1992). (Eds.) *Therapy as Social Construction.* London: Sage.

Miller, A. (1990). Introduction II. In R.J. Perelberg & A.C. Miller. (eds.). *Gender and Power in Families* (pp.8-9). London : Routledge

National Institute for Health and Clinical Excellence (NICE). (2008). Guideline no. PH9. Community Engagement to Improve Health. [Online] Available at: http://www.nice.org.uk/Search.do?keywords=community+engagement&newSearch=true&searchType=Guidance [Accessed: 12 October 2012].

Owusu-Bempah, K., Howitt, D. (2000). *Psychology beyond Western Perspectives*. London: BPS Books.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., Nadirshaw, Z. (2000). *Clinical Psychology, 'Race' and Culture: A training manual.* Leicester: BPS Books.

Patel. V. (2001*).* Poverty, inequality and mental health in developing countries. In D. Leon *&* G. Walt (Eds.) *Poverty, inequality & health* (pp. 247-262*).* Oxford*:* Oxford University Press.

Patel, V., Prince, M. (2010). Global mental health. A new global health field comes of age. *Journal of the American Medical Association* 303, 1976-7.

Patel, V., Boyce, N., Collins, P.Y., Saxena,S., Horton, R. (2011). A renewed agenda for global mental health. *The Lancet,* 378, 1441-2

Patel. V., Sumathipala, A. (2001). International representation in psychiatric literature. Survey of six leading journals. *British Journal of Psychiatry,* 178. 406-409

Rapley, M., Moncrieff, J., Dillon, J. (2011). *De-Medicalizing Misery: Psychiatry, Psychology*

and the human Condition. London: Palgrave Macmillan

Rind, B., Tromovitch, P., Bauserman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse in college samples. *Psychological Bulletin* 124, 22-53.

Rind, B., Tromovitch, P., Bauserman, R. (2001). The validity and appropriateness of methods, analyses and conclusions in Rind et al (1998): A rebuttal of victimological critique from Ondersma et al (2001) and Dallam et al (2001). *Psychological Bulletin*, 127, 734- 758

Saraceno, B., Barbui, C. (1997). Poverty and Mental Illness. *Canadian Journal of Psychiatry , 42, 285–290*

Sashidharan, S. P. (2001). Institutional Racism in British Psychiatry. *Psychiatric Bulletin*, 25, 244-247.

Somasundaram, D. (2007). Collective trauma in northern Sri Lanka: a qualitative psychosocial-ecological Study. *International Journal of Mental Health Systems,* 1:5. Online: www/IJMHS.com/content/1/1/5 [Accessed November 20 2007]

Strakowski, S.M. (2011). Do we need a DSM-V? Society of Biological Psychiatry Newsletter, 1-3. [Online] Available at: www.sobp.org/files/public/october202011newsletter20opt.pdf [Accessed 7 November 2013].

Summerfield, D. (2001). The invention of post traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal,* 322(7278), 95-98.

Summerfield, D. (2002). Mental Health of refugees and Asylum – Seekers, Commentary. *Advances in Psychiatric Treatment*, 8, 247-248.

Summerfield, D. (2012). How scientifically valid is the knowledge base of global mental health. *British Medical Journal*, 336 (7651), 992-994.

Tindall, C., Robinson, J., Kagan, C. (2010). Feminist Perspectives. In R. Woolfe, S. Strawbrige, B. Douglas & W. Dryden (eds.). *The Handbook of Counselling Psychology*. (pp. 213-234). London: Sage.

Tribe, R. (2004). A Critical Review of the Evolution of the Children's Play Activity Programmes Run by the Family Rehabilitation Centre (FRC) throughout Sri Lanka. *Journal of Refugee Studies,* 17(1), 114-135.

Tribe, R. (2007). Health Pluralism - A more appropriate alternative to western models of therapy in the context of the conflict and natural disaster in Sri Lanka? *Journal of Refugee Studies,* 20(1), 21-36.

Tribe, R. (2013). Is trauma focussed therapy helpful for victims of war and conflict? In K. Bhui (Ed.). *Elements of Culture and Mental Health: Critical Questions for Clinicians. (pp.1-6).* London: Royal College of Psychiatrists.

US House of Representatives (1999). July 12th Concurrent resolution of the 106th Congress resolution 107.

Vaillant, G. E. (2012). Positive mental health: Is there a cross-cultural definition? *World Psychiatry, 11, 93-99.*

Weerackody, C., Fernando S. (2011). *Reflections on mental health and well being.* Colombo: PRDA.

White, R (2013). The Globalisation of Mental Illness. *The Psychologist*, 26(3), 182-185

Williams, P.E., Turpin, G., Hardy, G. (2006). Clinical psychology service provision and ethnic diversity within the UK. A review of the literature *Clinical Psychology and Psychotherapy, 13(5), 324-338.*

WHO (World Health Organization) (2008). *mhGAP: Action Programme.* Geneva: World Health Organization.