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Commentary on 'Mental Health Across the Globe: Conceptual Perspectives from Social Science and the Humanities' Section

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This part of the handbook deals with transdisciplinary perspectives from the social sciences and humanities on some of the most crucial issues of the Global Mental Health (GMH) agenda. The various chapters take us on a captivating disciplinary tour across central GMH notions such as medicalization of distress, recovery from severe mental illness, space and mental disorders, culture and treatment outcomes, positive mental health and happiness, cultural idioms of distress and psychiatric classifications.

Miller (chapter 5) tackles issues of colonial and postcolonial psychiatry in the context of Africa and postcolonial India; Aldersey and collaborators examine the notion of 'recovery' from severe mental illness, using a comparative perspective in three different cultural contexts: the USA, New Zealand and Nigeria; McGeachan and Philo (chapter 2) posit a geographically informed analysis of mental health and illness and its spatial distribution, examining a wide range of concepts going from spatial epidemiology to therapeutic landscapes. Harding (chapter 4) contributes from a historical perspective to explain how modern concepts of mental health and illness are constructed in Japan and India, through a dialogue among ancient healing traditions and the legacy of colonial and postcolonial systems of mental health care in successive encounters with the West. Jenkins and Koselka (chapter 8) show us, from an ethnographic perspective, how persons and families living with mental illness are confronted with hard decisions when taking psychotropic drugs, and

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remind us to acknowledge the impact of culture in the course and outcome of treatment as crucial to formulating successful GMH interventions. White and Eyber (chapter 7) contribute to this section with a critical analysis of the key concepts of subjective and psychological well-being, including the discussion of happiness, as highly relevant notions to GMH. Finally, Thornton (chapter 3) adopts a philosophical perspective in focusing on the relations between cultural idioms of distress and the DSM-5 taxonomy of mental illness.

Under the title 'Reflecting on the medicalization of distress', Miller (chapter 5) attempts to explore the

> post-developmental critique of the dominant ideology within the Movement for Global Mental Health (MGMH) by locating what may seem to be primarily clinical debates within wider arguments about the validity of development theory.

The introduction points at some of the well-known criticisms against the Movement for Global Mental Health (MGMH) and its goals, and more specifically the inevitable medicalization of distress that the interventions proposed by the MGMH may lead to, under the false assumption that the Western model of development can be easily transferred or replicated across the globe, irrespective of the cultural, societal and geographical contexts (Fernando 2014; Summerfield 2012; Watters 2011; Kirmayer 2002). The section titled 'Changing models' tackles the concepts of 'culture' as defined by Kuper (1999) and 'idioms of distress' (Nichter 1981), such as '*koro*' (Yap 1965) and *ataque de nervios* (Oquendo 1995). In the section titled 'Historical Consciousness', issues of colonial and postcolonial psychiatry are discussed in the context of Africa and postcolonial India.

The literature review is somewhat helpful to track back the arguments for and against the medicalization of distress, as well as the emergence of cultural categories such as 'idioms of distress', a construct developed by anthropologists in the early 1980s. However, the concepts and examples are scattered across countries and cultures along five decades of recent history and remain to some extent disconnected from the main argument.

Since its first introduction to the academic discourse, 'idioms of distress' has turned into a self-explanatory term that is used to make sense of cultural categories as diverse as *ataque de nervios* (Guarnaccia et al. 2003), *susto* (Weller et al. 2002), *espanto* (Tousignant 1979), *ihahamuka* (Hagengimana and Hinton 2009), *llaki* and *ñakary* (Pedersen et al. 2010) and *neurasthenia* (Ware and Kleinman 1992), among many others. These 'idioms' are considered polysemic and idiosyncratic phenomena used to communicate a wide

range of personal and social concerns that may or may not be related to individual distress or mental disorder. Thus, physiological and psychological expressions of distress are not simple manifestations of a subjacent biological reality but also metaphors that reflect and represent a variety of meanings that serve many social and psychological purposes (Browner and Sargent 2007). In summary, idioms of distress may reflect past exposure to violence and trauma, but also present challenges and foreshadowed troubles. Yet, they are not mere reflections but influence and are in turn influenced by social relations and, thus, constantly transformed, recreated and invested with new meanings and attributions (Pedersen et al. 2010).

Miller continues his analysis to conclude that post-developmental theory has to some extent reinforced the critique of the dominant, biomedical model within the MGMH and calls for a healthy scepticism towards the medicalization of distress, where a false opposition may present 'a cultural preservationist defense of local systems of distress and healing' as the only valid alternative to psychiatric neocolonialism.

Aldersey, Adeponle and Whitley (chapter 6) examine the notion of 'recovery' as a polysemic term emerging in the early 1990s, which has a plurality of meanings. Today, the term 'recovery' evokes different understandings, which may loom large if we compare the understandings of this term from a service user perspective with that of a Western-trained psychiatrist and even that of a general practitioner. It becomes evident in the analysis made by Aldersey et al. that each one holds different meanings and has dissimilar expectations with regard to 'recovery'. These differences are even more accentuated if we compare the notion of recovery from the official discourses coming from countries in different stages of income and social development levels.

The central argument of the chapter by Aldersley and colleagues is organized around case studies from three different countries: the USA, New Zealand and Nigeria. Distinguishing between different conceptions of recovery among these countries, it clearly illustrates that their respective knowledge about recovery from severe mental illness is not necessarily connected with their actions regarding the management of mental illness and the interventions leading to an independent and autonomous life, supported employment and peer support, and—more importantly—to improved mental health outcomes (including the total or partial remission of symptoms).

In the USA, the notions of recovery are wide-ranging. The emphasis on recovery from mental illness is much influenced by the prevailing value system: the overriding notion to live 'an autonomous, productive and meaningful life' is in line with the values of rugged individualism and the productive citizen predominant in the USA (Myers 2010). In the New Zealand case, recovery

is strongly induced by an underlying egalitarian and community-based philosophy, with a heavy influence of Maori culture and service users' collective values and perspectives, in contrast with the individualistic approaches to recovery, which are typically exhibited in the USA and other countries of the Global North.

Nigeria represents the poorest and least developed of the three countries under examination, and features a mental health service delivery system with public community-based general hospitals, stand-alone psychiatric hospitals and a few private beds. In this country, the mental health care system was established under the Lunacy Act (1916) dating back to the colonial period. Today, many changes have been introduced following the 1991 National Mental Health Policy, which aims to cover all levels of care and promotes the integration of mental health services into primary health care (PHC). However, not all proposed changes have been operationalized, and to date 'recovery' remains a concept with no direct translation into action programmes.

According to the widely known World Health Organization (WHO) Collaborative Study (Sartorius et al. 1986) on schizophrenia and prognosis in ten countries, Nigeria compares favourably with other more developed and industrialized countries. The Nigerian case raises many questions regarding the explanation for better social and functional outcomes in severe mental illness as compared to more advanced countries. Positive family involvement and related contextual factors (i.e., peer support), appear to explain, at least in part, the better outcomes and prognosis of severe mental illness in Nigeria, despite a weak and poorly organized mental health system. The three case studies presented here by Aldersey et al. provide a useful matrix for analysing the recovery construct and its legitimacy in three different cultural contexts. Despite the obvious differences among the three countries, there is a common thread in the notion of recovery across countries and cultures, which includes the provision of humane, empowering and holistic mental health services.

However, the comparative analysis of the three cases does not include a discussion on the degree of westernization currently prevailing in the service delivery network in each country. While the USA represents a top-down approach of the concept of recovery, much imbued by a Western value system, the New Zealand case represents the bottom-up approach, involving the Maori culture and its own notions of healing and coping with and recovery from mental illness, in parallel coexistence with Western psychiatric practices. Finally, the Nigerian case represents more of a hybrid, where Western psychiatry coexists with traditional and religious healing practices, and the notions of recovery are culture-specific and not necessarily influenced by the Western value system. Pat Bracken and other 'critical' psychiatrists in the UK have argued for

a greater inclusion of people with mental illness into innovative alternative approaches to mental health care—also called 'user/survivor-led approaches'—more responsive to their needs and illness experience and steering away from biomedical approaches to recovery. Building on a critical perspective on the MGMH, these authors emphasize two categories of alternative approaches to the Western dominant model of recovery: non-Western approaches, mostly developed by other cultures and contexts to deal with persons with mental illness, and non-medical approaches, developed in Western settings by those who have not been helped by psychiatry (Bracken et al. 2014). They acknowledge the importance of preserving these alternative community-based approaches to mental health care, which in many ways may be equally or more effective in leading to recovery from severe mental disorders than the conventional Western-based mental health care models currently being used in high-income countries.

McGeachan and Philo (chapter 2) present us with a rich geographically informed analysis of mental health and its spatial distribution, which is highly relevant to current and future debates within GMH. Their analysis leads us to look at the individual living in a material space, never geographically static but continuously dynamic, cross-cutting into a range of not only material but also social and symbolic worlds, which in turn manifest at different scales. The 'local' and the 'global', to which now we may add the 'planetary', are some of the broader range of spaces for examining mental health across the globe. However, most of the research conducted in mental health geographies across the globe remains to this date within the context of the Global North.

The chapter focuses upon four interconnected strands of space and place in relation to madness[1]: spatial epidemiologies, the 'psychiatric city', the complex spaces of care and therapeutic landscapes. The relentless process of urbanization and the emerging large cities of the Global South, signals the importance of studying the complex mental illness geographies of these spaces. First, the spatial epidemiologies, showing the variations in the incidence of schizophrenia in the urban environment with decreasing frequency away from the city centre, and its correlation with low socio-economic status, high unemployment and low social mobility, depict an interesting matrix of analysis for the social epidemiologist. Regrettably, what remains to be understood beyond the simple existence of such correlations, are the reasons explaining such patterns of spatial distribution of mental disorder in the urban environment.

[1] The authors seem to prefer using the politicized concept of 'madness' as opposed to the more conventional medicalized notion of 'mental illness'.

Second, the 'psychiatric city' and complex spaces for care are useful constructs for analysing the spatial distribution of mental illness and mental health care structures, which may be further enhanced in an analysis from an historical perspective. The 'lunatic asylum' and its space(s) are objective representations of societal responses to the geographies of madness, shaped by the prevailing medical practices and moral values of the eighteenth and nineteenth centuries in Western nations. The images of the asylum and complex spaces of care we still see today in the former colonies in the Global South are a painful legacy of the Western lunatic asylums of the past.

Last, the notion of 'therapeutic landscapes', introduced by Gesler (1991), meant to represent places with 'an enduring reputation for achieving physical, mental, and spiritual healing', served to strengthen our understanding of the intimate interconnections between health and ill health, with space, place and identity. McGeachan and Philo present a comprehensive review of the whole range of therapeutic landscapes: from the natural and the built physical landscapes (i.e., gardens, public libraries and respite centres), to the social and symbolic environments, to the more culture-specific landscapes among Amerindian populations, to the landscapes of the mind or entirely imagined landscapes (Rose 2012).

Examining mental health and place from these geographical perspectives enables us to understand the complexities of asylum and post-asylum health care. Geographical approaches endorse the critique of 'one size fits all' when searching for delivery of mental health services which are socially relevant and culturally sensitive to context. When looking through the geographical lens at the individual dimensions of mental illness, the multidimensional and multi-scalar dimension comes to the fore. The transition from an individual focus to larger population scales, at either the national, regional or global levels, requires a geographical approach to mental health in which the voices of local actors are incorporated into planning and implementation of mental health services.

In the future, global–local interconnections and flows of concepts and ideas will remain crucial to the political ecology framework which is driven by disease ecology, health inequalities, social justice and the contextual effects of place. Some medical geographers are appealing to the diversity of approaches and conceptual frameworks required for their discipline to grow and develop further. Curtis and Riva (2010), among others, are rightly calling for a future of geography as a discipline informed by and building on 'complexity theory', which will be absolutely essential to explain the non-linear and recursive relationships between space and place and their impact on health.

Harding (chapter 4) contributes from an historical perspective to explain how modern concepts of mental health and illness are constructed in Japan and India through a dialogue established among ancient traditions and the legacy of colonial and postcolonial systems in successive encounters with the West, especially in the late nineteenth and twentieth centuries. The central argument of this chapter is aimed at understanding GMH by looking at two different national contexts. The discussion helps us avoid the tendency to universalize psychiatric conditions and underlines the crucial importance of local (micro level) initiatives as valuable responses to mental illness and psychosocial distress when confronted with globalized (macro level), mostly Western-driven diagnostic and therapeutic procedures.

When modern mental health care was established in these two countries, evident tensions emerged between those who pursued modernity via the import of Western medical ideologies in place of centuries-old practices and traditions, and those whose priority was to further explore and promote relevant insights from their own medical traditions while warily incorporating Western medical technologies. A second, no less important source of tensions emerged when taking emotional and psychological ill health of individuals and communities as evidence of the wrong sort of cultural exchange under the 'debilitating' influence of the West. Finally, additional areas of tension and controversy were created by the confrontation of individualistic approaches to mental health care in the West with the traditional extended family system in India and the particular role played by parents in Japanese families.

According to Harding, in the late 1940s, the heated debates about mind, culture and mental health, which had peaked in India (under British rule) and in Japan in the 1900s, declined steadily to give way to other public health priorities. In India, hygiene and control of infectious diseases, especially around military settlements, was considered a priority, thus allocated the scarce resources still available, while the mental health care of Indians and Europeans was segregated until independence in 1947 and relegated to a lower priority status. Nevertheless, in the mid-1950s, the exchange of therapies with the West was bidirectional and somewhat more balanced: while India contributed to Western mental health therapies with yoga and transcendental meditation, Japan added to the same therapeutic repertoire with Zen (i.e., seated meditation), and Morita and Naikan therapies drawing from centuries-old Buddhist insights.

Harding deepens his analysis of the debate in the late nineteenth and twentieth centuries in India over how mental health relates to Indian culture and medical traditions. The 1912 Indian Lunacy Act remained as such until 1987, when a new law was adopted with an emphasis placed upon treatment

rather than custody. The new Act in 2014 updated many of the regulations, including patient rights to appeal doctors' decisions, the decriminalization of suicide, restricting psychosurgery and banning electroconvulsive therapy (ECT) without anaesthesia. In 1954, mental health institutions were created at the national level for research and training, such as the All-India Institute of Mental Health, which later became the National Institute for Mental Health and Neurosciences (NIMHANS) in Bangalore, which contributed to decentralizing and demystifying mental health care, with the provision of basic psychiatric training of PHC workers.

India continued playing an important role in the globalization of mental health ideas up to the present. Harding poses as an example the power exerted by WHO in India's postcolonial relationship with the West, with the influential role given to Indian psychiatrists working within WHO, and the preferential funding allocated to mental health programmes in India in the 1970s. More recently, the WHO Mental Health Gap Action Programme (mhGAP) and the emergence of the MGMH may be seen as part of the global influence exerted by Indian psychiatry across the world.

The restructuration of mental health care in Japan followed a very different pattern, under the strong influence exerted during the US occupation (1945–1952) by American psychology and the adoption of the Mental Health Law (1950), which was responsible for establishing a network of psychiatric hospitals countrywide. Since then, critical thinking emerged in Japan about the ideas of 'self' (i.e., the *amae* theory), situated at the intersection of psychiatry, social psychology and social and cultural criticism, and was among the most notable contributions of Japanese ideas to GMH.

In conclusion, Harding offers us striking examples of how historical forces in both Indian and Japanese medical and religious traditions have played such a crucial role in the emergence of GMH ideas and practices, not only generating new therapeutic approaches to mental illness but also contributing innovations in family psychiatry—in the Indian case—and community-based psychiatry in the Japanese case.

In their chapter, Jenkins and Kozelka (chapter 8) focus on problems of efficacy and validity associated with the provision of mental health services, more specifically in the uses of pharmacological treatment for serious mental illness. The authors convincingly argue for the crucial importance of cultural understanding when delivering clinical interventions, whether pharmacological or psychosocial, in the treatment of severe mental disorders.

Ethnographic accounts in different cultures show that persons and families living with mental illness are confronted with difficult decisions when taking

psychotropic drugs, which always entails some degree of distress, considerable cultural dissonance and social stigma. The authors conclude that

> attention to how these cultural forces impact the course and outcome of treatment will be critical to formulating successful GMH interventions.

Studies conducted in both high- and low-income countries (e.g., USA and Ghana) consistently show high discontinuation rates (75–80%) of psychotropic medication, but there is scarce empirical data to explain the reasons for this. Most often, the discontinuation rates are explained by failures in logistics or lack of resources. On the other hand, health care providers must overcome their prejudice that the discontinuation of the medication is simply a problem of patient 'compliance' or lack of 'adherence' to treatment.

Jenkins and Kozelka start from the fundamental assumption that scaling up GMH services, including the use of psycho-pharmaceuticals, 'should be paralleled with an equal scale-up of culturally meaningful psychosocial services'. The authors further consolidate their claim by citing Read's work in Ghana (2012), by which after taking medication, a return to social functioning is generally more valued than symptom reduction. In short, taking psychoactive drugs and feeling better is a complex, nuanced process, which is driven by a number of social and cultural forces shaping the acceptability (compliance) or rejection (noncompliance) of treatment and medication. This process requires negotiation and renegotiation between the health provider and patient and above all careful fine-tuning, collaborative listening and active engagement with patients and their families as a precondition to successful treatment and compliance.

The main contribution of the chapter is to create awareness that the scaling-up of GMH services is not a simple matter of facilitating access to treatment, but should be understood as a more nuanced process beyond simple prescription, entailing a culturally informed understanding of the interface between patient and health provider, engagement with patients and their families and simultaneous attention to pharmacological treatment in tandem with the psychosocial interventions.

White and Eyber (chapter 7) contribute to this section with a critical analysis of the key concepts of 'subjective wellbeing' (SWB) and 'psychological wellbeing' (PWB) in the Global South, including the discussion of 'happiness'. They further examine the notion of *buen vivir* (living well) in the Latin American region, and present all of these as categories of wellbeing and therefore of relevance to GMH policy and practice.

The construct of SWB may be measured by how happy people are with their lives (i.e., the hedonic approach), which is equivalent to life satisfaction, also used as an indicator of 'global happiness' in economic surveys. White and Eyber review the most frequently used scales to measure SWB, which in general aim to assess 'how happy' people are, rather than attempting to find what happiness means. The construct of PWB by contrast to SWB, focuses on the substantive content of what constitutes positive mental health or optimal psychological functioning (eudaemonic approach) or what it means for a human being to 'flourish'. These new approaches are mostly derived from positive psychology and happiness economics, both positivist and empirical in orientation, in many ways different from the earlier philosophical and discursive traditions in non-Western countries defining happiness and wellbeing from a theoretical perspective.

The most substantive contribution made by White and Eyber to the discussion of SWB and PWB and the broader notion of happiness is the critical analysis of these constructs. In the first place, they acknowledge the grounding of these concepts in North American quantitative psychology and its unquestionable commitment to a methodological and ontological individualism. Second, they point at both SWB and PWB as measured mostly using quantitative methodologies and therefore reflecting the biases of universalistic approaches (i.e., *etic* as opposed to *emic* categories, close-ended rigid scales, social desirability bias etc.), over contextual ones.

In the last sections of the chapter, the authors make an effort to move away from these positivistic categories of wellbeing and discuss more contextual approaches under the title of 'psychosocial wellbeing'. In describing the main trends of psychosocial wellbeing, they distinguish the notion of 'inner wellbeing', as developed by S. C. White, on research conducted in India and Zambia. Inner wellbeing is defined as 'what people think and feel they are able to be and do' and encompass seven interrelated domains: economic confidence, agency and participation, social connections, close relationships, physical and mental health, competence and self-worth, values and meaning. However, the notion of 'psychosocial wellbeing', as proposed by White et al. (2014), can be criticized as being mostly focused on the intra-psychic and disconnected from real life (physical, material, cultural and social) and therefore of little relevance to the actual population being studied. A more holistic understanding of the notion of psychosocial wellbeing was attempted by the so-called Psychosocial Working Group (PWG), in connection with exposure to potentially traumatic events (such as armed conflict, war or natural disaster). The group described psychosocial wellbeing as a construct related to three domains: human capacity, social ecology and culture and value system.

According to White and Eyber, the manual developed by the Interagency Standing Committee (IASC) called *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007)

> ha[s] contributed to a reduction of the tensions between the psychosocial and psychiatric paradigms by establishing the contributions that each can make for different segments of the population. (pp. XX)

However, the IASC manual's effectiveness continues to be contested by many as it represents above all the experts' opinion (mostly psychiatrists and psychologists) and to a lesser extent the general common sense. The recommended psychosocial interventions are insufficiently tested in real-field situations and to date little evidence exists of their effectiveness or fitness-for-purpose (Pedersen et al. 2015).

Finally, White and Eyber discuss the related notion of *buen vivir* (translated as 'living well together'), which has been described as an equivalent to the notion of 'wellbeing' as expressed among some indigenous populations of the Andean region (Bolivia, Peru and Ecuador) in Latin America. *Buen vivir* represents a circular rather than linear concept, and emphasizes reciprocity—an important Andean value concerning the flow of resources and social relations with others (family, friends, neighbours) (Mayer 2004). Above all, *buen vivir* represents a culture-specific notion, which may hold different meanings for different people. For some it may be more concerned with material possessions, while for others it may signal good social interactions or even a balanced status in the relations between man and the environment. As such, the term *buen vivir* is constructed at the local level, and therefore has limited universal or global applicability. The discussion led by White and Eyber on the main trends in the literature with respect to positive mental health, and the associated notions of well-being, happiness and *buen vivir*, is still at the beginning of a long road and reveals the lack of consensus on its meanings and the existing gaps in the ways to measure it, yet it remains a highly relevant subject to GMH.

Thornton's chapter (chapter 3) focuses on the relations between cultural idioms of distress and the *Diagnostic and Statistical Manual*—5th edition (DSM-5, APA 2013) taxonomy of mental illness from a philosophical perspective. In previous DSM versions, the cultural idioms of distress, also known as 'cultural-bound syndromes', were described as culture-specific patterns of bizarre or aberrant behaviour or troubling experience that may or may not be linked to a particular DSM diagnostic category (APA 2000). As Thornton explains, this concept is replaced in the DSM-5 by three constructs: cultural

syndromes, cultural idioms of distress and cultural explanations. After discussing the issue of validity of the cultural syndromes within the new psychiatric taxonomy and the issue of cultural sensitivity in the Cultural Formulation, Thornton further illustrates the case with the example of '*khyal*'. This cultural syndrome, which has been described among Cambodians, consists of dizziness, palpitations, cold extremities, shortness of breath and other symptoms overlapping with other related conditions in the DSM-5: panic attacks, panic disorder, generalized anxiety disorder, agoraphobia, PTSD and illness anxiety disorder. The fact that '*khyal*' is described in the DSM-5 under the 'Glossary of Cultural Concepts of Distress' poses the question whether any cultural syndrome in the DSM-5

> can simultaneously aim for validity whilst admitting cultural variation. (pp. XX)

Thornton concludes that in spite of cultural concepts of distress being acknowledged in both the introduction and main body of the DSM-5, their articulation and description are constrained to an appendix and are left out of the taxonomy of mental disorders, thus challenging the idea of universal diagnostic categories.

The classification of mental illnesses represents an old tradition in psychiatry. According to Goldstein (1987), 'console' and 'classify' are the two founding principles of modern psychiatry from the eighteenth century onwards. 'Consolation' grows out of a religious tradition, while 'classification' emerges from the scientific inclination of psychiatry as a profession and its need for a reliable diagnostic system (Fassin and Rechtman 2009). The DSM and the International Classification of Disease (ICD) are classification systems allowing mapping of the psychiatric and medical domains, and the role of diagnosis is to determine a patient's location within the category borders represented by the system of classification. The borders of the classification can be seen as products of history and are changeable according to the prevailing theories of illness and attributions of causality at the time. However, classificatory systems are useful tools because they enable communication between practitioners, and with their patients and families, are used to indicate specific clinical interventions, and hold predictive and added forensic value. In the decade prior to DSM-5's publication, Thomas Insel, former Director of the National Institute of Mental Health (NIMH), expressed the hope that the forthcoming manual would classify and diagnose disorders based on biomarkers, such as disorder-specific brain activity patterns or chemical and structural changes. Therefore, it is little surprise that cultural concepts of distress are left behind in the DSM-5. A second statement, issued jointly with

the NIMH's president-elect, stressed that the DSM remained a key resource, but still insisted on the need for a diagnostic system that more directly reflects modern brain science. However, this remains an aspiration, which may be premature given current knowledge of the brain and the aetiology of mental disorders. The number of disorders listed in the DSM rose from 106 to 374 between the first and fourth editions; similarly, the criteria by which a diagnosis is reached have grown ever more inclusive. However, only a fraction (about 3%) of DSM disorders today have any known biological causes. Future classifications will certainly need to be based on different premises and better understanding of neurosciences and other disciplines relevant to psychiatric disorders, which are likely to lead to diagnostic systems that map much more clearly onto the functions and dysfunctions of the brain.

Note from the Editors Dr Duncan Pedersen sadly passed away on 26 January 2016 while completing fieldwork in Chile. Duncan died as he had lived—demonstrating a true commitment to promoting understanding about the needs of diverse populations across the globe. He was insightful and progressive in his thinking until the end. Speaking at the final plenary of the 2015 Canadian Conference for Global Health on 7 November 2015, Duncan urged attendees to be more mindful of the effects that larger determinants and structures have on health, and the need to promote social justice in the context of factors such as geopolitical tensions and climate change (http://www.csih.org/en/blog-3/). In an online post in October 2015, Pedersen and Kirmayer highlighted that 'the most serious global disparities in mental health are an intricate part of the forces of globalization and the current crises at the planetary level. Global warming, resource depletion, ecosystem degradation, poverty and social inequalities, violent conflict, war, and forced migration are among the important challenges that are shaped by cultural values and practices on both local and global-scales. This cluster of contemporary problems is part of the web of causes that contribute to the global distribution (and apparent world-wide escalation) of mental disorders and is powerfully shaping the GMH research agenda, which aims to support effective action' (see http://publications.mcgill.ca/reporter/2015/10/global-mental-health-at-mcgill-advancing-a-social-cultural-and-ecosystemic-view/).

At the time of his death, Duncan was finalizing arrangements for the *22nd Annual Summer Program in Social and Cultural Psychiatry* to be hosted at McGill University, Montreal, Canada. The title of the International Advanced Study Institute—the traditional curtain-raiser for the programme—had been confirmed as 'Psychiatry for a Small Planet: Eco-social Approaches to Global Mental Health'. The four central themes that Duncan and his colleagues had

identified for the event were (1) rethinking the politics, ethics and pragmatics of GMH 'from the bottom up' to ensure the voice of diverse communities; (2) the impact of urbanization and the built environment; (3) the implications of forced migration and displacement; and (4) the impacts of climate change on the mental health of populations and communities (https://www.mcgill.ca/tcpsych/training/advanced/2016). Although Duncan's absence was sorely felt by all those who attended the event, the *Duncan Pedersen Scholarship* that was launched at the meeting will help to ensure that his legacy lives on, and that for years to come students will be afforded the opportunity to progress the values and principles that he espoused.

The commentary that Duncan had kindly agreed to write for this volume was awaiting his final revisions at the time of his death. With the permission of his family, we have included it in its unfinished form. Duncan's passing on is a great loss for the academic community and, in particular, for those involved in GMH research and practice. He will be sadly missed.

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