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Welfarist Psychiatry Goes Global

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Introduction

Mental health problems represent a significant proportion of the global burden of disease (~10% disability-adjusted life years) yet receive a disproportionately low level of funding (less than 1% of most countries' healthcare budget) (Patel et al., 2016; Whiteford, Ferrari, Degenhardt, Feigin, & Vos, 2015). The situation is especially fraught in low- and middle-income countries (LMICs). Between 76% and 85% of people with severe mental disorders receive no treatment for their mental health problem in LMICs and untreated mental health problems account for 25.3% and 33.5% of all years lived with a disability in LMICs, respectively (World Health Organization, 2011). Governments from LMICs spend the lowest percentages on mental health worldwide and receive very little support from international aid and NGOs for mental health (Kakuma et al., 2011; Razzouk et al., 2010; Saxena, Thornicroft, Knapp, & Whiteford, 2007). Clinical trials are rarely conducted in low-income countries so the effectiveness of treatments in culturally diverse, low-income settings is largely unknown (Becker & Kleinman, 2013). Furthermore, a lack of appropriately trained health professionals in LMICs undermines the feasibility of a range of therapeutic approaches developed in the Western context (Becker & Kleinman, 2013; Saxena et al., 2007).

This situation has motivated a concerted effort to address global mental health by the WHO, the US National Institute of Mental Health, and the Global Alliance for Chronic Diseases, among others (Collins et al., 2011; World Health Organization, 2013). We argue that a welfarist approach to psychiatry will support this effort better than the dominant Western approach to psychiatry because it provides better tools to negotiate a variety of challenges. These challenges include the risk of entrenching flawed aspects of Western psychiatry in new populations, the neo-colonial imposition of Western mental health norms, reducing stigma towards mental illness, and preventing the use of psychiatry for immoral or political ends. Welfarist psychiatry corrects these significant flaws in the Western psychiatric model, avoids neo-colonialism by indexing aspects of patient welfare to the local sociocultural context, reduces stigma by abandoning the concept of 'normal' mental health, and provides grounds to restrict the misuse of psychiatry by appealing to objective aspects of personal and social well-being.

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We begin by describing welfarist psychiatry before outlining the relevant challenges to improving global mental health and explaining how welfarist psychiatry meets those challenges.

Welfarist psychiatry

Welfarist psychiatry (Roache & Savulescu, 2017) is a theoretical framework for psychiatry intended to replace the current dominant paradigm based on the concept of mental disorder.¹ The American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5) defines a mental disorder as:

A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (American Psychiatric Association, 2013, p. 20)

In welfarist psychiatry, the concept of mental disorder is replaced with the much broader concept of psychological disadvantage (PD). A PD is a stable psychological trait that tends to worsen well-being given the social and environmental context. In contrast to mental disorders, PDs do not necessarily form part of a syndrome, involve no threshold between health and dysfunction, may include socially deviant behaviour, and are not wholly attributable to the individual's 'underlying mental functioning' because they involve a mismatch with the environment. In what follows, we elaborate on the attributes and implications of the concept of PD.

PDs are always a matter of degree and involve no distinction between mental disorder and mental health. This entails that each of us has a variety of PDs, i.e. a range of psychological traits that, if enhanced or improved, would increase our well-being. For example, one might be nervous about public speaking, or overly risk averse, impulsive, stubborn, and so on. Most PDs don't undermine our well-being too seriously but, nevertheless, we could all benefit from enhancing our PDs up to the point that further adjustment no longer provided any improvement in well-being. For legal purposes, it may sometimes be necessary to draw sharp dividing lines: between the ill and the healthy, the guilty and the not guilty, those who must be punished by imprisonment and those not, and so on. However, adopting welfarism would help discourage the belief that such lines correspond to ethically or medically significant divisions. By abandoning a conception of 'normal' health, welfarist psychiatry doesn't distinguish between therapies (that aim to raise sub-normal health to normal health) and enhancements (that raise someone's well-being above normal levels). All effective psychiatric treatment of PDs can be considered enhancement in that all interventions aim to enhance well-being whatever the starting point. If we pair welfarist psychiatry with an egalitarian view of distributive justice (as is typical in healthcare), then we have reason to prioritise the treatment of more severe PDs that have a more serious impact on people's well-being. Therefore, psychiatric resources would still be weighted in favour of treating more severe PDs (including those that we currently recognise as 'mental disorders') but, where cost-effective, resources would still be channelled towards milder PDs that we may not presently count as disorders proper.

PDs are context dependent. For example, the tendency to experience unusually high levels of social anxiety is a relatively severe PD for someone—like a politician—whose lifestyle involves many stressful social encounters but not for someone easily able to avoid such encounters, such as a forest worker.² Likewise, in some cases, having a diminished mental capacity can enhance well-being, for example, a decline in the specific recall of traumatic

¹ The welfarist account of psychiatry is an extension of the welfarist account of disability (Kahane & Savulescu, 2009; Savulescu & Kahane, 2011).

memories of someone with posttraumatic stress disorder may improve their wellbeing (Earp, Sandberg, Kahane, & Savulescu, 2014). For such a person a greater capacity for recall would count as a PD. PDs arise from mismatches between mental traits and the environment; they lack the essentialism of mental disorders that are assumed to be problems of 'underlying mental functioning'.³ From the welfarist perspective, the debate over whether mental illnesses have organic pathologies or are just 'problems in living' is irrelevant. If PDs happen to lack organic bases, the practice of psychiatry remains unthreatened as long as psychiatric methods (whether biological or interpersonal) prove effective in treating PDs.

Which traits are considered PDs and the relative and absolute severity of PDs depends on the conception of well-being the welfarist adopts. It is beyond the scope of the present work to defend a conception of well-being, but any feasible account of well-being must accommodate both subjective and objective perspectives. There is a subjective aspect to well-being because each person has a degree of first-person authority when they describe their subjective state as, say, distressed or content, and in establishing their own goals and values. There is an objective aspect to well-being because people can wrongly identify their subjective states, their best-interests, and the factors that influence attainment of those interests. Objective goods might include social relationships and personal development. For example, a dyspraxic stay at home mother may mistakenly believe that her dyspraxia reduces her capacity to care for the home, thus over-estimating the negative impact of dyspraxia on her well-being. It may be that her dyspraxia actually has no negative impact on her capacity to care for the home. In this case, she would be wrong to see her dyspraxia as a PD (assuming it didn't undermine her well-being in other ways). More seriously, the value this woman places on caring for the home might be an 'adaptive preference' (the phenomenon where people adjust their expectations to their circumstances). She might take herself to have relatively high well-being because she values caring for the home but, had she the option to pursue a profession, she might have enjoyed even greater well-being. Assuming that it is bad for people to live in deprived or disadvantageous circumstances, this indicates that well-being involves more than people's subjective assessments. Another reason not to rely solely on subjective considerations when assessing well-being is that subjective assessments of well-being tend not to be permanently affected either by catastrophe or good fortune. For example, people who become paraplegic suffer an initial decrease in happiness, but after a period of adaptation they report themselves to be about as happy as they were before becoming paraplegic (Kahneman & Varey, 1991); and winning the lottery only temporarily increases winners' happiness (Brickman, Coates, & Janoff-Bulman, 1978). Losing a loved one causes grief, but most people adapt. We want to allow for the possibility that becoming paraplegic or winning the lottery can have a long-term effect on well-being. This requires factoring objective elements into our conception of well-being; for example, allowing that loss of independence, loss of mobility, and increased financial security can affect a person's well-being in a way that does not depend entirely on how an individual responds emotionally to these things, or how happy that individual is. This conception fits with some plausible moral intuitions. For example, there are few who would not strongly condemn a surgeon who, in the absence of reasons making it very difficult or impossible to do so, failed to perform a procedure that could reverse a patient's paraplegia following an accident, and who defended this decision by observing that the patient will, in time, adapt to paraplegia. On the welfarist account, then, judgment as to whether someone has a PD depends on the patient's first-hand reports of their experience and

2 Even traits associated with (statistically) normal species functioning may qualify as PDs in certain conditions. For example, an IQ of 100 may constitute a PD in a culture where the only available jobs are either so boring that they leave all but the least intelligent people frustrated, or so difficult that they are unavailable to all but the most intelligent. Therefore, welfarist psychiatry is quite different to naturalist conceptions of mental illness which take mental illness to be an unnatural impediment to normal species functioning that are, *inter alia*, undesirable for their bearers (e.g. see Boorse, 1975).

3 The welfarist can still distinguish between PDs that are predominantly caused by mental traits and those that are predominantly caused by the environment. Where a mental trait would result in a PD in a wide variety of the environments a person might realistically inhabit, it makes sense to say the PD is predominantly caused by the mental trait and vice versa.

their conception of a good life but also on an objective assessment of the patient's best interests. Clearly, subjective and objective elements of well-being can conflict. What a person most values and their happiness may conflict with their social relationships, or the capacity to develop their talents. It is beyond the scope of this chapter to try to address these fundamental value conflicts. For an evaluation of how different theories manage conflicts between subjective and objective components of well-being see Sarch (2012).

Considerations of well-being determine what counts as a PD, but they do not determine whether a PD should receive psychiatric treatment. The usual conditions of autonomous patient consent and consistency with distributive justice must also be met. Treatment cannot be forced on a patient even if it will increase his or her well-being and the patient might autonomously request treatments that will not address a PD or that risk undermining his well-being. We believe that doctors should accede to autonomous requests for such treatments (where they are legal) because supporting competent patients' autonomy over their bodies and psychologies is more important than increasing their welfare (Savulescu, 2007). However, those who believe that autonomy should sometimes be overridden in the name of welfare could still pursue a recognisable form of welfarist psychiatry. Similarly, different views of distributive justice will also yield variations in which PDs the welfarist should treat.

In addition to these familiar conditions on psychiatric treatment, however, there is a further condition that does not arise for the treatment of mental disorders. Whereas being diagnosed with a mental disorder entails that some form of psychiatric response is appropriate (given patient consent and distributive justice), having a PD underdetermines which institution is best suited to intervene. Somatic medicine, education, politics, and law are all motivated (at least in theory) by the general aim of improving people's lives, part of which involves preventing, mitigating, and treating PDs. Welfarist psychiatry is distinguished from these other fields, not by its aims, but its employment of psychiatric knowledge, techniques, and tools to achieve its aims.⁴ So the category of PD is sufficiently broad that psychiatric treatment is not necessarily an appropriate response or the only appropriate response. This is especially clear when a PD is the result of prejudice. In a homophobic society, for example, being a homosexual is a PD because homosexuality reduces one's well-being in contrast to either being heterosexual in that society or being in a non-homophobic society.⁵ Now, this PD could be resolved by changing people's sexuality with an as yet undiscovered psychiatric treatment (see Earp, Sandberg, & Savulescu, 2014) or by the elimination of prejudice, say through government-sponsored campaigns for gay rights. The welfarist can prioritise the governmental response over psychiatric responses on the grounds of justice; it is prejudiced society that is in the wrong, not the victims of that prejudice, and moral goodness is plausibly an element of objective well-being (Parfit, 1984). Furthermore, sometimes it is worth suffering with a PD because standing up for what is right is worth a cost to one's well-being. That said, the welfarist is more sanguine towards using psychiatry to help victims of prejudice than others might be. If there were poor prospects of alleviating a PD through non-psychiatric means (e.g. perhaps the government is complicit), there were psychiatric treatments that would improve well-being⁶ and that were consistent with distributive justice, and the patient autonomously consented to treatment, then the welfarist position would recommend psychiatric treatment despite the PD being caused by prejudice (Earp, Sandberg, & Savulescu, 2014). To refuse to treat in these cases entails forcing a loss of well-being on victims of prejudice in order to fight prejudice.

4 To avoid circularity here, we can understand 'psychiatric knowledge, techniques, and tools' in the sort of sociological terms described in Cooper (2002).

5 Kahane and Savulescu (2009) have argued that social prejudice should be excluded from the circumstances that are relevant to assessing disadvantageous states but here we follow Zohny (2016) in accepting that all circumstances are relevant.

6 Given that such treatment involves an assault on self-concept it is only likely to improve well-being in inescapable contexts of relatively extreme prejudice.

To this point we have defined PDs as psychological traits that tend to undermine patient welfare. There is, however, another kind of PD – psychological traits that tend to undermine social welfare, e.g. impulsive and violent tendencies. Again, psychiatric treatment may not always be appropriate for such PDs or it may only form part of the response; the judicial system, for example, will often play a significant role. Two kinds of case where psychiatric resources are brought to bear are where a person displays paedophilic or psychopathic traits. In some cases, these PDs undermine the subject's well-being by causing distress but some paedophiles and most psychopaths are happy with the way they are.⁷ Whatever loss of personal welfare paedophiles and psychopaths suffer, clearly these conditions worry us most because of the potential for very serious losses of well-being for others. In fact, even if paedophiles and psychopaths suffered no loss in personal welfare we would still want to consider these PDs. By recognising that social welfare contributes towards whether a condition counts as a PD, welfarism accommodates this intuition. The higher the risk of harm to others, the more severe the PD. When PDs pose sufficient risk to social welfare they can be treated for the benefit of others without patient consent and sometimes the patient may even be justifiably harmed. This concession doesn't necessarily pave the way for psychiatry to be used for morally dubious political ends. The limits of psychiatric power (like judicial power) can be set according to principles guiding the extent to which personal welfare can be overridden in the name of social welfare. Of course, there are disagreements over those principles and over how social welfare should be measured.⁸ These issues are front and centre when (below) we consider whether the West can justifiably limit the ways in which other cultures might want to use psychiatry.

Welfarist responses to global mental health challenges

Inadequacy of the Western psychiatric model

The Western psychiatric model based on the DSM-5 is the default conception of psychiatry that will be applied in the global context. This is because this model has become entrenched in the West and much of the funding and expertise for addressing global mental health will come from Western countries. However, the Western model is widely thought to have some serious flaws that undermine treatment and research which we should avoid passing on to other populations. One widespread concern is that many of the mental disorders described in the DSM-5 don't really exist.⁹ The DSM-5 classifies and diagnoses mental disorders based on symptomatology which gives rise to two serious problems. First, we cannot be sure that we are correctly grouping symptoms together into different kinds of syndrome (Goldberg, 2010). Perhaps, for example, some of the instances of depressed thoughts, feelings, and behaviour that we currently take to be part of the syndrome depression might actually be manifestations of different kinds of syndrome. A second problem is that the syndromes in the DSM have no connection to specific aetiologies and so the DSM syndromes exhibit equifinality and multifinality. In equifinality, two cases with different aetiologies present in similar ways. So when you classify disorders according to how they present, you end up with aetiologically heterogeneous groups that are not helpfully treated in the same ways and that lead research astray (Uher & Rutter, 2012). In multifinality, the same underlying causes of mental disorder present in quite different ways depending on developmental context. When we group cases

7 Accounts of well-being that include objective considerations such as 'moral goodness' (Parfit, 1984) can say that there is a lack of well-being even in cases of happy paedophiles and psychopaths because neither are morally good (at least assuming they act on their harmful desires). If they resist acting on their impulses, then they would retain the objective quality of moral goodness but they would lose out on some well-being through having to struggle to control those impulses. A purely subjective account of well-being would be unable to say what is bad for the patient about being a happy paedophile or psychopath.

8 In general, the Millian harm principle is a good place to start: that the sole ground for interference in liberty (and well-being) is significant harm to others (Mill, 2016).

9 In what follows we focus on the DSM system but analogous arguments can be made against the World Health Organization's International Classification of Diseases system.

according to presentation, multifinality misleads us into dividing similar cases into different groups depowering research and misdirecting treatment. Equifinality and multifinality are problems for any nosology that first seeks valid classifications based on symptomatology and then moves to develop causal knowledge, e.g. Ghaemi (2012), Sinnott-Armstrong and Summers (2019), Banner (2013). The DSM system is also accused of facilitating the unjustified proliferation of new kinds of mental disorders and overdiagnosis because of the lack of a clear threshold between healthy and disordered states (McHugh & Treisman, 2007; Parker, 2005; Singh, Filipe, Bard, Bergey, & Baker, 2013).

The discovery of an underlying physiological pathology that characterised and caused each of the syndromes described by the DSM would go a long way towards resolving these problems. Such a pathology would validate the syndrome, create a clearer distinction between who had a disorder and who didn't, and specify an important part of syndrome aetiology. It would also allow psychiatry to be easily applied in other contexts – if a population displayed the physiological pathology then they would have the syndrome (even if syndrome presentation varied somewhat by sociocultural context). Unfortunately, however, we have had little success in finding these biomarkers despite spending much time and effort searching for them. Nearly all the genetic risk factors we have found for schizophrenia for example, convey comparable risks for bipolar disorder, and for even other conditions such as depression, substance abuse and epilepsy (Insel et al., 2010). Despite this, many psychiatrists wishfully assume that physiological pathologies corresponding to each kind of mental disorder will be found. A growing body of research suggests that this assumption is likely to be false, e.g. (Kendler & Gyngell, 2019). The significant aetiological influence of psychosocial factors is likely to entail that biological factors will be insufficient to explain which disorders develop and even whether a disorder develops (Levy, 2019). To continue to assume that the essential pathologies of each mental disorder are physiological over-emphasises biological factors at the expense of psychosocial factors and encourages the view that psychiatric diagnosis is 'an objective statement of fact' which is best treated by medication (British Psychological Society, 2013, pp. 2–3).¹⁰

So, to some extent, Western psychiatry is likely to be incorrectly pathologising, misdiagnosing, overdiagnosing, and overtreating. Clearly, however, we cannot wait until we have developed a perfect form of psychiatry before we act to improve the treatment of mental illness in LMICs. Therefore, we will have to advance global psychiatry while simultaneously working to ameliorate the negative aspects of Western psychiatry. Welfarist psychiatry can help achieve this because it avoids a range of flaws in the Western psychiatric model.

Although welfarist psychiatry is symptom focussed, it does not make any assumptions regarding how PDs might be grouped into syndromes. Therefore, welfarist psychiatry just sidesteps the problem of correctly grouping symptoms into syndromes such as addiction, depression, bipolar disorder and so on. One might worry that this will mean that psychiatrists will often end up incompletely treating patients by only focussing on the most obvious symptoms of the patient's syndrome but this need not be the case. PDs will be statistically associated with one another so, based on the strength of those associations, the psychiatrist should look for any additional PDs associated with the presenting PD. In this way, the psychiatrist can treat the patient's particular constellation of symptoms without having to commit to labelling the patient with a particular syndrome that might be a poor fit. This leads to another concern that if welfarist psychiatry rejects the evidence-base developed to treat the DSM categories, then it will have to begin treatment design from scratch. Presumably, this would be grossly inefficient because there must be *some* truth in the research based on the DSM categories. The welfarist can, in fact, draw on the existing evidence-base but will do so with caution given multifinality and equifinality. Treatment guidelines developed for DSM syndromes are suggestive but must be taken with a grain of salt given that they have been tested on symptomatically heterogeneous groups of patients and those groups excluded people with similar symptoms but who failed to reach the DSM threshold. Therefore, the welfarist needn't

¹⁰ It is often assumed that pharmacotherapy is the best way to treat physiological pathology but biological pathologies are not necessarily best treated by medication just because they are biological. For example, heart disease might be best treated by exercise and healthy diet.

abandon the existing evidence-base but would support further research to resolve the confusions built into that evidence by the DSM categories.

The dominant psychiatric paradigm is waiting on the discovery of essential aetiology that will 'validate' each kind of mental disorder and it is common to assume that the validating aetiology will be an essential physiological pathology. PDs, in contrast, don't require such validation so the welfarist can get on with enhancing PDs without discovering their essential causes or if they are part of a wider syndrome. That said, the diagnosis of a PD underdetermines the aetiology, the prognosis, and the most effective treatment so the welfarist is interested to discover these characteristics. However, the welfarist does not expect that the causes of PDs will be exclusively or even predominantly biological. The most significant causes may well be psychological and/or social especially since PDs are dependent on sociocultural context by definition.¹¹ Furthermore, it doesn't matter to the welfarist if the causes of a PD are essential to a *kind* of PD, it only matter what is causing *this* PD. This raises the objection that welfarist psychiatry will be inefficient, having to rediscover the causes of each kind of PD again and again. This isn't true, however. Although there is no assumption of that PDs will fall into aetiological kinds from the outset, if PDs happen to fall into aetiological kinds, then the welfarist can take advantage of that by using similar treatments for each instance of the kind. A related concern is that the welfarist might end up inefficiently treating multiple symptoms that are downstream of a root cause rather than the root cause of the PDs. Again, although the welfarist has no preconception that different PDs will tend to arise together in a syndrome with a common cause, if such a syndromes exist, she can detect and address the common causes.

Moving away from the biology-focused disease model and considering instead the entire range of psychosocial factors that combine to reduce well-being, would reduce the current emphasis on medication as the primary means of treating PDs. A PD may be treated by addressing one or more of the biological, psychological, and/or sociocultural factors that contribute to a person's having a PD. The best form of treatment will be the one that best improves well-being. Someone whose high social anxiety qualifies as a PD, for example, could be helped by medication, talking therapy, or a career or other lifestyle change; none of which, in the absence of further information about the patient and his preferences, stands out as the best or most obvious option. That welfarism would widen the range of possible treatments for PDs would be a positive step for patient choice and autonomy. Welfarism discourages the view that a psychiatric diagnosis is always an objective statement of medical fact because well-being is partly subjective and dependent on local norms and social structures. The patient's own evaluation of how her well-being plays a key role in the diagnosis of a PD, and in the choice of treatment. On the welfarist approach, diagnosing a PD would simply not be possible without attending to the individual context of the patient. Doctors would be forced to look beyond the biological aspects of a psychological trait. The welfarist approach encourages doctors to get to know patients, which would be a step towards ensuring that those most in need of expert psychiatric assessment get the attention they require. This increased patient involvement should help address the marginalisation of patients' views, experiences, and cultural context. To the extent that global mental health research already emphasises psychosocial interventions and determinants of mental health it will fit more comfortably within the welfarist framework than the dominant psychiatric paradigm.

Another objection is that, even if welfarism doesn't prioritise pharmacotherapy, it may still worsen overtreatment and exaggerate the global mental health problem (Wakefield, 2007). This is because eliminating the distinction between serious mental disorders and less serious conditions removes one of the barriers to medicalisation (Vilhelmsson, Svensson, & Meeuwisse, 2011, p. 213). Therefore, the welfarist sees opportunities to treat everywhere, including psychological traits above and beyond what we take to be normal healthy function. These concerns are misguided, however. The major concern with overtreatment is that people are receiving

11 As outlined above, even when we restrict ourselves to the narrower category of DSM defined disorders, the empirical evidence suggests that mental disorders are typically caused by a range of interacting factors across, biological, psychological and social levels.

treatments (especially drugs) that are ineffective but welfarism only recommends treatment where it is expected to improve well-being. Welfarist psychiatry has the potential to target treatments to patients better than the DSM system because PDs are personalised while kinds of mental disorder are not. Additionally, considerations of distributive justice would ensure that resources were not disproportionately spent on milder PDs or PDs that would be more cost-effectively treated by other institutions, e.g. the judicial system. Welfarism won't exaggerate the scale of the global mental health problem because it aims to quantify the impact of PDs on well-being. The welfarist uses a continuum of severity so that milder PDs are counted for less and more severe PDs count for more.

Neo-colonialism

Even if Western psychiatry was perfectly calibrated to the Western context there would still be serious problems with the neo-colonial imposition of Western conceptions of mental illness on non-Western contexts (Kopinak, 2015). The DSM diagnostic criteria are a distinctly American construction of mental illness, albeit one that has been largely adopted across the Western world. To the extent that mental illness is different in non-Western populations there will be a mismatch with the DSM system. There is good reason to think that mental illness will be different in non-Western populations because of the genetic and sociocultural variations between populations.¹² As already mentioned, there is a significant body of evidence indicating that the development of mental illness depends on the interaction between specific genetic and sociocultural factors, e.g. characteristics of peer groups and parents, cultural factors like gender-specific norms about smoking, and stressful life events (see for example, Bromet et al., 2011; Kendler & Gyngell, 2019; Tienari et al., 2004).

This data shows that the prevalence and severity of the DSM mental disorders vary by context but we should also expect to see different presentations of those disorders and even different *kinds* of disorder caused by interactions between unfamiliar genetic and sociocultural factors. There is evidence of culturally distinct forms of anorexia nervosa, PTSD, schizophrenia, depression, and social anxiety disorder (Kitanaka, 2012; Watters, 2010). In Japan, for example, Taijin kyofusho appears to be a variant of social anxiety disorder where the sufferer has a fear of offending other people due to appearance or body odour. Perhaps this is created by a culture with a strong normative pressure to be sensitive to others' feelings.¹³ Some syndromes may be sufficiently different from Western disorders to warrant separate diagnostic criteria, for example: 'koro', found in Southeast Asia and Africa, involves a fear that one's sexual organs are disappearing or shrinking; 'amok', found in Malaysia, where sufferers, typically males, withdraw and brood after a perceived slight and then erupt with a frenzy of violence; and 'latah', found in Indonesia and Malaysia, where sufferers exhibit an exaggerated startle response while sometimes exclaiming normally inhibited sexually denotative words, but also often mimic others and readily obey others.¹⁴

A further consideration is that the local norms governing mentally healthy behaviour vary somewhat independently of how psychological traits present. Certain behaviours may count as mentally unhealthy in one

12 Of course, this hasn't prevented studies based on DSM criteria from gathering results in non-Western populations. These studies appear to confirm the relevance of the DSM categories in non-Western populations but, in fact, they simply assume them; they lack the capacity to detect aspects of mental illness that don't conform to the DSM categories and so we cannot know the extent to which those categories distort reality. That said, there are certainly many common features to depression all around the world.

13 There is also some evidence that the form of a disorder changes as the cultural context changes. The researcher Lee Sing contends that that a form of anorexia existed in Hong Kong that wasn't characterized by unhappiness about being over-weight neither did it involve an unrealistic body image. In the mid-1990s this changed when the Western idea of anorexia was introduced by journalists and public health officials alarmed at the lack of preventative programs). Now most sufferers conform much more closely to the Western form of anorexia. (See Watters 2010 for a summary of this research).

14 Despite clinical overlap with Tourette syndrome, it is now recognized as a distinct syndrome (Lanska, 2018).

normative context, but are simply unusual in another, or are taken as a sign of being gifted in another. While there is a large literature on risk factors across regions, it is essential to bear in mind that what counts as a risk factor for mental illness depends on the correlation between that factor and behaviour that breaks the local norms of mental health. If the norms of mental health are different between cultures, then so too are the factors that count as risk factors in that culture. Consequently, people who would never go on to be considered mentally ill by the local populace might be diagnosed as having a disorder or a risk factor by Western standards, while local variations in mental illness and associated risk factors might be awkwardly shoehorned into inappropriate DSM categories or left undiagnosed altogether (Bass, Bolton, & Murray, 2007).

Unfortunately, there are powerful political and economic motivations to impose Western psychiatric norms and categories globally (Singh et al., 2013). Pharmaceutical companies would prefer to sell the drugs they have developed for the Western market to the rest of the world because it is cheaper than investigating whether those drugs are effective in different contexts or developing new drugs (Jain & Jadhav, 2009). Similarly, governments and NGOs want to improve mental health as quickly and cheaply as possible so will be tempted to use the normative frameworks and treatments that are already available rather than spending the time and effort to calibrate them to the local populace. There is also pressure to quantify success in terms that make sense to Western donors and taxpayers. Furthermore, because Western psychiatry tends to assume the source of mental illness is at the level of the individual's biology; this directs focus away from the socio-political contexts that might significantly drive mental illness and makes it the individual's problem (Farmer, 2004; Summerfield, 2012). Therefore, repressive regimes and neo-colonial interests may be eager to embrace this individualising aspect of Western psychiatry for political gain and to the detriment of the local population's mental health. The welfarist approach can help resist these neo-colonial political and economic forces and improve global mental health by rendering psychiatry sensitive to the local norms governing behaviour and the local variations in the presentation of mental illness. Therefore, the welfarist approach should appeal to global mental health practitioners who are rightly concerned with addressing the social determinants of mental illness.

Welfarism is perfectly positioned to prevent neo-colonial psychiatry because PDs are indexed to patient well-being and local patients' well-being is intimately connected with their particular sociocultural, environmental and genetic situation. Welfarist psychiatry is, therefore, open to the possibility that the kind of things undermining or promoting well-being in LMICs may be quite different from those in the West. The local variation in the factors that cause PDs presumably give rise to conditions such as koro, amok, and latah, as well as culturally specific variations on the conditions are familiar with in the West, e.g. Taijin kyofusho. Where these conditions undermine well-being, they count as PDs. Clearly the symptoms of koro, amok, and latah undermine patient well-being and, in the case of amok, social welfare as well. The severity of these PDs depends on the extent to which it undermines personal and social well-being in the local context.

Welfarist psychiatry also accommodates the influence on PDs of the local norms governing behaviour; the welfarist doesn't assume that the Western norms for behaviour are universal. PDs typically develop when individuals consistently breach their society's norms, because individuals who fail to follow norms are exposed to distressing social opprobrium and threat of further sanction. Where these norms differ between cultures, so do the range of behaviours that develop into PDs. For example, in cultures that expect long periods of mourning, long-running depressive symptoms that would be counted as PDs in the West will not cause much concern and so won't be PDs, or will count as less severe PDs. Indeed, to *not* exhibit depressive symptoms throughout the expected mourning period might count as a PD. Likewise, particular patterns of substance use might be PDs in one culture but not another depending on local norms governing intoxication and pleasure-seeking. Cultural differences in value entail that each culture will prioritise the treatment of PDs differently so that, from the perspective of outsiders, it will seem that relatively mild PDs are being treated while apparently more serious PDs are being neglected. These different prioritisations are justified as long as well-being is maximally enhanced in each normative context (within the limits of distributive justice).

Given this sensitivity to local variations in PDs and their causes, welfarist psychiatry highlights the risk of allowing pharmaceutical companies to sell existing drugs in new contexts without clinical testing. Of course, it may be better to allow distribution of drugs despite the risk rather than delay treatment and spend money on clinical trials. Nevertheless, the welfarist account makes this risk clear, whereas those who assume Western conceptions of mental disorders are universal are likely to cause harm through ignoring this risk. Furthermore, welfarist psychiatry is open to the potential efficacy of local treatments (pending clinical trials) given that they may well be more suited to the local conditions.

The welfarist's emphasis on the role of sociocultural context should also help avoid the detrimental power dynamic created when mental disorders are assumed to be inherent to individuals and so be an individual's problem rather than a social problem. Welfarist psychiatry like any form of psychiatry has limited political power. It is better placed to intervene at the level of the individual rather than the individual's sociocultural context. However, welfarist psychiatry doesn't make the bioreductive assumption that PDs develop exclusively at the individual level and so are problems only for, or related to, the individual. So, if certain political policies are causing PDs, welfarist psychiatry can highlight that publicly and can let individual patients know when their PDs are significantly caused by sociopolitical factors.

Avoiding prejudicial and harmful forms of psychiatry globally

Given the fundamental issues with Western psychiatry and the problems of neo-colonialism, we might be tempted to simply adopt whatever conception of mental health and treatment is used locally. This, however, faces the problem that local norms of mental health are not necessarily right, and local treatments are not necessarily effective just because they are local. Such norms might create false mental illnesses out of prejudice or for political ends, e.g. homosexuality, or ignore real mental illness. After all, until 1973, the APA pathologised homosexuality which provided official support for humiliating and traumatic 'conversion therapies'. Even those Western psychiatrists who are suspicious of the DSM categories would feel certain that homosexuality is not a mental disorder. But what are the grounds for this certainty? Similarly, even where the presence of mental illness is not in dispute, the locally preferred means of treatment might, to Western eyes, appear ineffective or detrimental for patients, e.g. untested herbal remedies or spiritual interventions aimed at removing evil spirits. Are there objective grounds on which to exclude ineffective or harmful treatments? If well-being is at least partly objective, this would block objectively harmful treatments. For example, female infibulation might remove the capacity for sexual functioning, which is a part of the good life. Whether or not it is desired, it is harmful on an objective account of well-being, as we will argue in greater detail below.

A related concern is that many LMICs exhibit a strong stigma towards people with mental illness and a disinclination to care for them (Becker & Kleinman, 2013; Olugbile, Zachariah, Coker, Kuyinu, & Isichei, 2008; Razzouk et al., 2010; Shibre et al., 2001). Stigmatized individuals tend to adopt harmful coping mechanisms such as secrecy or withdrawal (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Yet normative pressure and opprobrium, the close relatives of stigma, play an important social role. Sometimes normative pressure results in positive behavioural change and sometimes a society needs to exclude or marginalise dangerous or uncooperative people for social welfare. When individuals' behaviour breaches social norms, what grounds are there to insist those people are mentally ill and require medical treatment when the local population sees them as dangerous, uncooperative and deserving of opprobrium and sanctions? Clearly, we need some objective standard to justify the imposition of norms and practices on other cultures. The welfarist account can provide a helpful solution as we describe below.

The welfarist's sensitivity to local norms raises the risk that the welfarist will accommodate *any* psychiatric practices and norms, even those that are clearly immoral, ineffective, or harmful. Welfarist psychiatry entails a default preference for treatments and norms favoured by the local population because such treatments and norms will tend to be better received, and so result in greater personal and social welfare, than if one insists on disfavoured treatments and norms. However, this default position can be overridden by consideration of

objective aspects of well-being. The best treatments and norms are those that result in the greatest increases in well-being taking into consideration both subjective and objective aspects of well-being. So, the welfarist doesn't assume that patients and local populations are necessarily right in their assessments of well-being and what influences it.

To illustrate these points, reconsider the example where a culture is prejudiced against homosexuality and there is pressure to treat homosexuality with psychiatric interventions. As discussed above, homosexuality would count as a PD in this culture because the attitudes of others would clearly undermine the well-being of homosexual people. This wouldn't, however, necessarily justify psychiatric treatment primarily because treatment requires patient consent (and the patient would have several good reasons not to consent). But, as we have also seen, treatment without consent can be justified when a PD is a threat to social welfare. We can imagine a society where homosexuality is seen as such a threat to social welfare that the society believes the conditions are met to justify treatment without consent. The welfarist can reject this application of psychiatry, however, because this society is wrong that homosexuality risks social welfare.¹⁵ Just as there are objective and subjective aspects to personal welfare there are objective and 'subjective' aspects to social welfare. Social welfare would be undermined because of the distress felt by the prejudiced public based on their false beliefs about the threat of homosexuality but, objectively, homosexuality wouldn't undermine social welfare at all. In fact, social welfare would probably improve if homosexual people were treated as free and equal (and it would improve further if the prejudiced public accepted that).

Another kind of challenging case is where both the local public and the patient favour a form of ineffective, dubiously effective, or harmful treatment. For example, consider a homosexual man who agrees with his local culture's negative assessment of homosexuality and so would consent to conversion therapy if it were available. The objective evidence about these treatments is that they are ineffective in changing sexuality and cause serious harm (Beckstead & Morrow, 2004). In this case, the welfarist should restrict access to the treatment because it is highly likely that the objective harm to well-being will far outstrip the subjective benefit of receiving a favoured treatment. Where favoured treatments only risk a small amount of harm it might, on balance, be worth providing them for the subjective improvement in well-being. Where possible, welfare may be maximised by providing dubiously effective interventions that have a low risk of harm in parallel with treatments that are known to improve objective well-being. The promotion of treatments unpopular with the local culture will be justified to the extent that they are expected to raise objective aspects of well-being sufficiently that it will outweigh the subjective cost to well-being. But, of course, this would never justify forced treatment of autonomous patients.

One might object that the welfarist approach remains neo-colonial because the supposedly objective assessment of well-being will be an inherently Western conception of well-being. In response, the welfarist can readily admit that epistemic humility requires the accommodation of reasonable disagreement over which factors influence well-being and how much they do so. Despite differences between reasonable assessments of well-being, there will be significant consensus especially over more serious mental illnesses (Stein, 2012). Nevertheless, some views of well-being will remain unreasonable. So, it is possible to accommodate different culture's views on well-being while still ruling out certain psychiatric practices and norms that would be bad for well-being on any reasonable view. Of course, this raises the issue of what counts as reasonable but we cannot do justice to that debate here.

¹⁵ When working in such a society it might be tempting to appeal to the DSM position that homosexuality is not a disorder. Although this might be an expedient solution, it comes with the significant downside of reifying the authority of the DSM when there are serious concerns that it undermines good psychiatry. Of course, one might only appeal to the DSM when it happens to align with immediate goals and otherwise ignore it but such inconsistency undermines credibility.

Finally, welfarist psychiatry should help to reduce stigma against people with mental illness both in LMICs and the West. On the welfarist model, there would not be a well-defined group of ‘mentally ill’ people to stigmatise and there would be fewer accurate generalisations about what those diagnosed with PDs are like. This is because we all have psychological traits that, to a greater or lesser extent, make our lives worse given the environments we inhabit, and which limit the realisation of our potential. These may be as debilitating as severe depression or as mild as a tendency to procrastinate. Whilst this is unlikely to eliminate stigmatisation and discrimination—these attitudes hardly require accurate generalisations about those at whom they are directed—emphasising that PDs affect us all would be a step towards breaking down the perceived divide between the mentally ill and the normal. Treating people with stigma is not usually the result of careful reflection, however, it might be the case that certain populations would prefer to treat the mentally ill with stigma rather than psychiatric care. After all, many in the West continue to feel that addiction should be met with sanctions rather than healthcare. The welfarist can guide which PDs to treat with psychiatric care and when to use judicial sanctions or stigma based on the impact these interventions have on personal and social well-being. The promotion of psychiatric care for addiction and other PDs is justified where it improves personal and social well-being. For many kinds of PD, judicial sanction and stigma undermine well-being and when they do they would not be endorsed on a welfarist approach.

Conclusion

Welfarist psychiatry can be used to improve global mental health without passing on the problematic concept of ‘mental disorder’, the contested DSM syndromes, and unhelpful bioreductionist assumptions; all of which haunt mainstream Western psychiatry. The welfarist also avoids the neo-colonial imposition of Western norms and treatments on others by being sensitive to the relationship between the patient’s psychological traits and his or her environmental context. This includes sensitivity to the local norms governing behaviour and mental health. There is no assumption that the treatments and norms that have proven effective in the Western context will be effective in other contexts. But neither does the welfarist assume that the local population’s preferences for mental health norms and treatments are ideal just because they have developed in that context. By appealing to objective measures of personal and social well-being, welfarist psychiatry can prevent harmful applications of psychiatry without neo-colonial imposition of the West’s values. Finally, welfarist psychiatry contributes to reducing stigma by abandoning the strict distinction between ‘normal’ mental health and ‘abnormal’ mental illness.

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