Chapter 1
Why Historical, Cultural, Social, Economic and Political Perspectives on Mental Health Matter

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Abstract We, the editors, have encouraged contributors to provide historical, cultural, social, economic and political perspectives on the development of mental health in the diverse nations of the Asia-Pacific region. Such a multi-pronged approach is required to understand this complex phenomenon. Most nations in the region were or became colonies of European powers. Just when psychiatry itself was being formed as a branch of medicine in Europe, it encountered non-Western cultures with deeply rooted, different approaches to mental disorders. Despite the subsequent growth of Western-derived psychiatry in such countries, cross-cultural issues remain significant for the current and future development of policy and services. Indeed, as those involved in the new effort to reduce the burden of untreated mental illness in low- and middle-income countries (LAMIC) realise, cultural appropriateness is central to success. In the last decade or so a debate has developed between epistemic and policy communities as to how best to do this. We believe it will advance understanding if we put the current situation in LAMIC, where globalisation is producing rapid, often disruptive, cultural, economic and social change, in a comparative historical context: the health effects, physical and mental, of this current transformation may be compared with the health impact of the 'modernisation' of the West in the nineteenth century. The rise of asylum psychiatry itself in Europe may be seen as an organised, expert response to the growth of mental disorders produced by the speedy, initially unregulated, impact of industrialisation and urbanisation on traditional ways of life, just as the rise of public health in the same era may be viewed as an organised, expert response to the growth of threats to physical health from 'fevers' and other communicable diseases.

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We need to apply what some health analysts have called the 're-socializing' disciplines—history, anthropology, sociology and political economy—to understand more fully mental health in the Asia-Pacific region, and so, hopefully, to contribute more effectively to its promotion.

Editors' Aims

We aim to present the reader with historically, culturally, socially, economically and politically informed accounts of psychiatry and of policy and service development in a number of the diverse nations of Asia and the Pacific. Many of these nations are former colonies of the British, French, Dutch, Spanish or German empires that flourished for a substantial part of the last 200 odd years during which psychiatry, like biomedicine, a product of the modernisation of the West, came into being. Having spread to the non-Western world, psychiatry now faces the issue of how best to respond to mental disorders on a global basis. But, we believe that if that is to be done properly, we need to employ analyses that draw on what Farmer et al. (2013) term the 're-socializing disciplines' in order to understand the complexity of mental health and its determinants in the current era, an era when the nation state and global forces coexist in a rapidly changing and often uneasy relationship.

For one of us (ML) this is the third in a series of edited books, together, addressing the full range of health problems in the countries of Asia and the Pacific. The first, Lewis and MacPherson (2008), is concerned with public health and highlights the large role still played by CDs (communicable diseases) in the disease burden of LAMIC (low- and middle-income countries) in the Asia-Pacific region. The second, Lewis and MacPherson (2013), focuses on the contemporary health transition in LAMIC and the accompanying double disease burden—the recent, speedy rise of serious, chronic NCDs (non-communicable physical diseases), while CDs remain significant. All three books emphasise the importance of understanding the historical, cultural, social, economic and political contexts of nation states if their contemporary health problems are to be addressed as well as possible. For the other (HM) this book is a contribution to building the still new discipline of global mental health (Patel et al. 2014), a process that must ensure that theory and practice are developed on the basis of an equal exchange among colleagues from all countries and all relevant disciplines and an understanding of the widely differing mental health system histories and contemporary contexts. In pursuit of these aims, in the present book on mental health we have tried, as far as possible, to engage as co-authors of particular chapters distinguished mental health specialists and historians or social scientists.

We have included chapters on the following countries: Cambodia, Indonesia, Malaysia, the Philippines, Singapore, Thailand, Vietnam, Taiwan, Japan, South Korea, India, Pakistan, Sri Lanka, Australia, New Zealand, Fiji, Papua New Guinea and the smaller Pacific Islands nations (SPIN). Each chapter focuses on a particular

country, except for the SPIN chapter that deals with a number of very small, new, island nations in the Western Pacific. While we commissioned a chapter on China, unhappily, it has never been delivered despite our efforts over a long period to achieve this end. Delay in production of the book has become such that we have decided we must proceed to publication despite this gap. We hope in having chapters on Singapore and Taiwan we have at least some coverage of Chinese cultural perspectives.

We attempt to show how the history and the changing cultural, social, economic and political contexts of these countries, have influenced the pattern of disorders and the development of therapies, services and policy. In addition, we look at the influence, in each country, of supranational forces such as colonisation and modernisation, the development of health policy through bodies like WHO, the spread of Western-derived, international classification and diagnostic systems (the successive versions of the relevant section of the International Classification of Diseases and of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders) and the global diffusion of Western psychiatry itself, as the source of modern, professional knowledge and training.

We are keen to introduce historical, as well as cultural, social, economic and political, perspectives to contextualise what clinical, epidemiological and health services research tells us about mental disorders and their treatment. To understand global health, including mental health, we need to take a biosocial approach where the application of the 're-socializing disciplines'—history, anthropology, sociology and political economy—is necessary to understand the causal complexity of contemporary diseases and disorders and so provide effective remediation (Farmer et al. 2013).

Epidemiology is a key discipline of population health inquiry. As an abstracting, universalising and quantitative discipline, it seeks to identify determinants of disease across time and place. In contrast, history focuses very much, but not wholly, on the particularity of phenomena associated with a specific time and place and employs a qualitative more often than a quantitative approach. It preferences particularistic and qualitative complexity over capacity to generalise. Epidemiology privileges generalisability. History examines the variety of human experiences of disease and disorder (including the attempts to explain and treat) over time as anthropology and sociology do across populations and space. These disciplines highlight the particularities of different cultures, societies, economies and polities in contrast to the universals of human biology.

Diversity in Asia and the Pacific

The Asia-Pacific region is characterised by remarkable diversity in political and economic systems, cultures and societies. Political systems include constitutional monarchies, parliamentary democracies, some recent and some long-established and one-party regimes. Nation states range in size from Leviathans like India

(population of 1.31 billion) to minnows in the Pacific. Six Pacific Island states (Palau, Cook Islands, Tuvalu, Nauru, Niue and Tokelau) have populations of fewer than 20,000.

As noted at the beginning of this chapter most of the countries included in this volume have a history of colonisation by one or other of the European powers or, more recently, by Japan and the USA, and many of the chapters pay particular attention to the influences of colonisation on the mental health of populations and on the development of mental health systems. In the post-colonial period some former colonial territories have broken up into separate nation states, such as India and Pakistan, Vietnam, Cambodia and Laos, and Malaysia and Singapore. While they have a common colonial history of psychiatry and mental health system development—the British in India and Pakistan, and in Malaysia and Singapore, and the French in the former Indochina—they have generally developed very different mental health system development trajectories in the post-colonial period. These trajectories have continued to be influenced by international forces, such as the long war in Vietnam followed by a 20-year trade embargo by the USA, and have been more directly influenced by national political, economic, social and cultural factors. Spectacular economic growth in some countries has enabled investment in health and education systems, while economic stagnation in others has resulted in relative neglect particularly of mental health. Some countries have enjoyed relative political stability, while others have experienced internal turmoil, armed conflict or human catastrophes on a massive scale, such as the Pol Pot era in Cambodia, and China's great famine and the cultural revolution. These and many other national developments have had a profound impact on the mental health of populations and on the development of mental health systems.

The Asia-Pacific region currently consists of countries at the lowest and highest levels of economic and social development. In purchasing power parity dollars (PPP$) Singapore has the highest gross national income per head (60,110), 25 times that of Cambodia or Papua New Guinea (less than 2500). Life expectancy at birth ranges from a high of 87 years in Japan to a low of 62 years in Papua New Guinea and below 70 years in Pakistan, India and the Philippines. In terms of the UN Human Development Index the region contains three countries ranked in the top 10 (Australia—2, New Zealand—7 and Singapore—9) and seven countries that rank below 100 among the 188 UN member states (Indonesia—108, the Philippines—117, Vietnam—121, India—135, Cambodia—136, Pakistan—146 and Papua New Guinea—157). In the Pacific, Palau, Fiji, Tonga and Samoa are ranked in the top 100, while Micronesia, Kiribati, Vanuatu, Solomon Islands and Papua New Guinea are ranked among the bottom 88 UN member states.

Regardless of their particular histories, or of their current size or resources, all countries in the region must deal with the economic upswings and downturns that are already a major feature of the new century and the direct impacts of massive economic transitions on the mental health of populations. They must also deal with the continuing and accelerating social and cultural changes that are wrought by the revolution in communications and related technologies, internal and international migration, global trade and other economic regimes and rising security tensions.

Political instability has been a prominent feature of the Asian and Pacific regions, for example in Myanmar and Thailand and in Fiji and the Solomon Islands. The current tensions arising from competing claims in the South China Sea may yet spill over into destructive conflict.

Such a variety of nations, and a variety of political, economic, social and cultural histories and contexts, offers a comparative perspective that may provide insights useful for development of better understandings of health and illness and for more effective and acceptable mental health policies and practices.

Major Themes in the History of Psychiatry

We believe readers will benefit if they read the nation-focused chapters of our book in the light of the following major themes in the history of modern psychiatry from its origins in Western Europe two centuries so ago to its globalisation in the last two and a half decades or so.

The Health Effects of the West's Modernisation in the Nineteenth Century

It is widely accepted that the rapid and massive, socioeconomic change produced in nineteenth-century Western Europe by, initially, unregulated urbanisation and industrialisation impacted, in the beginning, negatively on physical health status, as indicated by life expectancy at birth (LEB). But by late in the century, rising incomes (per capita income in England and Wales, where the process of industrialisation began, increased more than two and a half times between 1820 and 1900) translated into improved working class nutrition. This, along with development of public health regulation and infrastructure, especially provision of clean water and safe sewage disposal in urban areas (infrastructure made possible by the greater national wealth), promoted resistance to key CDs (then the primary causes of mortality); at the same time exposure was reduced.

From the 1880s or so LEB began a secular rise, as it did, in turn, in other Western European countries and in offshoots of Europe like Australia and the USA. Thus, in England and Wales, while LEB was 39 years in 1820 and remained 39 in 1850, it increased to 48 in 1900 and reached 71 in 1950 (Caldwell 2006; Lewis and MacPherson 2013).

What is less easy to demonstrate is the magnitude of the parallel, adverse effects of such rapid socioeconomic change on the mental health of Europeans and New World Europeans. This is partly because for mental disorders, unlike physical ones, there is no convenient, reasonably reliable, macroindicator like LEB.

Increasing Insanity or Growing Institutionalisation of the Insane, or Both, in the Nineteenth-Century West?

There is no doubt that during the West's modernisation in the nineteenth century, patient populations of lunatic asylums soared: in England and Wales, almost 300,000 committals and in the USA, by World War One, almost 250,000 patients were located in state psychiatric hospitals, while in New South Wales (Australia) and in Ireland about one in 300 people were asylum inmates. Asylums themselves proliferated and grew in size (Wright 1997).

Moreover, many psychiatrists of the time believed insanity was increasing due, they said, to the deleterious effects of urban, industrial society. Contemporary, Western civilisation was producing sensory overload and so mental illness. Distinguished alienists from across Europe like J.E.D. Esquirol, Jacques Moreau de Tours, Wilhelm Griesinger, Richard von Krafft-Ebing, Hack Tuke and Cesare Lombroso argued those unfortunates who could not meet the demands of civilisation for higher levels of mental organisation and production were filling the ranks of the mentally ill.

For eminent, American neurologist, George Beard, the characteristic mental disorder of the times was neurasthenia ('nervous weakness') the symptoms of which were variously anxiety, pains, headaches and sexual dysfunction. The disorder arose because the body's nervous energy was depleted by the following features of modern society: steam power, the periodical press, the telegraph, women's education and science. Alienists were also encouraged in this pessimistic view of the advance of civilisation by the French psychiatrist, Benedict Morel's influential doctrine of hereditary degeneracy and, later, by the eugenists' call for state measures to prevent reproduction by the unfit in order to halt an alleged decline in the physical and mental 'vigour' of the European 'race' (Lewis 1988; Rosenberg 1998; Raimundo Oda et al. 2005; Shorter 2005).

The connection between industrial civilisation and mental illness was as widely accepted in medical circles as that between industrial civilisation and leading causes of physical illness and of death—fevers, tuberculosis and the great killer of babies, summer diarrhoea. The psychological cost of progress was as real as the cost to physical health of urban population density, inadequate, working class diets and unhygienic dwellings and workplaces (Rosenberg 1998).

Many modern historians of psychiatry, influenced by the ideas of French philosopher, Michel Foucault, have not been concerned with whether the incidence of insanity itself was increasing, but rather with the proliferation of asylums and their populations; they see these phenomena as resulting from the all-powerful, modern state's plan to confine and control the unproductive and disruptive (including the insane) and so to regulate, and promote efficiency, in the new industrial society (Porter 2003). In this scenario, asylum doctors, eager to advance their own professional interests, were the agents of the control of the insane. Wright (1997) has argued, as a variation, this 'great confinement' was driven primarily not by these aspirational psychiatrists, but by working class families who, unable to

provide the family-based care of pre-industrial times (because of the demands of the new, industrial, labour regime), were themselves increasingly placing their mentally disordered members in asylum care.

Others believe patient populations grew dramatically at least in part because the population incidence of mental disorders was growing: especially, alcoholism (alcoholic dementia and delirium); general paralysis of the insane (neurosyphilis); and, possibly, schizophrenia (Shorter 2005).

Certainly, nineteenth-century European and American doctors voiced growing concern about the widespread, adverse effects of alcohol abuse. The cheapness of industrially produced liquor encouraged demand, and drunkenness became a major problem of urban social order.

Doctors identified alcohol abuse as an increasing source of physical and mental illness. Habitual drunkenness was, then, seen as a physical cause of insanity like trauma and syphilis.

Psychiatrists in particular were very concerned because so many of their cases seemed to be alcohol-related. Eminent American doctor, Benjamin Rush, claimed 33% of cases at the Pennsylvania Hospital were such; in England experts claimed 30–50%; in Hanover, Germany, 16% and Stephansfeld, France, 11%; in Sydney, Australia, 10% and Melbourne, 9%; although early figures from Yarra Bend asylum, Melbourne, were much higher—in the 1850s, 50–70% of admissions were said to be alcohol-related (Lewis 1992; Shorter 2005). But it was not only doctors who drew attention to the connection between illness and widespread alcohol abuse, especially among the poor. In 1850, **Punch**, the popular London weekly magazine, observed the filthy, urban environments in which the poor lived bred depression and despair, and many sought relief in heavy drinking (The Peel Web 2014).

Syphilis was widespread in nineteenth-century European and New World European populations. With no effective cure, a considerable number of the infected developed general paralysis of the insane (GPI) ten to 20 years after infection. They became asylum inmates because of symptoms like mania, and they eventually died from GPI. In 1838–1846, of 489 cases of insanity at Sydney's Tarban Creek asylum, 14 (all male; because of widespread female prostitution and the colonial population's high masculinity, most sufferers were male) were paretics. At Melbourne's Yarra Bend, in 1863, 28 of 52 male deaths were from GPI. In 1882–1894, 8% of admissions at Melbourne's Kew asylum had GPI, the high figure probably reflecting the fact of high syphilis infection rates among the men who had flocked in great numbers from overseas and other Australian colonies to the Victorian goldfields in the 1850s. In NSW, in 1883–1887, GPI was responsible for 3.5% of admissions, where in England the figure was as high as 8.4%.

There was a steady downward trend in GPI admissions (Victoria) from 1913, decades before penicillin became available as the first, effective cure for syphilis. The arsenical drug, Salvarsan, used on asylum paretics in Australia from just before World War One, was found to be ineffective against neurosyphilis, but may have had some effect in reducing early syphilis and so the incidence of GPI.

A major peak in GPI admissions occurred in 1913 and a much lesser one in 1935. The 1913 peak was probably the result of the exposure of Australian troops to syphilis in the Boer War (and possibly to the immigrant intake of the late nineteenth century). The 1935 peak was partly the result of very substantial syphilis infection rates among Australian troops during World War One, one of the highest among combatant nations: Australia, 178 hospital admissions per 1000 men in the field; Britain, 25 and Germany, 27 (Lewis 1988; Cumpston 1989; Lewis 1998; Shorter 2005; Noonan 2014).

Warner (1995) has argued the process of modernisation in Victorian England increased the incidence of schizophrenia as changing socioeconomic factors were mediated through biological mechanisms. At the early stage of industrialisation, because of better care, many brain-damaged, upper class babies survived where such lower class infants died. This led to higher rates of schizophrenia among the well-to-do. At a later stage, well-nourished, upper class parturients with well-formed pelvic cavities and better obstetric care produced fewer, brain-damaged children, and so the incidence of upper class schizophrenia decreased. Working class women had to wait some time longer for the benefits of better nutrition and obstetric care to reduce damage to babies and so to lower the incidence of working class schizophrenia.

Beginning in the 1970s, studies of schizophrenia in non-Western countries suggested its course could differ according to the country's stage of modernisation as well as the local culture. The character of schizophrenia might be a genetic-biological universal, but its course could apparently be influenced by modernisation and, perhaps, by cultural factors (Fabrega 2001). A recent overview of knowledge about schizophrenia noted, first, the incidence varies very much across locations; second, the risk increases linearly with the degree to which the environment in which children mature is urbanised; third, the risk is higher in some ethnic, immigrant groups. Poverty and social isolation may be the factors underlying this association with urbanisation and migration so that public policy aimed at reducing poverty and isolation may help reduce rates of schizophrenia (Van Os and Kapur 2009).

Western psychiatry emerged as asylum medicine just when nineteenth-century Europe was undergoing rapid and far-reaching, social and economic change. Arguably, it did so as a medical response to the mental health costs of modernisation. In the same way, public health was a response to the high costs to physical health of CDs. Both disciplines had become well established as medical specialties by the later nineteenth century.

The Spread of Western Psychiatry to the Non-Western World

The unprecedented economic and military power arising from the pioneering modernisation of the West enabled the creation or expansion of Western empires in Asia, the Pacific and Africa in 1850–1914. Along with empire came a belief in the

superiority of Western culture and especially its products, including science, medicine and psychiatry. The West saw itself as having a civilising mission, a responsibility to bring backward peoples into the modern world (Kirmayer and Swartz 2014).

The expansion of empire brought Western psychiatry into greater contact with the Asian, traditional, medical systems, as well as tribal and folk systems. In the colonies Western psychiatrists encountered culturally different disorders, different explanations and different therapies.

After World War Two, Western empires dissolved but Western psychiatry was, by then, firmly established as international psychiatry, with American and, to a lesser extent, British psychiatry the dominant forces. Even before the end of the nineteenth century France had forfeited leadership of Western psychiatry to the German-speaking world. The long period of German leadership ended with the triumph of Nazism in the 1930s, the Holocaust and the emigration (mainly to the USA) of many, leading, Jewish clinicians and scientists (Shorter 2005).

Globalisation, in an extended sense initiated by the West as long ago as Columbus' discovery of America and then greatly promoted by nineteenth century, Western industrialisation and imperialism, has in the last 25 years reached a new level of intensity, impinging even more on the cultures, economies, polities and social structures of non-Western, developing countries. Psychiatry as one of the West's cultural exports is becoming truly globalised, but in some non-Western countries attempts are being made to modify it and reconcile its theory and practice with major, indigenous, healing traditions.

Another expression of current globalisation is the depth and rapidity of social and economic modernisation in developing countries. The cost to physical and mental health is comparable to that experienced in the modernisation of the West in the nineteenth century. But this time psychiatry, as a response to the rising level of mental disorders in LAMIC psychiatry, will deal with cultural differences of a higher order than those it faced in its early years in Europe two centuries ago.

In the colonial era, European psychiatrists' contacts with indigenous approaches to mental disorders had challenged the universality of the classification and diagnostic systems of Western psychiatry, which owed so much to Emil Kraepelin's [1856–1926] work and particularly his description of the major disorders, dementia praecox and manic-depressive disorder. While Kraepelin's and Wilhelm Griesinger's [1817–1868] emphasis on the biological basis of psychiatry prevailed in Europe, after his contact with indigenous groups in Southeast Asia and the USA, Kraepelin himself accepted his system did not apply satisfactorily to their disorders; and that, moreover, culture seemed to have a significant role, shaping both the frequency and expression of disorders. Indeed, he believed a new comparative psychiatry had to be developed to deal with these matters (Marsella and Yamada 2010).

In the history of modern psychiatry, as it became a medical specialty, there have been two causal poles—one, the biological, looks to the brain (and genetic inheritance) to explain mental disorders, while the other focuses on the role of personal

and social context, and so the psychological and, to some extent, the social realm for its explanations (Grob 1998).

Although psychodynamics and psychotherapy became increasingly significant in the first six decades of the twentieth century (especially in North America), biology 'struck back' via pharmacology from the 1950s when an effective antipsychotic, chlorpromazine, became available. In the 1960s the anxiolytic benzodiazepines arrived, replacing the long-established but less efficient and problematic barbiturates. Influential 'neo-Kraepelinians', led by Gerald Klerman, sometime head of the American National Institute of Mental Health, called for a determinedly medical model of psychiatry in which the focus would be on the biology of mental disorders (Shorter 2005; Marsella and Yamada 2010).

Even while the psychodynamic and, then, the biological approach prevailed in the twentieth century, the importance of sociocultural forces was addressed by a number of psychiatrists in the USA and Canada. They could point to international studies that showed variations in psychiatric disorder rates, aetiology and manifestations across nations and cultures. In addition, anthropologists like Margaret Mead showed how culture influenced what constituted the normal and the abnormal in a particular society.

A great advance in transcultural psychiatry came in the 1970s because of the work of figures like Arthur Kleinman (Harvard psychiatrist and anthropologist) and Laurence Kirmayer (McGill University). As Kirmayer notes, the old transcultural psychiatry saw culture's effect restricted to pathoplasticity, while biology determined pathogenesis. The new view is cultural context, via systems of meaning, also influences symptom schema. But it goes further and says culturally determined behaviour patterns—diet being a good example—can influence biology; so that culture and biology interact. Psychopathologies arise not simply from malfunctioning brains but from defective learning and interpersonal relations in families and larger social groupings (Kirmayer 2006). They are not just localised in the brain and reducible in aetiology to biological or even biological and psychological factors. They are influenced by cultural (including religious), social, economic and political factors.

Marsella and Yamada propose that mental health can only be fully attained if the 'hopelessness' of poverty, the 'anger' arising from inequality, the 'despair' from powerlessness, the 'self-denigration' from racism and the 'confusion' from cultural disintegration are banished (Marsella and Yamada 2000). Like Kirmayer, they argue that life-changing events at the macrolevel, via sociocultural pathways, have impact at the synaptic level. Rapid, destructive, social changes set off a chain reaction. They induce, in turn, social stress (in families and other groupings), psychosocial stress (like alienation), identity stress ('who am I?'), psychobiological changes (like hopelessness), behavioural problems (like alcohol and other drug abuse, and interpersonal violence) and synaptic changes (in serotonin and other chemicals), even if we do not yet fully understand how these hierarchically ordered interactions specifically function (Marsella and Yamada 2010).

Mental and Physical Health Effects of Rapid Social and Economic Change in Asia and the Pacific

By the late nineteenth century the adverse physical health effects of Western modernisation were reducing as mortality from CDs began a secular decline; LEB began to rise to historically unseen heights. This was the first phase of the health transition in the West, a complex process of changes in health, disease and mortality resulting from demographic and associated social, economic, cultural and political changes.

The next phase in the health transition dates from the interwar period, when mortality from what became an 'epidemic' of major chronic non-communicable diseases (NCDS) like cardiovascular disease, cancer and diabetes began, retarding the advance in LEB. Only late in the twentieth century was the drag of NCDs reduced as mortality from some like heart disease declined.

Now such has been the speed and magnitude of the current modernisation process in developing countries (including those in the Asia-Pacific region) that for them the two phases of the Western health transition have been compressed. They are experiencing at the same time a double (physical) disease burden as mortality and morbidity from CDs remain high even as those from NCDs rise sharply (Lewis and MacPherson 2013).

From the 1950s, as NCDs came to dominate the patterns of mortality and morbidity in the developed world, epidemiology's 'causal' focus shifted to multiple, proximate, biological risk factors like high blood pressure, the presence of which increased the probability of disease in the individual. More recently, the role of macroeconomic, social and cultural factors has enjoyed greater recognition because of the persistence of a social gradient in mortality and physical health status across countries, even as health status at the national level improves. The work of contemporary investigators like Marmot et al. (2010) and Wilkinson and Picket (2010) strongly suggests physical and mental disease rates will change as their social, cultural and economic environments change and that the way a society is organised is itself a notable determinant of health status.

Even in richer countries, from where deep poverty has disappeared, significant socioeconomic inequalities continue; the social gradient persists because the psychosocial effects of relative deprivation mean anxiety, depression and insecurity—a sense of control over one's life—are experienced differentially according to level of socioeconomic status. The prevalence of illness and death is distributed differentially (Hunter and Tsey 2003; Lewis and MacPherson 2013).

In the same line of thinking, another distinguished investigator, Ezra Susser, proposes we look beyond concern with individual risk factors to an 'eco epidemiology' approach in which 'causality' functions at different levels—at the macrolevel, according to distribution of wealth and social status; at the individual level, via personal attitudes and behaviour; and at the micro level, via cellular and molecular events (Lewis and MacPherson 2013). This schema much resembles

Marsella and Yamada's hierarchically organised model of 'causal' pathways in mental disorders that we have outlined above.

In the early 1990s Sugar and colleagues drew attention to the exploding growth of 'social and behavioural pathologies' in developing countries as globalisation destroyed traditional, social, cultural and economic orders. They noted globalisation offered great gains like rising national wealth and falling infant mortality rates, but these were matched by great costs like increasing violence, substance abuse, mental disorders and family breakdown, as well as rising rates of NCDs like heart disease and diabetes. A major social and behavioural pathology like cigarette smoking addiction was wreaking havoc on physical health as seen in rocketing mortality and morbidity from cardiovascular disease and cancer in the developing world: in China, cardiovascular death rates increased 250% in 1957–1984, as cigarette production rose 10% each year. Mental disorders like suicide were often higher in developing countries: in the late 1980s where suicides of young men were 30 per 100,000 population in the USA, they were 75 (15–19 years) and 110 (20–24 years) in Micronesia; in 1967–1987 alcohol was implicated in almost half of suicides there (Sugar et al. 1994). Two decades of globalisation later, Marsella (2012) again addressed this issue of the various, globalisation-induced positives and negatives for individuals and nations. He lists among the negatives, rising 'social dysfunctions and disorders'. His list includes many of those identified by Sugar and colleagues in the earlier years of globalisation.

Marsella (2012) asks why psychology (as the study of mind and behaviour) has not contributed more to understanding of the connection between globalisation and mental health problems, especially suicide. In seeking to explain this, he points to, first, its historical focus on individual behaviour where causes are situated in the person whether they be neurobiological, personality-focussed or based on the person's particular developmental history; and located, also, only in proximate social environments like the family, school or workplace. Second, he points to the underlying assumptions of psychology, notably its individualism, materialism and reductionism. These derive from its origins in Western culture where an epistemological distinction between the individual and society is fundamental. They limit its capacity to advance understanding of behaviour in countries with non-Western cultures where this is not critical.

Summerfield (2012) and Kirmayer (2006) make similar points in relation to psychiatry. Summerfield says Western psychiatry is hampered in its cross-cultural applicability and efficacy by its 'foundational assumptions'. From the enlightenment on, the individual has been the prime focus of inquiry, and 'mind' is located in the head, while everything 'social', being outside the body, is a separate and less significant realm of explanation. This basic conceptual distinction produces in policy and practice a division of psychiatric from social interventions, even while social problems like violence, inequality and poverty are increasingly recognised as ultimate causes of mental disorders. At the least, a narrow, biomedical approach to mental disorders in the developing world reduces community mental health services, WHO's much advocated solution, virtually to the provision of medications (Summerfield 2012).

Kirmayer takes this last point about services further. Greater provision to poor populations of community mental health services and medications for depression and other significant disorders in order to reduce the suffering of a plethora of untreated people is to be applauded. But this must not become a substitute for the social and political reforms that need to be implemented to remedy the systemic inadequacies and injustices that, at some steps removed, produce the suffering. In the current, globalising phase of psychiatry, as universal mental health becomes a goal, two polarised approaches have developed. On the one hand, there are the clinically oriented who, firm in their belief in the transferability of Western psychiatry to other cultures, are focussed on practical achievements; essentially, 'scaling-up'—much greater provision—of services and treatments to the masses of neglected patients in developing nations. On the other, there are the social scientists and non-clinical researchers who, eager to advance the building of a coherent and self-reflexive, cultural psychiatry, tend to ignore the everyday demands and obligations of clinical practice (Kirmayer 2006).

Scaling-up of mental health services and a larger share of the health budget, in developing countries, is a necessary but not sufficient condition for improving mental health.

On the grounds of effectiveness (let alone equity), larger social and economic reforms are also needed to reduce poverty, because poverty in a rapidly changing society and culture involves not just material deprivation—poor nutrition, inferior housing, insanitary environments, dangerous workplaces and overcrowding—but associated interpersonal and psychological threats like violence, abuse of women and children, hopelessness and constant feelings of insecurity.

Another threat to material and psychological security is the heightened risk of physical illness when no financial safety nets exist and illness-induced inability to work means lack of income. Moreover, empirically, mental disorders cluster with physical diseases in the life world of the poor. Mental disorders increase the risk of CDs like TB and of NCDs like diabetes. Conversely, physical diseases like HIV/AIDs increase the risk of mental illness (Farmer et al. 2013; Becker et al. 2013). We should be talking, then, about the existence of a **triple**, not a **double disease burden** (our emphasis) in developing countries?

Of the ten leading causes of the global burden of disease, depression ranks third. Even in low-income countries it is as high as eighth. It is first in middle-income countries and, not so surprisingly, first in high-income countries: in the USA in 1980–2000, the reported prevalence of depression increased by 76%.

The global burden of disease is expressed in DALYS (disability-adjusted life years). The DALY was developed in the 1990s as a single, quantitative indicator that combines the traditional indicators, morbidity (disability) and mortality (premature death). It offers practitioners, policymakers and researchers alike a more reliable estimate of the total disease burden and how it is distributed among diseases and disorders (Becker et al. 2013).

By revealing the relative contributions of particular diseases and disorders to the total burden, the indicator much facilitates the establishment of priorities for remedial interventions and allocation of scarce resources. Further, the use of

DALYS can focus attention on diseases and disorders that have been neglected as neuropsychiatric disorders have been in LAMIC. These represent almost 27% of years lived with disability in such countries. Indeed, the largest, neuropsychiatric disability rates in the world are found in East and Southeast Asian nations. On the downside, the burden of disease approach, unintentionally, tends to highlight the distinction between physical and mental disorders, thereby reinforcing a long-standing failure to appreciate the way physical diseases and mental disorders cluster, especially in poverty-ridden environments (Becker et al. 2013).

As now constituted, the DALY does not capture the subjective dimension of illness: the individual suffering and what Arthur Kleinman has termed 'social suffering'—the suffering of whole families and communities. Since the DALY addresses years of disability-free life lost to individuals, it omits the negative effect at this collective level. Further, the DALY approach really measures the 'aggregate quantity of ill-health'. To establish fully 'the burden of disease', the support available to the sufferer from family, friends and public services would need to be included.

The subjective experiences of suffering, pain and stigma are missing because they are irrelevant to the concern of the DALY approach with the effect of diseases and disorders on human productivity and, so, on economic development. Further, a reliable count of cases cannot be assumed given the lack of services and other obstacles in poorer countries such as inadequate, large-scale collection of statistics.

The fact is the biosocial and cultural complexity of global health is such that we must employ the 're-socializing' disciplines (the social sciences and humanities)—history, anthropology, sociology and political economy—to provide the additional information needed to obtain a comprehensive, just and humanised picture of the effects of physical diseases and mental disorders in an increasingly globalised world (Becker et al. 2013).

We hope the combined efforts of the contributors to our edited volume constitute a useful step towards realisation of this aim of employing historically, culturally, socially, economically and politically informed accounts to help capture the full complexity of mental health and its determinants in the early twenty-first century.

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