VOICES FROM THE FIELD

A short conversation with Arthur Kleinman about his support for the global mental health movement

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In December 2012 the British Journal of Psychiatry (BJP) published a paper entitled 'Psychiatry beyond the current paradigm' by 29 consultant psychiatrists in the UK, myself included (Bracken et al., 2012). We suggested that at the heart of a crisis currently facing psychiatry is the failure of the dominant technical paradigm (which treated the mind as if it was an organ) to deliver what it has long claimed to deliver. We pointed to a growing body of evidence highlighting the primacy of non-technical aspects of mental healthcare.

The BJP invited Professor Arthur Kleinman of Harvard University, a figure of international status in psychiatry and medical anthropology, to write a responding editorial (Kleinman, 2012a). In it he wrote that 'academic psychiatry is in trouble, becoming the narrowest of biological research approaches of decreasing relevance to clinical practice and global health' (Kleinman, 2012:421). In contrast he commended several programmes associated with the emergent global mental health movement, saying 'these approaches appeal to those health professionals and students for whom social justice and care for the suffering of the poor are central, and have moral force' (Ibid:421).

In reply to this editorial, and before writing to Kleinman himself, I wrote the letter below to the BJP, which they published on their website.

Letter 1 - to the BJP in response to Arthur Kleinman's editorial: **The global mental health field fails the tests set by Arthur Kleinman's own work**

Arthur Kleinman makes one misjudgment in his cogent editorial on our paper. He has been deceived by the claims of the global mental health field to represent humanistic and context-sensitive practice of the kind he has long advocated. Whilst their rhetoric is of respect for local traditions and perspectives, the reality is of the global deployment of the narrowly biomedical model of mental disorder which Kleinman is criticising. The field gives itself away when it says the task is to address the 'treatment gap': this means exporting what we have and they do not, and are judged to need. 'Local initiatives' here means training local

workers to administer Western mental health technologies. But to assume that Western psychiatric categories like 'depression' are universal is to commit what Kleinman has called a 'category fallacy', which is the issue of validity in psychiatric research and practice. Invalid approaches are those which fail to address the felt 'nature of reality' of subjects, and thus cannot be humanistic and cannot work. To cast Western knowledge as universal, whereas indigenous knowledge is merely local and ignorable, is to propagate a new imperialism. Global mental health workers are the new missionaries (Summerfield, 2012).

Global mental health is a 'top-down' movement whose effect is to sell the products of the Western mental health industry to the non-Western world. Good news for the pharmaceutical industry. Yet, as we discuss in our paper, the evidence base for, say, antidepressants or talk therapies is weak and contested even in the West. Most of the variance of outcome is accounted for by non-specific/placebo factors.

And what of context? The World Bank calculates that 1.4 billion people in the world are in 'absolute poverty', which is to say they will never have a decent meal in their whole lives. As many again are scarcely better off, similarly mired in bare survivalist modes of existence. The UN Children's Fund (UNICEF) says that 3.5 million children under the age of 5 die of starvation every year (Dembitzer, 2012). These are "the wretched of the earth", to use Fanon's phrase: would anti-depressants and Western talk therapy improve their lot? Who in the non-Western world is asking for them?

Shortly afterwards, I wrote to Arther Kleinman twice and received two replies, which I reproduce below (with some shortening for conciseness).

Letter 2 – From me to Kleinman

Dear Professor Kleinman
 I am writing to you as one of the signatories of the paper 'Psychiatry beyond the current paradigm' in this month's BJP to which your admirable editorial on rebalancing academic psychiatry is a response. I enclose a letter of mine which the BJP have just posted up on their website. I and others would be very pleased if you could comment on this to us, and on the surprise of those of us familiar with your oeuvre that you appear to have offered unqualified support to the global mental health movement when it does not begin to pass the tests you yourself have set over the years. Do you feel that the summarising remarks I make below do not reflect the movement as you assess it?

Arthur Kleinman responded thus:

Letter 3 – from Kleinman to me

I think you and I are thinking of two very different kinds of things. My BJP editorial was not about psychiatric anthropology nor cultural psychiatry. It was about global mental health implementation programs that bring useful services to places where there are none for people who otherwise are without potentially helpful interventions. I'm thinking of Partners In Health's work in Haiti and Rwanda; Vikram Patel in Goa; innovative programs at Peking University and Shanghai Mental Health Center; as well as other impressive community projects in South Africa, Australia, Hong Kong and Taiwan.

Your letter paints an entire field with too broad a brush of criticism that should be addressed to particular programs. I don't buy the wholesale criticism of humanitarian assistance that is fashionable in certain circles today. Yes, much of the criticism about PTSD as an industrial enterprise is appropriate, but there are many humanitarian projects that do 'good' in the world. Be careful in generalizing the category fallacy to everything in global mental health. If it generalizes to everything, then it means nothing. And I don't believe it means nothing. Be careful as well of Whitehead's fallacy of misplaced concreteness. It is cultural psychiatry that disappoints me more than global mental health, which at least is trying to do something useful for people who are suffering.

Please see my essays on Caregiving in The Lancet to see what I value most in global health (Kleinman, 2012b).

I wrote to him a second time.

Letter 4 – my reply to Kleinman

Thank you for your reply. I was not addressing the general purposes of your editorial and certainly not writing from the ivory towers of academic psychiatry. I intend no broad brush, least of all to the field of humanitarian assistance: in my days as an Oxfam consultant I was aware of good projects and bad ones. What I was seeking was a conversation specifically about the clear-cut endorsement you gave the Centre for Global Mental Health / Sangath (associated with Vikram Patel and colleagues) as examples of enlightened practice a world away from the sterilities of academic psychiatry you described. I was suggesting that whilst their rhetoric suggests attention to the social and economic determinants of poor mental health, the practice will be simply the globalisation of (Western) biomedical psychiatry-diagnostic categories, treatments and research paradigms.

The paper in Nature of July 2011 entitled 'Grand challenges in global mental health' authored by Pamela Collins and other representatives of the National Institute of Mental Health NIMH), and Vikram Patel, surely makes this transparent.(6) Whilst there are the briefest of references en passant to 'extreme poverty, war and natural disasters' and to 'exploration of sociocultural and environmental contexts', the thrust of the paper is that global mental health is primarily a biomedical discourse. There is no mention of local understandings grounded in background culture, of already-existing healing traditions, or of any contribution from anthropology. The centre for global mental health and Sangath websites convey the same impression. Collins et al write that 'future breakthroughs are likely to depend on discoveries in genomics and neuroscience', which I suppose is the NIMH position (Collins et al, 2011: 30).

Above all the paper grounds itself in a table purporting to itemise the global burden of mental, neurological and substance-use (MNS) disorders, probably a WHO table. This associates a list of (Western) psychiatric categories with disability-adjusted life years (DALY's) for high-income and for low-and middle-income countries. Regarding the latter, 'unipolar depressive disorders' is rated at 55.5 DALY's, 'bipolar affective disorder' at 12.9, 'panic disorder' at 6.2, 'obsessive-compulsive disorder' 4.5 etc. These categories are to be seen as universal, so that the methodology that captures unipolar depressive disorder in Canada will capture the same thing in Cambodia. Isn't this a fundamental error of validity, your category fallacy etc, so that the table is misleading nonsense? Would you disagree with this? How does importing DSM depressive disorder to a non-Western country with other ways of framing things, followed by the marketing of anti-depressants, and where local people are necessarily preoccupied with poverty, lack of rights etc, satisfy the moral domain of caregiving as you have articulated it in the Lancet?

Many of the examples you allude to in the Lancet seem 'severe' cases, and there's no question of minimising the poverty-exacerbated plight of people with neurodevelopmental and neuropsychiatric problems, chronic psychosis (howsoever caused, typically organic) etc, evident in my native Zimbabwe as elsewhere. There's a much stronger a case here for outside assistance, including medication.

And behind all this, there is the resonant question regarding the effectiveness of Western mental services in the West. How reliable are its claims? This is a huge industry with a vested interest in the biologisation of everyday distress, still claiming that there remains 'massive unmet need' in Western society and that 1 in 3 or 4 have a mental disorder whether they know it or not. To read that 1 in 8 of the US adult population may take an SSRI anti-depressant in any one year (similar trends in UK) is to reflect on an industry out of control. Is this a model whose successes suggest exportability?

Professor, as before I and others would be very pleased to have your further comments - on paragraphs 2 and 3 above in particular.

Arthur Kleinman's second reply was:

Letter 5 – Kleinman's reply to me

I try to maintain several different approaches to health, suffering and care.

I am committed, and have been since before I directed the World Mental Health Report (Desjarlais, R. et al. 1995, Oxford U Press) to the implementation of global mental health services for those with the most severe mental illnesses. I regard the failure to provide adequate services for these health problems as a scandal and requiring a moral response as much as academic and clinical ones. Here the great failure is psychiatry's separation from global public health and from health policy discourse.

And this occurs among poor populations in poor societies at the same time that medicalization is exporting depression to the middle class in these societies. The problem is not one or the other, but both processes.

Then there is the situation of cultural approaches in psychiatry and in health care generally. Here the category fallacy is still important, but so is what Paul Farmer calls the immodest cultural claims of causality, which amount to a cultural reductionism ever bit equal to biological reductionism, and equally dangerous.

My own work, if you have followed it, has moved from a cognitivist emphasis on meanings in illness and care to the primacy of moral experience and practices. (See What Really Matters; my essays in The Lancet and elsewhere; my piece with Peter Benson in PLoS Med on Anthropology in the Clinic; and the books I have co-authored in recent years: Deep China and forthcoming; Reimagining Global Health, (California, May 2013)

Your criticism of Vikram Patel's program is the first I have come across of this nature and raises a potentially serious concern that I will need to look into more fully. And I will do so. But much as I respect some of the contributors to the anthropological critique of humanitarian assistance, I find much of it exaggerated and distorted, and presented as if the critics occupied the moral high ground, which they don't. There being no moral high ground to occupy here. Medical anthropology and cultural psychiatry are part of the same messy world of suffering and care as all the other fields.

I have just left for sabbatical to finish my caregiving book and unfortunately don't have time to continue this exchange.

Conclusion

To conclude, this brief exchange does at least partly clarify why Arthur Kleinman has lent his name to global mental health initiatives whose operating assumptions- essentially universalist, Eurocentric ones- seem in tension with much of his own work that spans several decades and with basic tenets in medical anthropology. In both letters to me he gives primacy to a moral and humanitarian imperative to act, contrasting this with what he sees as the disengagement and irrelevance of armchair academics- including cultural psychiatrists- in Western metropolitan centres. As he notes above, he sees the global mental health field as 'at least trying to do something useful for people who are suffering'. But how far does this take us? Are these suffering people likely to regard Western mental health approaches as useful amidst the struggle for survival that is their daily lot? I take his point about the dangers of exaggerating the explanatory power of 'culture' but my critique is as much, if not more, about context, and the overarching dilemma of lives blighted by poverty and lack of rights. Kleinman's statement that this is the first time he has encountered a critique of this nature is very surprising, but he does call it a 'potentially serious concern' and says he will examine it. I do not know if he has done so.

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