

## How ‘evidence-based’ is the Movement for Global Mental Health?

David Ingleby<sup>a</sup>

<sup>a</sup>*Centre for Social Science and Global Health, University of Amsterdam, The Netherlands.*  
Corresponding Author – Email: [j.d.ingleby@uu.nl](mailto:j.d.ingleby@uu.nl)

A central claim in publicity for the Movement for Global Mental Health is that the movement is both ‘rights-based’ and ‘evidence-based’. In this article we focus on the second claim, critically examining the evidence on which the movement’s programme is based. The concepts and methodology of the movement are those of mainstream Western psychiatry, so we first review briefly the inadequacies and inconsistencies of this framework, in particular the problems of identifying, measuring, explaining and treating ‘mental illnesses’. We conclude that the scientific knowledge base of contemporary psychiatry has been gravely distorted by its dependence on financing from the pharmaceutical industry, which has led to exaggerated attention on biomedical theories and treatments with a corresponding neglect of social factors and prevention. Second, we examine the problems of transferring this framework to low and middle-income countries. Adopting a biomedical view enables the movement to evade awkward questions regarding the cultural embeddedness of the issues it deals with and their relation to social, economic and political conditions in these countries. Confident claims are made by the movement about the nature and prevalence of ‘mental illnesses’ across the world, the burden they represent, and the benefits to be expected from tackling them by ‘scaling-up’ mental health services based on Western knowledge. However, cross-cultural psychiatric epidemiology is not sufficiently developed to be able to support any of these claims and the considerable quantities of data that are produced as ‘evidence’ turn out to be largely based on guesswork. The article concludes that Western psychiatry can certainly provide low- and middle income countries with instructive examples – but they are mainly examples of what *not* to do.

**Keywords:** Global mental health, transcultural psychiatry, cross-cultural validity, pharmacological industry, low- and medium-income countries, evidence base

### Introduction

This article challenges the aims and the assumptions of the Movement for Global Mental Health (MGMH). It argues that Low and Middle-income (LMI) countries cannot simply adopt ideas and methods developed in High-income (HI) countries, but need to develop or build on locally relevant approaches based on the particularities of their own situation.

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Moreover, it rejects the movement's claim on its website ([www.globalmentalhealth.org](http://www.globalmentalhealth.org)) and elsewhere that 'two principles are fundamental to the Movement: scientific evidence and human rights'. We will attempt to show that the MGMH, on the contrary, systematically flouts both principles. In this article, we will mainly focus on the movement's *scientific* pretensions.

The MGMH overlooks the fact that current psychiatric nosology, diagnostic procedures, explanatory models and treatments are highly contested, and are only to a limited extent 'evidence-based'. Selective biases operate which reflect powerful professional and corporate interests, as well as other social pressures. In particular, the role ascribed to disorders of the brain in the dominant biomedical model of mental illness is much larger than currently available evidence warrants. Intense controversy also surrounds the effectiveness of drug treatments and the way in which they work. The assumption that mental disorders are essentially biological phenomena is used by the MGMH to sidestep difficult questions about the validity of transferring concepts, findings and treatment methods from one world region to another. The 'evidence base' currently available from LMI countries is extremely flimsy: estimates for these countries of the prevalence of mental disorders and the effectiveness of treatments are routinely made by unwarranted extrapolation from HI countries. In short, countries considering 'scaling-up' their mental health systems would be very unwise to adopt current psychiatric theories and practices without critically examining their scientific validity.

Regarding the claim that the MGMH is 'rights-based', it is certainly true that equal access to high quality care in all countries is a cornerstone of the universal human right to health. The question is: what is high quality care? Moreover, preventing illness and tackling the social determinants of health are today regarded as much more important than simply providing treatment once people become ill. The slogan that accompanied the report of the WHO Committee on Social Determinants of Health (CSDH, 2008) was 'Why treat people only to send them back to the conditions that made them sick in the first place?' Regarding the social roots of mental disorders, present-day psychiatry in general, and the MGMH in particular, are deafeningly silent. The research agenda of psychiatry has been dominated in recent decades by the pharmaceutical industry, which is only concerned with treatment. After all, reducing mental disorders by tackling their causes would in no way serve the industry's financial interests.

The claim by the MGMH to be defending the rights of the almost 6 billion people who live in LMI countries is thus highly questionable. The only obvious beneficiaries of 'scaling-up' Western psychiatry are the pharmaceutical industry and the mental health professions themselves. The movement's claims about the likely benefits for people living in LMI countries are unconvincing. In the HI countries where psychiatry has taken shape, expenditure on mental health services has steadily increased, without any overall decline in the rates of mental illness. Meanwhile, there is increasing concern about the human-rights

aspects of medicalising everyday problems and labelling increasing numbers of people as 'mentally ill'. A thorough examination of the likely risks and benefits should precede any decision by LMI countries to 'scale up' psychiatric services.

No approach which ignores the social roots of mental disorders can be expected to help the inhabitants of these – or indeed any – countries. Leaving aside problems that have a clear organic cause, such as epilepsy or dementia, most of the problems that the MGMH classifies as 'mental, addictive or developmental disorders' are related to deprivation, oppression, stress and violence – they do not simply happen to people out of the blue. As alternatives to the medicalising, depoliticising approach of contemporary psychiatry and the MGMH, other visions are available which focus not on individuals isolated from their social context, but on the *social* dimensions of suffering, resistance and recovery. However, attempts to build up locally valid and relevant approaches risk being wiped out by 'scaling-up' individualistic Western approaches to mental health.

In recent years, ethical standards of good practice have been agreed on by international development organisations to protect LMI countries from exploitation by those aiming to promote their development (e.g. OECD, 2005). Foremost among these ethical standards is the commitment to strengthening existing, locally developed systems which take into account actual needs and contexts, rather than the introduction of systems developed elsewhere. In our view, the current programme of the MGMH takes us back to the era before the importance of this principle was recognised. It is an intrinsically 'top-down' approach, implemented without consultation and informed discussion with the intended beneficiaries about the costs and benefits of the policies proposed and the alternatives available. As Tomlinson & Lund (2012: 2) point out, there is in fact no 'groundswell of community-based advocacy initiatives for mental health' in LMI countries. This is not to say that problems should be left unattended – but a movement based on Western ways of framing the problems is not likely to attract 'grass-roots' support in LMI countries, except from people inclined to view everything Western as modern and status-enhancing. Remedies for the suffering of people in LMI countries must be backed by the people living in those countries and must respect their values and interests, rather than those of professions and industries eager to expand their own activities in this vast and profitable new area.

The rest of this paper will focus on the scientific weaknesses of the MGMH, which are rooted in those of biomedical psychiatry itself. In order to recruit support for improving mental health services in LMI countries, a much broader perspective must be developed. This should pay attention to a wider spectrum of views on the kinds of problems that Westerners call 'psychiatric', in particular work in Transcultural Psychiatry on indigenous approaches. Service users and communities in LMI countries should play the leading role in such a movement; if a contribution is required from HI countries, this should be offered with an appropriate degree of humility. Last but by no means least, a critical reappraisal of the current

state of mental health services in HI countries would also be of great benefit to these countries themselves. Health budgets are under increasing pressure in the current financial crisis, and mental health systems must show themselves responsive to the current wave of criticism if they are to retain – or regain – the confidence of politicians and the public.

### **Scientific shortcomings of the psychiatric knowledge base**

It is hard to deny that the scientific ‘state of the art’ in psychiatry lags far behind that in most other medical disciplines. This is not necessarily a criticism of the discipline itself. One could argue that its task is a more difficult one, because mental health problems are more complex and harder to unravel than most medical disorders. In addition, psychiatry has never enjoyed the same level of public research funding as other disciplines. Whatever the cause, however, psychiatry’s scientific underdevelopment means that an appropriate degree of modesty is called for when claiming that it has the answer to the problems of LMI countries. Such modesty is conspicuously lacking in statements by the MGMH.

Disagreements and controversies are endemic to the field of mental health, though this in itself does not make the field ‘unscientific’. What *does* make contemporary psychiatry unscientific is its reluctance to engage in open debate about its fundamental assumptions. Some of the most powerful bodies in psychiatry seem at times to wish to avoid critical scrutiny altogether. A recent example of this is the extraordinary lack of transparency surrounding the fifth revision of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA). Attempts to suppress criticism backfired, resulting in a high-profile media circus in which opponents of the revisions battled publicly with the Association’s highly-paid public relations representatives (Frances, 2013).

### *The identification and diagnosis of ‘mental illness’*

There is a crucial conceptual difference between ‘mental illness’ and ‘physical illness’. In the case of most physical illnesses, the defining features are objectively identifiable biological phenomena. In contrast, as First (2010:695) puts it, ‘not one single laboratory marker has been shown to be diagnostically useful for making any DSM diagnosis’. As the Chair of the DSM-5 Task Force, in a remarkable display of honesty, admitted: ‘We’ve been telling patients for several decades that we are waiting for biomarkers. We’re still waiting’ (Kupfer, 2013: online).

Of course the criteria for *all* kinds of illness, whether mental or physical, include a normative component, because societies only regard deviations from normality as ‘illnesses’ if they cause unacceptable impairment of function (disability) and/or suffering. Because there is

room for disagreement about what constitutes ‘acceptable’ disability and suffering, the precise criteria for physical as well as mental illnesses are always influenced by value-judgements (Sedgwick, 1982). As one would expect, groups who lead a relatively comfortable life tend to have a lower threshold of tolerance for health problems than those used to hardship. However, this does not alter the fact that the distinguishing features of a physical illness can be defined in objective, biological terms.

This is not the case for most mental disorders, which manifest themselves in *unusual cognitions, behaviour or feelings*. The problem is that considerable variations in these three functions can result from occurrences and life events unconnected with illness. Extremes of sadness, despair, fear or anger may arise simply as normal responses to abnormal situations. Stress can also influence cognitions and, as the ‘hearing voices’ movement has demonstrated, ‘abnormal’ thoughts and perceptions are quite frequently experienced by many people whom nobody regards as mentally ill (Romme & Escher, 1989).

This is why the ‘intelligibility criterion’ is crucial in psychiatry (Morgan, 1975; Ingleby, 1982). It is always necessary to judge whether a given reaction is ‘understandable’ or ‘makes sense’ in the context in which it occurs. Might a perfectly normal individual react in the same way? Could the so-called symptoms be a normal reaction to an abnormal situation? DSM-5 continues in the sensible footsteps of its predecessors when it says that ‘an expectable or culturally approved response to a common stressor or loss, such as death of a loved one, is not a mental disorder’ (APA, 2013: 20). This makes human judgement an essential ingredient of any psychiatric diagnosis. ‘Mental illness’ thus refers to unusual thoughts, behaviour or feelings which (a) are regarded as not ‘making sense’ in the context in which they occur and (b) cause unacceptable disability or distress. Such a definition seems to cover the way most lay people understand the term, as well as most mental health professionals - until recently (cf. Wakefield, 1992).

However, in recent decades there has been a drive in psychiatry to replace this traditional definition by one based on the assumption that *all* mental disorders are in reality brain disorders – in other words, to abolish the distinction between mental and physical illnesses altogether. The problem with this view is that despite an enormous volume of research in disciplines such as neuroscience, neurochemistry and genetics, it has still not been possible to identify biological criteria for the mental disorders traditionally recognised by psychiatry. Confronted with this fact, biological psychiatrists tend to argue that more time and effort is needed: we are on the threshold of making the necessary breakthroughs, but we are not quite there yet. This, however, puts the claim that modern psychiatry is ‘evidence-based’ in a totally different light. The central assumption of the biomedical paradigm - that mental disorders are really brain disorders - turns out to be an article of faith rather than ‘evidence-based’. Moreover, the evidence that we *do* have makes it highly unlikely that existing classification schemes will ever be found to correspond to distinct neurological or genetic

abnormalities. Therefore, if LMI countries devote their precious resources to interventions based on existing diagnostic categories, they must expect that further investments will be required to realign the mental health system with a new system of biologically-based categories, if and when such a system is developed in the future.

*Measuring the prevalence of 'mental illnesses'*

As we have seen, classification systems in psychiatry are subject to frequent changes in which empirical evidence plays at best a partial role; moreover, individual interpretation and judgement is necessary to make any diagnosis. Perhaps the most widely publicised recent illustration of the uncertainties surrounding diagnosis was the inability of expert psychiatric witnesses in 2012 to reach agreement on whether the Norwegian mass murderer Anders Breivik was mentally ill. Here, we are talking about diagnoses made by psychiatrists in individual cases – but when it comes to establishing rates of illness in whole populations, even more difficulties are encountered.

*Clinical* data on rates of illness (i.e. rates computed from information about patients in treatment) are an unreliable indicator of prevalence in the population, because the number of persons entering treatment bears an unknown relation to the total number who have the illness in question. For this reason, epidemiologists have to devise alternatives to clinical diagnosis in order to estimate levels of illness. In psychiatric epidemiology this usually means asking a sample of the population to answer questions about their behaviour and experience, using standardised questionnaires and checklists. Most of the epidemiological data used by the WHO and the MGMH is based on such methods.

However, as pointed out by Horwitz & Wakefield (2006), these methods omit a crucial ingredient of all psychiatric diagnoses: the judgement as to whether the supposed symptoms are *understandable* in the context in which they occur. As the DSM-5 itself stresses (APA, 2013: 20): “it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis”. A great deal of additional information about an individual patient is required in order to decide whether abnormal behaviour or experience is “a normal reaction to an abnormal situation”. For this reason, questionnaire data can never accurately predict diagnoses, however closely they try to adhere to the diagnostic criteria.

In particular, questionnaires completed by groups exposed to conditions that generate high levels of ‘negative’ emotions and behaviour – such as poverty, hardship, oppression, social exclusion and violence – will suggest a higher level of psychopathology than would be found if due account were taken of the context in which these emotions and behaviours occur (Horwitz, 2007). As we shall see later, this is a particularly relevant consideration when instruments developed in HI countries are used to estimate rates of mental disorder in LMI

countries. Such instruments are not capable of making the crucial distinction between ‘distress’ and ‘illness’. Data collected with these instruments tell us primarily about the prevalence of sadness, despair, fear or anger among the populations of LMI countries, but this can never be a reliable indicator of the prevalence of mental illness.

### *Explanations of ‘mental disorders’*

In psychiatry, the view that all mental disorders have a biological origin has a long history: the ‘father of psychiatry’, Emil Kraepelin, was one of its most fervent exponents. During the twentieth century this approach experienced intense competition from psychological approaches, such as psychoanalysis, behaviourism and humanistic psychology, as well as social-scientific perspectives. In the 1960’s and 70’s, criticism of biological psychiatry from ‘anti-psychiatry’, human rights movements and ‘survivor’ organisations forced it on to the defensive. The field of mental health became a multidisciplinary one, shared by many disciplines and perspectives.

After the 1980’s, however, psychiatry – and biological approaches in particular – made a dramatic comeback. Within mental health services, psychiatry reasserted its dominance; today other professions are allowed to co-exist with it, but strictly in a subordinate capacity. The MGMH is a case in point, being firmly dominated by psychiatrists. Admittedly, psychological therapies are accepted as an adjunct to medication, and sometimes even on their own; they represent the ‘human face of psychiatry’, answering to patients’ wish to be listened to, but they are seldom seen as tackling the fundamental problems. Moreover, they are often seen as too expensive, particularly for settings with few resources. Much of psychology, in fact, has been replaced by neuroscience, while American psychologists have been lobbying since 1984 – not without success – to be allowed to prescribe psychotropic medication.

We do not wish to deny that a mass of evidence has been accumulated, using advanced techniques such as structural and functional neuroimaging, pharmacological studies and the analysis of neuroreceptors, showing that variations in behaviour and experience are accompanied by variations in brain processes or activity (see e.g. Charney *et al.*, 2002:42-52). However, this only confirms that behaviour and experience are *mediated* by the central nervous system: it does not mean that the *causes* of abnormal behaviour and experience are to be found in brain disorders. Sigmund Freud, for example, developed alternatives to the organic theories in vogue in his day, without ever abandoning his conviction as a neurologist that all behaviour and experience has a neural substrate. In contemporary neuroscience, however, the distinction between correlation and cause tends to be systematically overlooked.

The current dominance of biological explanations for psychological problems can be viewed

as a self-fulfilling prophecy. On the assumption that biological processes are the root cause of mental disorders, vast amounts of money are invested in research into these processes and pharmacological ways of influencing them. Negative results tend not to get published (a phenomenon known as ‘publication bias’), so that positive research results generate even larger volumes of research funding. Turner *et al.* (2008) showed in a meta-analysis that antidepressant studies with favourable outcomes were 12 times more likely to be published than those with unfavourable ones. The bias created by non-publication of negative outcomes artificially inflated effect sizes in the published literature by one-third. Conversely, for psychological and social approaches a downward spiral can be observed: reduced research funding lowers the chance of building up adequate evidence about these approaches. As a result, they are classified as ‘not evidence-based’, so that research funding diminishes even further. In the end, only approaches with wealthy financial backers will be regarded as ‘evidence-based’ – which, in the field of mental health, means chiefly biochemical ones.

The key to understanding the dominance of biological models thus lies in the adage ‘follow the money’. Most recent research in psychiatry has been financed by the pharmaceutical industry. Sobocki *et al.* (2006:2691) reported that ‘the total funding of brain research in Europe was estimated at €4.1bn in 2005, of which public grants amounted to less than €900m. Thus, industry funding accounted for 79%’. The picture in other HI regions is probably similar. The investigation of psychological and social factors holds out no promise of financial reward for the pharmaceutical industry and is therefore not subsidised by it. Thus, as well as manipulating published results, the pharmaceutical industry has distorted psychiatry’s knowledge base by financing a mountain of evidence on pharmacological treatments which it is impossible for other approaches to rival in quantity.

A major drawback of this system of health research financing is that commercial sponsors have very little interest in prevention (except perhaps when expensive vaccines are involved). From this it is clear that the recent shift from public to private funding of scientific research on mental health has had disastrous consequences for the development of knowledge – as indeed it has in many other areas of science. Instead of pursuing promising results and challenging hypotheses, research follows the trail of larger profits for its commercial sponsors. As a result, far less attention is currently paid to non-biological approaches to mental health than 40 years ago. Psychological approaches, if they are not themselves biological, are represented by little more than ‘cognitive behaviour therapy’ (CBT). This is not necessarily because other approaches are less promising – chiefly, it is simply because they are starved of research money. As Anestis (2009: online) put it, ‘for the vast majority of mental illnesses, some form of CBT is considered to be the front-line empirically-supported [psychological] treatment. There is one reason for this - few other forms of psychotherapy are being researched at all, or at least in the manner necessary to be classified as empirically supported’.

If an intervention does not further the interests of a wealthy sponsor, it will have great difficulty in acquiring the status 'evidence-based'. For this reason community-based interventions, for example, stimulating citizens' participation in solving their own problems, are seldom adequately researched. Research to identify 'good practices' should as far as possible be financed and carried out by bodies that are not themselves involved in the practices being investigated. The decline in the volume of publicly-financed research means that this is seldom the case.

The bias created by commercial research financing affects not only the topics that are researched, but also the research methods used. The positivistic, quantitative methods that are suitable for biomedical research are not the only ones that deserve the label 'scientific' – yet it is their norms which, mainly by sheer force of numbers, have come to dominate research on mental disorder. Interpretative, qualitative methods such as those employed by many social scientists and psychologists are a handicap for researchers trying to publish in high-impact journals. Yet only these methods are capable of investigating communicative processes and human interactions governed by frameworks of meaning, which is essential for understanding the working of health systems and many other areas of human life.

### *The effectiveness of treatments*

As we have seen, both theoretical studies and treatment evaluations in psychiatry show a self-fulfilling tendency. Because negative results tend not to get published, simply spending more money on investigating a given approach will be likely to improve the 'evidence base' for it. Such 'publication bias', however, is not the only way to distort research results and influence scientific opinion – indeed, the pharmaceutical industry's advertising budget is much larger than its research budget. A great deal of money, effort and creativity is deployed to ensure that positive effects of drug treatment are exaggerated and that evidence about damaging side-effects is suppressed. These range from advertising, through sponsoring of professional activities, to monitoring and manipulation of clinicians' prescribing behaviour. Drug companies provide psychiatrists with research contracts, lucrative part-time work and free gifts (Scharfstein, 2005), on a scale which exceeds that in any other medical specialities.

Thus, although pharmacological treatments are often only slightly more effective than placebo treatment (if at all), this fact is masked by the manipulation and selective reporting of results (see e.g. Moncrieff *et al.*, 2005; Turner *et al.*, 2008. In a study by Kelly *et al.* (2006:1647), 'favorable outcomes were significantly more common in studies sponsored by the drug manufacturer (78%) than in studies without industry sponsorship (48%) or sponsored by a competitor (28%).' Many treatments also have dangerous side-effects, about which evidence is suppressed. On 2<sup>nd</sup> July 2012 the *New York Times* reported as follows:

In the largest settlement involving a pharmaceutical company, the British drug-maker GlaxoSmithKline agreed to plead guilty to criminal charges and pay \$3 billion in fines for promoting its best-selling antidepressants for unapproved uses and failing to report safety data about a top diabetes drug, federal prosecutors announced Monday. The agreement also includes civil penalties for improper marketing of a half-dozen other drugs' (Thomas and Schmidt, 2012).

Manipulation of research findings by pharmaceutical companies is far too large a topic to cover adequately here, but it is important that LMI countries should take full account of the pharmaceutical industry's track record of unscrupulous corporate greed when deciding whether to trust the knowledge base it has helped to build up. Recent scandals may well encourage the industry to curtail its most blatant practices, but the corruption of the psychiatric knowledge base has already taken place.

Even if all traces of manipulation and bias were somehow to be eradicated from psychiatric research, problems would still remain over the interpretation of results from clinical trials of effectiveness. Firstly, there is the issue of the 'external validity' of these trials. To what extent can we assume that the results reported will be found in practice? As Rothwell (2010:94) observes, the effects of interventions 'will often depend on factors such as the characteristics of the patient, the method of application of the intervention and the setting of treatment'. Favourable results obtained in a clinical trial may not be replicable in practice. Secondly, many treatment methods cannot by their very nature be investigated using the 'gold standard' of randomised, double-blind clinical trials. An inert pill can be substituted for a drug in order to provide a control group to measure placebo effects – but what control groups can be devised for psychotherapy or community-based interventions? As Kirmayer (2012:250) puts it:

...not all interventions lend themselves to RCTs. Psychosocial interventions may be difficult to standardize (though there are now fidelity measures for many psychosocial EBPs), randomize (because they must be tailored to individuals), and blind (because psychosocial treatments may require explicit awareness, engagement, and commitment from patients for efficacy)

What should we conclude regarding the effectiveness of psychiatric treatments in general? Results vary widely according to the conditions studied, but for many common conditions, as well as psychotic disorders and personality disorders, the effectiveness of drug treatments is far more limited than their proponents usually suggest. When allowance is made for publication bias, such treatments often produce outcomes that are hardly more favourable than placebo treatment. A major study of antidepressant effectiveness called STAR\*D (Sequenced Treatment Alternatives to Relieve Depression),<sup>1</sup> costing \$35 million, showed that 'anti-depressants and CT [CBT] fail to result in sustained positive effects for the majority of

people who receive them' (Pigott *et al.*, 2010:277). In addition, many widely-used drugs in psychiatry appear to have a palliative rather than a curative effect; rather than being specific to particular conditions, they have a wide range of applications (Moncrieff, 2008). They may make it easier for people to live with their problems, but the mechanism by which they do so may not be very different from that of non-legal drugs, religious rituals and folk remedies.

Another way in which we can examine the effectiveness of psychiatric treatments, in particular pharmacological ones, is by looking at the mental health of whole populations.

- In the USA from 1988–1994 through 2005–2008, the rate of antidepressant use in the United States increased by nearly 400% (Pratt *et al.* 2011). In roughly the same period (between 1991-1992 and 2001-2002), the prevalence of major depression among adults more than doubled (Compton *et al.*, 2006).
- In Australia, Jorm (2011:444) showed that although treatment availability has increased greatly since 1997 and unmet need has been reduced, figures on population mental health 'do not show an improvement and possibly some worsening'.
- In the UK, Brugha *et al.* (2004) examined trends in service use and treatment between 1993 and 2000. They found a fourfold increase in the use of antidepressant medication (cf. the figures just quoted for the USA), but hardly any increase in the provision of psychological interventions. In the same period the prevalence of mental disorder did not significantly change. The authors conclude (*ibid.*, 378) that 'widespread increased prescribing of psychotropic medication has not improved the mental health of the nation'. They also emphasise that prevention is likely to yield better health gains than treatment.
- In Iceland, the effect of a ninefold increase in antidepressant sales between 1975 and 2000 was not associated with reductions in either suicide rates or out-patient visits (Helgason *et al.*, 2004).

Of course, several alternative interpretations are possible for the failure of increased drug consumption to improve the population's mental health. Perhaps a reduction in the rate of disorders has been masked by an increasing readiness to complain about psychiatric problems and seek treatment for them, and/or by a worsening of risk factors for mental disorders (though it is not clear what these might be). A more alarming explanation is the iatrogenic hypothesis put forward by Whitaker (2010), who claims on the basis of reviewing many studies that although psychiatric medications may be effective over the short term, they increase the likelihood that a person will become chronically ill over the long term. Whatever the correct interpretation, LMI countries should not assume that scaling-up psychiatric services will lead to any dramatic improvements in population health.

*How scientific is psychiatry?*

It would be going too far to call psychiatry a ‘pseudo-science’ simply because of continuing unresolved controversies surrounding mental disorders. What does seem indisputable, however, is that the understanding and treatment of such disorders are still at an early stage of development. This is not just due to lack of time and money: it is because psychiatry’s research agenda has been distorted by vested interests. The decline of public financing for research and its replacement by commercial sponsorship, which is an important part of the neo-liberal political agenda implemented in many countries since 1980, has inevitably been accompanied by a reduction in the quality and diversity of scientific research. Scientific curiosity seldom leads researchers in the same direction as the search for profit.

As we have seen, much research on the effectiveness of pharmacological treatments is biased: a lot of money and painstaking effort has gone into manipulating results in this area. Moreover, the domination of psychiatry by the pharmaceutical industry has generated an additional kind of bias in the form of ‘agenda setting’ (Gosden & Beder, 2001). All this has stunted the development of psychiatry by suppressing approaches that offer an alternative to the biomedical paradigm. There is a lack of healthy controversy and balance in the perspectives adopted. Independent academic research on mental health – which often tackles different questions, uses different methods, and reaches different conclusions than commercially-sponsored research – is relatively scarce. We thus reach the paradoxical conclusion that the large amounts of money devoted by the pharmaceutical industry to research have actually impoverished the knowledge base of psychiatry, rather than enriching it.

Only independent financing – or at the very least, funding from diverse sources – is able to create the open arena in which science can develop optimally. Unfortunately, mental health has enjoyed such a low priority on the public agenda that biological approaches have been able to acquire an increasing monopoly of knowledge production in this area. The lesson for LMI countries is that they should beware of basing their decisions on psychiatry’s knowledge base in its present form.

**Can the knowledge base of Western psychiatry be used in non-Western settings?**

A word is in order about what we mean by ‘Western’ psychiatry. In using this term we do not wish to suggest that no psychiatric profession exists in LMI countries. Far from it: the profession has been present in some of these countries, albeit on a limited scale, since the arrival of the colonists. The term ‘Western’ refers to the *origin* of these ideas and practices.

We have seen that the current knowledge base of Western psychiatry is shaky: psychiatric nosology, diagnosis, epidemiology, aetiology and treatments are all riddled with serious flaws. A healthy dialogue between disciplines and paradigms is suppressed, as qualitative research and social, psychological and cultural approaches become steadily more marginalised. Open and critical discussion within the profession is opposed by powerful interest groups, while biased research is endemic. To the extent that the MGMH has uncritically taken over this body of knowledge, it has incorporated these shortcomings in its own approach. Yet even supposing this body of knowledge could somehow be reformed to meet acceptable standards of scientific integrity, the question would still remain: how easily can it be transferred to the very different situations existing in most LMI countries? In this section we will concentrate on the inadequacy of the MGMH's answers to this question. In our view the movement underestimates the difficulties of generalising psychiatric research methods, theories, findings and treatments to LMI countries. It would be untrue to say that it pays no attention to these problems, but we will argue that the adaptations proposed are far too superficial. This is because the movement's basic approach, like that of current psychiatry, is biomedical and universalistic.

The range of problems which the MGMH sets out to tackle is very wide, including 'mental, neurological, and substance use conditions (MNS)'<sup>2</sup>. These are equated with 'conditions that affect the nervous system' (GCIMH, 2010:online), further specified as 'depression, anxiety disorders, schizophrenia, bipolar disorders, alcohol and drug use disorders, mental disorders of childhood, migraines, dementias, and epilepsy'. But what exactly does the phrase 'affecting the nervous system' mean? If it is a synonym for 'having a neural substrate', then it applies to *all* human experience and behaviour: that clearly cannot be the intended meaning. The phrase must mean that these conditions are *caused* by abnormalities of the nervous system – in the same way that we speak of multiple sclerosis, for example, as 'a condition affecting the nervous system'. However, as we have seen, the search for markers of mental disorders in the brain has spectacularly failed to yield useful results. Migraines, dementias and epilepsy may be organic disorders – but concerning the biological causes of the 'mental' and 'substance use' conditions listed above, little evidence has been uncovered. By embracing a biomedical view of all these conditions, the MGMH has committed itself to a paradigm which, as we argued above, is both unsupported by evidence and extremely limited in its therapeutic achievements.

However, the enormous tactical advantage of adopting the biological paradigm is that it legitimates a universalistic approach to mental health problems. Leaving aside variations between gene pools and physical environments, there is no reason why a given biological disorder in Calcutta should differ from the same disorder in Copenhagen. For example, remedies for epilepsy that work in one place are highly likely to work in another. What excuse could there be for withholding such remedies from large parts of the world's

population? Why should we wait to see if they work there? What reason could there be for thinking that they won't?

If it were that simple, critics of the MGMH would indeed not have a leg to stand on. 'Scaling-up' would indeed be all that is required – i.e. making sure that LMI countries enjoy the same treatment provisions as HI countries, and to the same extent. Yet, as the leaders of the movement must know, it is not that simple. For most MNS conditions, no clear organic aetiology has been established: even the widely publicised 'chemical imbalance' theory of depression is not taken seriously any more (Moncrieff, 2008). On the other hand, most of these conditions are intimately bound up with their social and cultural context. Different contexts are likely to call for different methods for preventing and treating them – indeed, they may oblige us to change our view of the very nature of these conditions. The only common denominator in the rag-bag of problems labelled 'MNS' is that they provide the mental health professions and the industries that service them with a huge and unprecedented opportunity to expand their activities in LMI countries, whose population is five times larger than that of HI countries.

In what follows, we will discuss in more detail the shortcomings of the MGMH's universalistic approach to diagnosis, epidemiology, aetiology and treatment. Because the WHO programme on mental health shows a great deal of overlap with the GMH agenda, both in terms of the individuals involved and the ideas and arguments used, most of these criticisms also apply to WHO's activities in this field.

### *Cross-cultural validity*

The question here is which mental disorders are found in different countries and world regions, and what criteria should be used for identifying them. A crucial issue here is the cross-cultural validity of Western psychiatric nosology and diagnostic instruments. A great deal of work on this issue has been carried out within the field of Transcultural Psychiatry. (Despite its name, this discipline does not confine itself simply to 'culture' but also pays increasing attention to socioeconomic, political and historical factors.) Drawing on approaches from transcultural psychiatry, Fernando (2014) offers a wide-ranging review of the issues involved in discussing mental health in a global context.

Both the MGMH and the WHO adopt the same solution to the problem of cross-cultural validity in mental disorders - they simply ignore its existence. The series of articles in the *Lancet* with which the movement was launched (Chisholm *et al.*, 2007) makes virtually no reference to work in transcultural psychiatry. The WHO has a long tradition of ignoring issues of cross-cultural validity, going back to the first International Pilot Study of Schizophrenia (IPSS) in 1973. Of this study Kleinman (1977:4) writes:

Its strength comes from reifying a narrowly defined syndrome affecting patients in nine separate cultural locations, but that is also its weakness. It is unable to systematically examine the impact of cultural factors on schizophrenia since its methodology has ruled out the chief cultural determinants. The homogeneous patient sample in each culture represents a fraction of all cases labelled as schizophrenia in those societies, and excludes all those carrying the most extensive cultural imprint.

The same universalistic approach underlies the *World Health Report 2001* (WHO, 2001), which reads like an exuberant manifesto for the biomedical approach. Although ‘today we know that most illnesses, mental and physical, are influenced by a combination of biological, psychological, and social factors’, the report makes clear which of these is most important: ‘we know that mental and behavioural disorders have a basis in the brain’ (*ibid.* 4). High-tech developments bordering on science fiction can be relied on to clear up the remaining puzzles about mental disorders:

*The World Health Report 2001* appears at an exciting time in the history of neuroscience.... Innovations in brain imaging along with neuropsychological and electrophysiological studies will permit real time cinema of the nervous system at work (*ibid.* 5).

This triumphant ebullience contrasts sharply with the sober conclusions – a decade later – of First (2010) and Charney *et al.* (2012), and the decision of major pharmaceutical companies in 2010 to disinvest from the field of neuroscience (Nutt & Goodwin, 2011a, 2011b) because of its failure to produce an adequate return on investment.

### *Epidemiology*

The data in the WHO 2001 report concerning the prevalence and burden of mental disorders came from the Global Burden of Disease (GBD) study (Murray & Lopez, 1996). The biomedical bias of the GBD study is made clear by its decision to classify all mental disorders as ‘neuropsychiatric conditions’. In order to estimate the prevalence of mental disorders world-wide, standardised symptom checklists such as the CIDI (Composite International Diagnostic Interview) were used. However, several sources of bias may contaminate results when such instruments are used to identify people suffering from mental disorders:

- As we noted above, these instruments collect no information about the context in which symptoms arise and therefore cannot distinguish between illnesses and ‘normal reactions to abnormal situations’ – for example, between ‘illness’ and ‘distress’. As

Horwitz (2007) points out, people more exposed to distressing life events will therefore be automatically more likely to be classified by checklists as ‘mentally ill’. The risk of medicalising normal, healthy reactions to situations that cause distress is therefore inherent to such instruments.

- As we also saw, a fundamental criterion of ‘illness’ is the seriousness of the condition. When estimating the degree of seriousness, no matter how precisely a researcher tries to define the intensity of suffering (e.g. by asking people how many times a day, how loudly and for how many minutes they cry), there will always be a strong subjective element. People used to suffering and accepting it as inevitable will be less likely to express their pain than those accustomed to a life of ease. In LMI countries, this bias is likely to work in the *opposite* direction to that mentioned above. Putting it simply, the hard conditions of life in LMI countries may be expected to cause more suffering, but an attitude of acceptance may lower the tendency to complain about it.
- Considerable cultural differences are to be expected in the meanings that supposed symptoms have for respondents and the extent to which they will be prepared to talk openly to strangers about them.

Further problems concerning cross-cultural validity will be discussed below. However, because it starts from a universalistic, biomedical view of mental disorders, the WHO 2001 report had no qualms about announcing (p.x) that ‘about 450 million people alive today suffer from mental or neurological disorders or from psychosocial problems such as those related to alcohol and drug abuse’ – as if this were no more problematic than counting the number of people with only one leg.

In that report, depression (defined as a ‘unipolar major depressive episode’ or MDE) was identified as the most common of all ‘neuropsychiatric’ conditions: the WHO’s current point prevalence estimate is 121 million sufferers worldwide.<sup>3</sup> Depression is also considered to be the most burdensome of all diseases in terms of YLD’s (years of life lived with disability), and to rank fourth in terms of DALY’s (Disability Adjusted Life Years). These figures sound authoritative and indeed dramatic, but in view of the present state of psychiatric epidemiology they need to be taken with a large pinch of salt (see Brhlikova et al., 2011).

- Regarding prevalence, sources used in the GBD for different countries used incommensurable methods; for many countries – especially LMI ones - there were no data at all and figures were simply guessed.
- In order to estimate the length of a typical episode of depression, figures from the USA and the Netherlands were assumed to be valid for the rest of the world.
- Regarding premature death resulting from depression, it is virtually impossible to judge how many deaths are directly due to this cause because of comorbidity: for

example, people may often become depressed because they are physically ill. This also makes it impossible to accurately measure impairment or disability.

- The degree of disability resulting from depression of varying degrees of severity was estimated either by an ‘expert panel’, or – once again – by data from a Dutch study (Üstün *et al.*, 2004). It is quite implausible to assume that these figures, or any other uniform estimates, can be relevant to people living in widely varying circumstances all over the world. Moreover, whereas the disability resulting from a physical limitation can be estimated reasonably objectively, this is unlikely to be the case with the effects of a disorder of affect: the cultural meaning and social consequences of mental disorders vary widely.

Since the GBD reports of 1996 and 2000, more data have been collected on mental disorders world-wide and there have been some improvements in methodology. However, even now a thick fog of uncertainty hangs over such epidemiological data. A recent study by Bromet *et al.* (2011) as part of the World Mental Health Survey studied major depressive episodes in 18 HI and LMI countries. This article shows much more awareness of the dangers of bias and differences due to study design than the WHO 2001 report. Rather than talking about aggregate figures for the whole world, Bromet *et al.* point out the often extreme differences between countries. In several previous studies, the highest-scoring countries had prevalences for depression that were up to 33 times higher than in those scoring lowest. However, some of these wide variations could have been due to poor standardisation of methods. The present study was better controlled, but still reported very large cross-national differences in prevalence rates. Twelve-month prevalence in HI countries ranged from 2.2 and 3.0 (Japan and Germany) to 6.6 and 8.3 (New Zealand and the USA). In LMI countries they ranged from 3.8 and 4.0 (Shenzen, China and Mexico) to 8.4 and 10.4 (Ukraine and São Paulo, Brazil). There was no significant difference between the averages in HI and LMI countries (5.5 and 5.9) – indeed, given the large amount of variation within each group - it hardly makes sense to compare them.

The study also examined the degree of impairment that accompanied MDE, and here again there were wide variations between countries. Although the authors puzzlingly state that the study found ‘cross-national consistency’ in the impairment associated with MDE, inspection of their tables shows that in Pondicherry (India) and Japan, recent MDE increased impairment scores by only 1.3 and 1.9 units, while in Ukraine and the Netherlands the increase was far greater - 11.1 and 13.8. Clearly, the assumption that depression is equally burdensome for people in all countries is totally unwarranted. Again, given the large variations between countries in each group, it makes little sense to compare HI and LMI countries in respect of the impairment caused by MDE.

Lastly, Bromet *et al.* examined the influence of socio-demographic factors on MDE. On average, rates among women were twice as high as among men (in keeping with the results

of many other studies), though here too there were considerable cross-national differences. Age and marital status were also important factors – but again, the patterns observed in different countries varied widely. In HI countries, poverty was clearly associated with depression, but the associations in LMI countries were variable.

One interesting comment in Bromet *et al.*'s report shows how even sophisticated epidemiologists have difficulty in dealing scientifically with response biases related to social and cultural factors. For example, data from Nigeria were excluded from the study 'because of the extremely low prevalence of MDE and other disorders' (Bromet *et al.*, 2011: 13). (The 12-month prevalence of MDE was 1.1, half of that found in Japan.) The justification which the authors give for this seemingly *ad hoc* decision was that 'these low prevalence estimates raise questions about the willingness of respondents in the Nigerian survey to disclose symptoms to strangers or lay interviewers, and the appropriateness of the CIDI structure for that setting' (Ibid: 13). But if these doubts were so strong in the case of Nigeria, why did they not apply, for example, to Japan? And might not the high scores found in New Zealand and the USA also reflect biases generated by the survey procedure?

Despite these flaws, however, the study by Bromet *et al.*, published 10 years after the WHO 2001 report, is far superior to it and shows just how primitive the methodology of that report was. Firstly, Bromet *et al.* demonstrate that there are very large differences between countries in the prevalence of depression, revealing the existence of a large amount of variance that seems much more likely to be accountable for by social and cultural determinants and measurement biases than by biological differences between the inhabitants of those countries. Secondly, the alarming statements in the WHO report about the prevalence of depression and the burden which it represents were made with a degree of confidence which the epidemiological 'state of the art' at the time simply could not justify.

Indeed, it would not be going too far to accuse the WHO 2001 report of crude sensationalism. On p. 30, for example, the report warns that 'the outlook for depression is even grimmer', because in 2020 this condition was projected to represent a higher percentage of the total burden of disease, to become a higher-ranking cause of DALYs lost, and to form (in developed regions) the 'highest ranking cause of burden of disease'. Leaving aside the bizarre method used to calculate DALYs, this statement is highly misleading. The main reason why depression was projected to become a relatively larger problem was that other illnesses were projected to become smaller ones!

The impression we are left with is that the authors of the WHO 2001 report were strongly motivated to 'pump up the numbers' regarding mental disorders. They also presented a grossly over-optimistic view of the effectiveness of pharmacological methods of treatment. In all fairness, it should be said that this took place before the systematic manipulation of results in this research had been discovered and publicised: even allowing for the date, however,

neither the alarmism nor the optimism are justifiable. Nor has the WHO changed its tune since this large-scale fraud was unmasked. What is also striking is that the report's emphasis is almost entirely on treatment: prevention is mentioned in it, but the impression is given that hardly anything can be done on that front. This is not surprising, because recent psychiatric research has been largely financed by the pharmaceutical industry and has therefore paid very little attention to the social determinants of mental illness.

In the wake of the WHO 2001 report, extensive campaigns were launched in many countries to popularise the notion that depression (in particular) was a very common problem, that far too few people were being treated for it, that it was caused by a 'chemical imbalance in the brain', and that a simple course of drugs could usually remedy it. Many of these campaigns, needless to say, were financed by the pharmaceutical industry. Yet the WHO participated enthusiastically in them, and in 2008, launched the Mental Health Gap Action programme (mhGAP) to ensure that such claims gained world-wide publicity.

As Chorev (2012) has demonstrated, the WHO has, throughout its existence, had to perform the delicate task of mediating between a small minority of wealthy nations which largely fund the organization, and the demands of poorer member countries, which hold the majority of votes. The WHO is therefore well used to dealing with 'Big Pharma' and other interest groups that want to keep the focus on expanding the demand for expensive treatments, rather than tackling problems at their roots. (In the interests of balance it should be pointed out that corporate interests are not the only ones which the WHO has had to resist: before the breakup of the Soviet Union, this bloc lobbied vigorously for the export to developing countries of the high-tech specialist facilities of which it was a major supplier.) It is safe to assume that the governments of those HI countries in which the pharmaceutical industry accounts for a large percentage of GDP have also lobbied strongly within the WHO for the promotion of drug treatments. (Of course, 'Big Pharma' is not only a Western phenomenon: the Indian pharmacological industry is reported to have become the world's third largest in terms of volume.)

All the same, it remains puzzling that the WHO gave such uncritical credence to biomedical views on depression. In its defence, one can argue that the weight of scientific opinion around the year 2000 seemed to favour the biomedical approach: even the US National Institutes of Health gave it their backing. Few people at the time could have anticipated that in 2012, a leading pharmaceutical company would have to pay a settlement of \$3 billion to settle criminal charges involving manipulation of data (as discussed earlier). Fortunately, a more critical perspective seems to be emerging, and it is to be hoped that the WHO will eventually take note of it.

## **Conclusion**

Approaches to mental health developed in HI countries are only to a limited extent ‘evidence-based’ and there are many reasons for doubting that in their present form, they will be a sensible way for LMI countries to invest their scarce resources. LMI countries should subject these approaches to critical evaluation and be aware that fundamentally new ones may need to be developed. These approaches must take as their starting-point the experience and understandings of ordinary people living in those countries, not the views of ‘experts’ (even native ones) representing Western psychiatric knowledge and the corporate and professional interests underlying it.

The MGMH presents a vastly over-optimistic view of the level of scientific development in psychiatry. Compared with the state of scientific knowledge in the rest of medicine, our understanding of mental disorders is at a primitive stage and is riddled with contradictions and unsettled controversies. Increasing expenditure on interventions has failed to bring about a reduction of the total burden of mental disorders in HI countries. LMI countries would therefore be ill-advised to implement existing approaches: more creative, radical and locally appropriate strategies are needed. There are important differences between the contexts in which psychiatry has developed and those that prevail in LMI countries. Approaches which have been successful in HI countries, insofar as any exist, are unlikely to be successful in other contexts without drastic modifications. (However, we should not overlook the likelihood that *any* kind of intervention which is tried may have great success due to non-specific or placebo factors. The fact that someone is doing something for them – whatever it is – tends to make most people feel better for a time.)

Contrary to the MGMH’s claim that its proposals are ‘evidence-based’, we argue that most of them are highly speculative, bordering sometimes on what psychiatrists themselves like to call ‘magical thinking’. The movement grossly exaggerates the likely benefits of the interventions being proposed, and in doing so places the interests of those promoting such interventions – in particular, the pharmaceutical industry – above those of the populations receiving them.

Undoubtedly, LMI countries have a lot to learn from HI countries. Many health problems in those countries, both physical and mental, result from industrialisation and urbanisation and have been seen earlier in Europe and North America. However, what LMI countries mainly have to learn from HI countries is how *not* to tackle these problems. In health care generally, the most instructive case is that of the USA, where refusal to take action on the social determinants of ill-health – both mental and physical – combined with an inequitable, inefficient, profit-driven health system, has resulted in the highest *per capita* health costs in the world, combined with a low ranking on most measures of population health. Rather than

repeating experiences in the West, LMI countries should treat them as an object lesson in the paths that lead nowhere.

## Notes

<sup>1</sup> <http://www.edc.gsph.pitt.edu/stard/public/about.html>

<sup>2</sup> According to Bass *et al.* (2012), this term was coined by the WHO to define the scope of its mental health

Gap Action Programme [mhGAP].)

<sup>3</sup> [http://www.who.int/mental\\_health/management/depression/definition/en/](http://www.who.int/mental_health/management/depression/definition/en/)

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