DECOLONIZATION OF MENTAL HEALTH? THE EARLY DAYS OF AN ONGOING PROCESS FROM A GLOBAL HISTORICAL PERSPECTIVE[1]

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Decolonizing mental health: an introduction

The goal of this article is to introduce the concept of decolonization of mental health from the study of the beginning of this process during the Cold War. To do so, we have as an object of discussion the emergence of global and local projects in transcultural psychiatry. As main documentary analysis, we selected the final report of the World Health Organization transcultural project that was conducted between 1965 and 1973, entitled *International Pilot Study of Schizophrenia* (WHO 1973). The IPSS consisted of cross-cultural psychiatric research conducted in nine countries (USSR, Czechoslovakia, Denmark, UK, Nigeria, India, Taiwan, Colombia, and US). Its main purpose was to create a common medical language, through an epidemiological and statistical study about schizophrenia in different socio-cultural contexts. This was the first major project on global transcultural psychiatry of the WHO and it can be considered the beginning of Global Mental Health, not necessarily as we understand it today. Our goal is not to outline the history of transcultural psychiatry, the WHO, or the IPSS. Our interest is to analyse the concept of decolonization of mental health and how it was appropriated by different transcultural perspectives during the first decades of the Cold War.

We understand colonization as a project that extended beyond the territorial and political scope of national and economical disputes around the world. It also affected medicine and mental health in several forms. Colonization, and consequently the processes of decolonization, also took shape in the local and global mental health guidelines carried out in the Anglo-Saxon and Western European contexts. During the Cold War, the local and global projects of transcultural psychiatry, even considering different cultural contexts, were based on the nosographic conceptions hegemonically established by Anglo-Saxon and Central European psychiatry (Beneduce 2019, Mills 2014, Mills & Fernando 2014, Antic 2022). It was the root of a global discussion about the link between culture, society, and mental health.

Decolonization in the field of mental health is understood in our research as an ongoing process consisting in the identification of different nosography, symptoms and treatments that do not fit into the Anglo-Saxon/Western psychiatric

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guidelines (Beneduce 2011, Fanon 2011). The cross-cultural project named *International Pilot Study of Schizophrenia* can be considered the first institutional (WHO) and large attempt to decolonize mental health from a global perspective. However, it was limited for some reasons that we will point out in the next sections of this paper.

Another alternative, which emerged during the Cold War, was the ethnopsychiatry and transcultural psychiatry in Western/Eastern Europe (Sharankov 1947, Petrov 1941), specifically the one that emerged in the Italian context, with which we maintain a closer dialogue so far. Ethnopsychiatry[2] (specifically in Italy, but not only) was formed by concepts from (medical) anthropology, psychoanalysis/psychiatry, and folklore studies from Eastern Europe during the socialist period (Cannarsa 1992, De Martino 2012/1948, 1961). This approach was elaborated as an alternative to the psychiatric interpretations of the time by considering different cultural forms of subjective suffering and treatment for such anguish (De Martino 2013/1961). This field was developed during the post-war period in some countries (Canada, Switzerland, France, Italy, among other small research groups) and it adopted transdisciplinary and cross-cultural investigation in its clinical and ethnographic methodologies. It is an anthropological-psychoanalytical-medical approach that takes into consideration, perhaps more than others, the different cultural aspects in the formation and handling of subjectivity. Ethnopsychiatry is also, for the most part, a clinic engaged in social and extra-clinical aspects. It was an approach that incorporated the decolonization of mental health considering the cultural specificity of healing processes instead of adopting a universal approach such as the IPSS.

Regarding ethnopsychiatry, we are not talking about colonial psychiatry or the "ethnopsychiatry" that was criticized by the Martinican psychiatrist Frantz Fanon (1925–1961). Although Fanon is a chapter apart in the discussions about transcultural psychiatry during the Cold War, it is not possible to discuss the decolonization of mental health without conveying some of his studies (Fanon 2008/1952, 1968/1961).

Fanon was directly linked to the decolonial movements. He was a psychiatrist that studied and considered the subjective and political consequences of such processes of domination and violence. The author argued that colonization projects had taken root in the subjectivity of black people, who always sought to approach

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[2] Ethnopsychoanalysis was the concept used by Hungarian-French anthropologist and psychoanalyst George Devereux (1908–1985) at the beginning of his studies. The author later switched to the term "ethnopsychiatry". As Herzog stated, "Ethnopsychoanalysis can be said to form one crucial tributary precursor to the approaches now more familiarly labelled – in our twenty-first-century moment of massive global migrations, multi-ethnic societies also within the West, and countless public mental health initiatives in both the developed and the developing world – as "transcultural psychiatry" or "intercultural therapy"" (Herzog 2017: 211).

the white-European model as a reference of authority and social model (Fanon 2008/1952, Fanon 2011, Beneduce 2011). It was a colonization of subjectivity that generated traumas and consequences for minorities and non-white populations, based on structural racism and white Eurocentric superiority. This structure was present, above all, in the psychiatry developed in the colonial context.

For Fanon, it was clear that decolonization, including in mental health, was an ongoing process. Important authors in the field of ethnopsychiatry/psychoanalysis today, such as Beneduce (2011) and Cherki (2006), recognize the timeliness of Fanon's studies and the perception that decolonization would be a long process, especially because it ended up taking part of subjectivity and social structures. Nevertheless, Fanon did not focus his project on revenge between blacks and whites, on settling the score of a violent project from the past that still holds its traumas. It was a project of "healing history" and "redeeming the past", focusing on social, political, and medical intervention in the present (Beneduce 2011: 69, Fanon 2008/1952).

The Martinican psychiatrist recognized the importance of Europe in several fields of knowledge and society. However, he criticized European hegemony and the projects that aimed to universalize this "superiority". Specifically in *The Wretched of the Earth* (Fanon 1968/1961), he proposed the construction of new paths, including in psychiatry, that were not under the power of white-European models. Realizing that the "dream" of the colonized was to approach the white-European model (Fanon 2008/1952), Fanon also noticed the importance of the decolonization of subjectivity from this Eurocentric pattern (Beneduce 2011; Cherki 2006).

Although Fanon's studies help us to elucidate the concept of decolonization of mental health during both the Cold War and today, our focus for the present article is on another bias. We intend to understand the roots of the first global institutional projects that timidly contributed to this process of decolonization of psychiatry. We also aim to identify some alternatives that emerged during the same historical moment. The European ethno clinics, as we call them, lead us to a different decolonial project in the same context, although they were still "outsiders" amid the Anglo-Saxon hegemony of the mental health field.

However, we must point out an important difference between these projects, as they were dealing with different conceptions of colonization and decolonization. The global transcultural project from WHO (IPSS) was indirectly criticizing colonial psychiatry, which considered the mind of colonized people as inferior and unable to develop schizophrenia as it occurred in Western societies. An important concern of the IPSS, but also of the WHO, United Nations, and other institutions and researchers at that time (Antic 2022), was to defend the concept of "world citizenship" and consequently the "universal psyche": we are all equal and have the same mental structure, so schizophrenia is universal and could be present in all societies. The decolonial aspect would be in the fact that everyone would have the same psychic structure and, therefore, would be on the same level. A clear opposition to colonial psychiatry (Carothers 1953). This statement would call into question the European (mental) superiority over the colonized populations, and it would "decolonize" mental health from its universalistic approach.

The paths adopted by ethnopsychiatry in its beginnings were distinct.[3] This branch did not focus on the psychic structure as the same in all societies and did not hierarchize them as more developed or less developed. There was an emphasis on cultural specificity, more inspired by anthropological theories instead of aiming at a universal explanation of symptoms and mental functioning (Beneduce & Taliani 2015). Moreover, ethnopsychiatry identified the complexity of other cultural languages used to manage the suffering of the existing, the subjective pain (De Martino 2013/1961, Devereux 1951, 1953). Thus, it proposed not only other languages to treat mental suffering, but this approach perceived these other languages within its epistemological systems, and not necessarily through the hegemonic psychiatric discourse. Due to this epistemological difference, our documentary analysis and core discussion in the next topics will focus on global transcultural psychiatry, especially the WHO project called IPSS.

(Global) transcultural psychiatry and decolonization: the early days of an ongoing project

We can divide the history of Global Mental Health into two moments: its beginning in the 1960s and 1970s from transcultural investigations, and its consolidation as a field of institutional research at the beginning of the 21st century. Our interest refers to this first moment and its connection to the beginning of transcultural psychiatry. Nevertheless, as stated by Wu (2021), what we understand as GMH nowadays is not connected to the "globalized psychiatry" of WHO via IPSS. "In contrast with today's emphasis on local cultures, the WHO's early experts assumed there was universality in mental disorders", in this sense, "Global mental health is an initiative that seeks to detach itself from the hegemonic powers of 'globalized psychiatry'" (Wu 2021, position 4665–4688).

The term "Global Mental Health" as a field of study is a very recent concept dating back to the early 21st century. Although it was used in different historical contexts, such as by David Satcher (Cohen et. al. 2014) in the United States, the concept was consolidated as an international approach through the WHO's World Health Report 2001 and soon after in 2007 through the *Lancet* series *Global Mental Health* (Kohrt 2021). From this *Lancet* call to action emerged the *Movement for Global Mental Health* (MGMH). The GMH "includes clinicians, government policymakers, public health researchers, mental health consumers, and members of development agencies and the World Health Organization (WHO)" (Kohrt 2021: 22). By prioritizing access to mental health care for the largest number of people, GMH has focused its call to action on low- and middle-income countries, although it is not restricted to them" (Gureje & Stein 2014).

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[3] Not just ethnopsychiatry, but also some French transcultural psychiatrists and anthropologists during the post-war period such as Henri Collomb, Jean Rouch, and Roger Bastide (Bullard 2007).

The history of Global Mental Health in its encounters with transcultural psychiatry has coped with issues that are still being criticized by doctors and researchers in contemporary times (Kohrt 2021). Patel et. al. (2014), for example, criticize possible problems that occur in Global Mental Health today: the use of psychiatric categories that are not valid for other cultural contexts; biological interventions that are not very effective given the social causes of health problems; the influence of the pharmaceutical industry in the formulation of medical projects; the possibility of GMH becoming a new form of medical imperialism. We can identify that these issues were already circulating, from different perspectives, in the early debates of (global) transcultural psychiatry and ethnopsychiatry during the Cold War.

During the late 19th and early 20th centuries, we can notice different examples of psychiatric and ethnographic projects that sought to understand the different cultural and ethnic manifestations of mental disorders in societies outside the Anglo-Saxon or Western European world. Even undertaking comparative readings and incorporating diverse cultural groups, there was no global and strategic project focused on mental health as a prioritized public policy at that time. As an example, Cohen et. al. (2014) cite the investigations of Sir Andrew Halliday (1781? – 1839) in Africa, West Indies, and even the work of one of the founders of modern psychiatry Emil Kraepelin (1856 – 1926) in the Dutch asylums in Java. Kraepelin, besides being important for the formulation of the DSM (*Diagnostic and Statistical Manual of Mental Disorders*), noted that "different stages of modernization across societies influenced the presentation of mental illness" (Kohrt 2021: 18).

Other projects were undertaken among colonized populations, and they considered that these groups did not have a mind evolved enough to present the mental sufferings seen in the Western world (Antic 2022, Carothers 1953). Kohrt (2021: 17–18) cites as an example the British anthropologist Charles Seligman (1873 – 1940) and the medical anthropologist W. H. R. Rivers (1864 – 1922) in the Cambridge University expedition in Papua Guinea and Australia. They found out that there was a low rate of mental disorders in the population of these localities. This discovery served as the basis for many colonial psychiatrists that considered these "primitive populations" as having underdeveloped minds not prone to the mental disorders verified in Western societies. We must not forget that even part of the anthropology of the 1920s and 1930s, such as the French anthropologist Lévy-Bruhl for example, provided support for colonial concepts of "primitive cognitivism" (Kohrt 2021: 18).

During the early 20th century, through a methodological mix between Freudian psychoanalysis and anthropology, significant investigations emerged to verify the presence of the Oedipus Complex in different non-Western groups. As an emblematic example, we can mention the "Culture and Personality" interdisciplinary movement that emerged in the USA during the interwar period. Freudian theories, embedded or not in anthropological perspectives, were pioneers in the process of universalizing the human psyche, even before the theorization of the IPSS and other global projects. The approach of the Hungarian psychoanalyst and anthropologist Géza Róheim (1891 – 1953) was used by many researchers at the time to prove that Oedipus Complex occurred even in matriarchal societies, reinforcing the universalism of Freudian studies. Some of his most important works are *The Riddle of the Sphinx, Magic and Schizophrenia*, and *The Gates of the Dream* (Kohrt 2021: 19).

Amidst different projects that considered the universalism of human subjectivity, we can also identify some alternatives that searched for cultural variations of mental disorders even before the large WHO project on schizophrenia. In this sense, as an example, we can mention the beginning of transcultural psychiatry in Canada at McGill University, which started in the 1950s through the work of Wittkower, Prince, the Murphys, among others. The beginning of this research centre in Canada had the participation of European psychiatrists, such as Eric Wittkower (1899–1983), who worked at the Medical/Psychiatric Clinic at the Charité University in Berlin during the 1920s and 1930s.

In this same Cold War context, Michel Foucault's philosophy considered madness as a cultural construct, and psychiatry was seen by the author as a technique of control rather than a cure. These same notions of madness and mental "diseases" as political and cultural constructs can be verified in the work of the Hungarian psychiatrist Thomas Szasz (1920 – 2012) and the numerous anti-asylum movements, specifically in Franco Basaglia's (1924 – 1980) "Democratic Psychiatry" in Italy. These were important formulations in the process of social re-insertion of subjects suffering from mental disorders. They were also important for the reformulation of psychiatry and slightly for the decolonization of mental health as they emphasized the social, political, and cultural aspects in the construction of the so-called "mental illness" (Basaglia 2018/1966; Kohrt 2021).

Regarding the Foucauldian interpretation, which became well known when addressing the history of "madness", there is a different reading elaborated by the historian Megan Vaughan (Beneduce 2011). The French philosopher understood madness through the marginalization and repression of these individuals (discipline and punishment). However, this Western-European model conveyed by Foucault was not verified in the former European colonies and the colonial psychiatry treatises. In the ex-colonies, the medical-psychiatric discourse defined the colonized as a less developed "other". There was not a group of marginalized mad people, but an entire society classified as "different" and less developed. Therefore, repression and violence against everyone was the only thing left (Beneduce 2011).

The examples are innumerable, and it is not up to this article to describe them exhaustively. However, these were not very ambitious expeditions or investigations in quantitative terms. We cannot claim that the aforementioned examples were global projects, despite the attempt to perform a cross-cultural analysis.

We can define the beginning of Global Transcultural Psychiatry as a larger institutional project from the *Cornell-Aro Mental Health Research Project* (1963), "which compared the prevalence and presentation of mental disorders in regions of Nova Scotia, Canada, and Western Nigeria" (Cohen et. al. 2014: 10); and especially from the transcultural psychiatric project developed by WHO named *International Pilot Study of Schizophrenia* (IPSS, 1966 – 1974). The IPSS sought to identify the cultural aspects of the symptoms of schizophrenia in different places of the world (nine research centres), including the Global South and the Global North.

It is interesting to observe that global mental health projects emerged during the Cold War from transcultural psychiatry initiatives, making us question this moment of dichotomization of Europe and the World. Mental health, in this historical

moment, opened an interpretative alternative for the contemporary history of Europe. While there were numerous political and economic conflicts between capitalist and socialist blocs, there was also an intense network of investigations around the world, including Eastern Europe and the Global South. The IPSS project itself is one of the most emblematic examples of the beginning of Global Mental Health in connection to transcultural psychiatry, and it is also the reason why we have adopted it as an important source to discuss the decolonization of mental health.

Because these were projects that developed globally and were intended to be global, we believe that adopting a global historical approach is more than necessary and justified in this case. Global does not mean that some event occurred in the entire world in the same manner and time (Conrad 2016). We might have unbalanced connections, regulated by political, cultural, and economical interests, and history of transcultural psychiatry sheds light on these links. There were unbalanced exchanges between the West and East in Europe, which turned the Cold War into a period of global links. Connections, however, are unequal and immersed in a web of interests and restrictions. The (dis)connections were also internal, in Eastern and Western Europe, and not binary between the "blocks".

Transcultural psychiatry was not the only approach to participate in global, regional or local debates on mental health during the Cold War. Other significant movements emerged to reform the psychiatric system in Europe or even in Global South: the end of the so-called insane asylums, the search for alternatives in the treatment of mental disorders beyond compulsory hospitalization, and the processes of healing based on the reintegration of patients into society. Some examples are: Basaglia's Democratic Psychiatry in Italy (Basaglia 2018/1966), the anti-asylum movements in Latin America (Lüchmann & Rodrigues 2007), or even the psychiatric reforms in Eastern Europe, such as the changes in mental health in Bulgaria analysed by Milenkov et. al. (1991) (Milenkov & Fangerau 2006) and elaborated by the psychiatrist E. Sharankov (1903 – 1997) from the 1940s on (Sharankov 1947).

Many of these psychiatric proposals had common statements, but also different perspectives in some cases. In this sense, a global historical approach must also make its choices, and global, as we already mentioned, does not mean studying a topic worldwide. In this article, we are considering especially the early global and transcultural projects during the Cold War in Europe, which approached the issue of decolonization of mental health, not necessarily advocating it directly.

IPSS and its specific connection with decolonization

Our interest here is not in the history of the IPSS or the WHO, but in the analysis of the final report to understand the epistemological basis of the project through the dissemination of its results and limitations. A study of the entire IPSS would require an analysis of the research centres in the nine countries and an investigation of the minutes of meetings and debates at the headquarters in Geneva. The documentary analysis is restricted to the final report published in 1973 and it will be analysed to understand how the project collaborated (or not), through its results and conclusions, to the discussion on decolonization of mental health.

We will conduct a brief analysis of the final report of the *International Pilot Study of Schizophrenia*. To do so, we will take into consideration the documentary analysis, as well as what was discussed by Antic (2021, 2022) and Wu (2021) in their recent publications. We understand that in official documents such as this, ambiguities, contradictions and debates are not presented, or are presented mildly. IPSS results were obtained from a defined methodology that was following WHO's purposes at that time. With these limitations in mind, we can move on to a historical analysis of the material, using as a reference point, particularly, the debate on decolonization of mental health.

Although our interpretation moves toward what was developed by Antic (2021) and Wu (2021), we have some considerations to raise that may differ from the analysis made by these historians. The IPSS and the ICD-9 (International Classification of Diseases) were the main achievements of a WHO's ten-year investigation named "International Social Psychiatry Project". The IPSS, part of this ten-year project, was an initiative within the scope of social and epidemiological psychiatry, based on the search for a common language among professionals to cope with mental disorders. Schizophrenia, in this case, received special attention. The WHO, not only in its mental health projects, had as one of its pillars the classification (the ICD for example, but not only), the prevention and control of diseases and mental disorders. The institution emerged as a promoter of global health, although at that time the concept was not used as we understand it today, either as Global Health or Global Mental Health. The WHO is the institutional root of Global Health, and the IPSS represents, in our reading, the institutional roots of GMH.

We might have a different reading regarding the process of decolonization of mental health as stated by Antic (2021, 2022). The concern in searching for a "universal psyche" from the IPSS was more related to an attempt to create a common language among mental health professionals in different cultural contexts than to criticize colonial psychiatry directly or to prove the universality of human mind. Colonial psychiatry, by considering the low levels of mental disorders in former European colonies (Carothers 1953, Beneduce 2011), ended up conveying a difference in the minds of the colonized by emphasizing that they did not have an advanced mental structure as the Europeans, and therefore manifested less mental illness. This hierarchy of psychic structures, typical of Carothers' colonial psychiatry, seems to be an indirect achievement of the project.

Thus, the project's implication in the decolonization of mental health from a search for the "universal psyche" seems to be more related to a classification, to a common language among psychiatrists from a symptom-based perspective. "Decolonization" would be an indirect achievement of the project, not an epistemological basis or one of the central goals. By concluding that schizophrenia occurred in similar ways around the world, considering Global South and Global North, we may conclude that the human mind is the same, with cultural and social variations that could accelerate or increase the rate of mental disorders. It was an indirect attempt to decolonize the superiority of the white European mind from this concept of "universal psyche", denying the biological superiority of human mental structure. However, the same could not be said for cultural and social aspects. The following excerpt from the final

report, from the topic "Social and cultural factors influencing diagnosis" regarding "functional psychosis", incited such a debate in my analysis:

> „Finally, and particularly important in international comparisons, social and cultural influences on the clinical picture have an important effect on diagnosis. Clinical practice is rather variable in respect of these. For example, a West Indian man who had recently arrived in England, who belonged to a religious sect that practised some form of voodoo, and who had a poor command of English and perhaps a low intelligence would be likely, if he became excited or depressed, to present a clinical picture very different from that presented by a well-educated Englishman. The diagnosis would also be more likely to be schizophrenia" (WHO 1973: 34).

This excerpt from the final report is not enough to prove the entire idea conveyed by this WHO project. Nevertheless, in view of what we discussed earlier, we could note a timid process of decolonization of mental health, but not necessarily in the cultural and social aspects. This statement could be evidenced by the adjectives used by the authors to describe the opposition between the West Indian and the Englishman: "low intelligence" and "well-educated" respectively.

The methodological basis of the IPSS is a different approach from that advocated by John Colin Dixon Carothers in his WHO publication "The African Mind in Health and Disease. A Study in Ethnopsychiatry" (1953). This book was reissued in 1970 and had a considerable impact on Western psychiatry (Beneduce 2011). When addressing Carothers' psychiatry, Beneduce states that:

> „Thus was born his "ethnopsychiatry". On the other hand, the author observes, if the cerebral cortex derives from the outer layers of the embryo, as does the skin, why be surprised by the psychological differences between Europeans and Africans when the differences detected in their epidermis seem obvious to us? As in a monotonous psalm, the phrases about impulsivity, the low degree of psychic integration and emotional immaturity, the low capacity for synthesis of Africans also return in Carothers [my translation from Italian]" (Beneduce 2011: 26).

The final report does not present an engaged critique of the ideas postulated by Carothers or by other strands of colonial psychiatry, even though it adopted an epistemology focused on the universality and therefore equality of the psychic structure and schizophrenia. As we mentioned before, it was one of the first global projects of transcultural psychiatry. Therefore, this questioning of Carothers' theories, as well as the idea of decolonization, seem to be indirect criticisms and achievements of the IPSS. We can, however, understand the reasons for it: the IPSS was not designed to be an intellectual critique. Its purpose was to identify and classify the global problems of schizophrenia and mental health. It was a cross-cultural epidemiological initiative with different indirect achievements.

In reviewing the literature on the topic, the IPSS does not deny the biological and psychogenetic aetiology of schizophrenia, however, they do not restrict it to the physical dimension. Nevertheless, some of these social factors were not inserted in a decolonized perspective, and they present a hierarchical conception of cultural development, usually based on the Western European model (low-high education,

for instance). That is the reason why we affirm that decolonization, as an indirect achievement of the project, came from the identification of the similarity of the human mind and schizophrenic symptoms, and not from the different cultural possibilities of definition and treatment of the so-called mental disorders investigated by the IPSS. This last proposition can be found most prominently in ethnopsychiatric studies from the 1950s onward, such as Ernesto De Martino (2013/1961), Risso & Boker (1964), and George Devereux (1951, 1953); or in transcultural psychiatry via Collomb and other anthropologists (Bullard 2007).

Social factors were also important for the IPSS, and transcultural psychiatry was one of the first approaches within psychiatry to incorporate non-biological explanations for mental disorders. In this sense, it was not an exclusive discussion within the IPSS, but a global concern in the transcultural field. The state-of-the-art included in the project explains that no biological or genetic test can diagnose schizophrenia (WHO 1973: 18). Thus, the IPSS considered different aetiological explanations in its reviews, even though this was not the scope of the project: the focus was on symptom-based research and diagnosis. They were not interested in the causes of mental disorders.

This biological pre-disposition of schizophrenia could be triggered by social and cultural phenomena, and therefore could present different symptoms according to the sociocultural background of the patient. Social factors could determine the course of the disorder, such as age, sex variations, drug, alcohol, genetic composition, physical diseases, or malnutrition: "The incidence, course, and prevalence of schizophrenia are therefore likely to vary in different parts of the world simply because of the operation of biological, social, and administrative factors of these types, which are differentially distributed in various populations" (WHO 1973: 29).

The WHO project promoted an idea of the common human mind and medical language, an indirect "decolonization" of the psychic structure by searching for universal symptoms and common psychiatric language. The IPSS did not severely question the cultural and medico-political hierarchization regarding symptoms and etymological classifications of schizophrenia and other mental disorders considered by the project. Nevertheless, we must clarify that it was out of the scope of the project since the core idea was to prove that schizophrenia occurs in global contexts with cultural variation of symptoms. Focusing on cultural specificity would not be a valid methodology for the results they intended to achieve.

The focus of the project is made very clear in the second chapter: it was a symptom-based research, not an investigation of the aetiology of schizophrenia. The report presents a comprehensive discussion of schizophrenia, using as bibliography studies developed by well-known European psychiatrists such as Kraepelin, Carothers, Bleuler, Murphy, Kramer, etc. Although it refers to studies developed in the USSR, such as the Institute of Psychiatry of the Academy of Medical Sciences, the authors and the epistemological basis of the project continues to be the Western psychiatric bias, in other words, USA, UK, and Central Europe. A good example is the standard form used in the surveys, such as the Present State Examination (PSE) related to the Medical Research Council Social Psychiatry Unit in London and developed by John Wing (WHO 1973: 22); or even the diagnostic exercise on schizophrenia held in the

London Seminar (1965) and other US-UK diagnostic studies (WHO 1973: 35).

The principal investigators were of Thai and Germanic-Croatian origin (Dr. T. Y. Lin and N. Sartorius), and many psychiatrists from other parts of the world participated in the elaboration and execution of the project. However, it is noticeable that the perspectives adopted were similar, after all, they aimed to achieve the same goal and unification of the psychiatric language in identifying the symptoms of schizophrenia. The constant meetings and training proposed were important in this process of standardization of the investigation (Wu 2021, position 3048), allying similar results in all nine field research centres (Aarhus, Agra, Cali, Ibadan, London, Moscow, Prague, Taipei, and Washington). Video interviews as well as software for quantitative research were essential for the medico-political project of standardizing results and classifications (WU 2021). However, this unification process did not occur without methodological challenges:

> „In spite of the apparent similarity of many of the crude prevalence rates of schizophrenia quoted for different parts of the world, there is a possibility that these rates are made up differently in different areas (…) Katz et. al. (1969b) have shown that, even where diagnosis is agreed upon, patients from different cultural backgrounds can present with widely different symptom pictures. This could make it even more difficult to develop comparable diagnoses across cultures“ (WHO 1973: 30).

In the process of elaborating the project, which occurred years before its official launch in 1966, Wu (2021) states that its development was not linear. Debates and different opinions circulated in the meetings in Switzerland, the headquarters of the IPSS and the WHO. The position of the psychiatrists involved in the project, whether in meetings at headquarters or local research centres, could vary. The IPSS adopted a very clear methodology, within the framework of social and epidemiological psychiatry, and the participants had to be minimally in agreement with this approach. This does not mean that the health professionals maintained the same stance during their respective careers, inside or outside their countries. To be accepted or simply to be part of the team, some theoretical alignment may have been necessary. This could result in changes in the initial approaches adopted by psychiatrists, especially if they were not under the IPSS methodological guidelines. As Harry Yi-Jui Wu stated, “The Mental Health Unit could not have been successful without a shared ethos among WHO participants and core staff” (Wu 2021: position 3025).

A timid attempt to decolonization: criticism against the IPSS and its universalism

The IPSS came under some criticism in the 1960s and 1970s. The contemporary study of this cross-cultural research also incorporates different readings: sometimes defending the “decolonial” aspect of the project, sometimes understanding it as a problematic universalist discourse, still closely linked to the hegemony of Western psychiatry. The debate is complex and demonstrates many other aspects developed by

authors such as Antic (2021, 2022), Wu (2021), and Onchev (2019). We will prioritize Wu's work because he points out, more than the others, the criticisms suffered by the IPSS in the past and recently.

A key question in this debate between mental health and culture, and one that is still a challenge for mental health researchers, is the following: are we all the same? Do we have the same psychic structure? If this statement is valid, why do patients react in different ways to treatments based on contemporary nosography? Can our subjective suffering be defined by psychiatric classifications?

The IPSS took a clear position on this discussion and worked to achieve this result: a universality of the diagnostic classification of schizophrenia that could be found globally.[4] The organization and development of the project were coined to accomplish this goal, which could be read as an "ideological universalism" (Antic 2022). I prefer, in this case, to talk about "political universalism", since public or institutional health policies incorporate medical as well as political discursivities.

As we have previously discussed, the "decolonization" proposed by the IPSS from its psychic universalism was an indirect achievement of the project and a criticism of the hierarchization of the human mind defended, for example, by Carothers' colonial psychiatry. We cannot forget that he published via WHO, years before the elaboration of the IPSS, his book "The African Mind in Health and Disease: a Study in Ethnopsychiatry" (Carothers 1953). At least in the final report of the IPSS, we do not perceive a severe criticism of this author and colonial psychiatry, even though the universalistic epistemology could be understood as a position of the IPSS against colonial psychiatry's methodology. This example mentioned by Wu (2021) is interesting to comprehend what we have just stated:

> „For example, Edward Margetts (1920–2004), a Canadian psychiatrist who served as an expert consultant for the WHO, developed his interest in using photography to document patients' symptoms while he worked in Western Kenya during the 1950s. The method enabled him to document several conventional treatments of mental disorders there and to frame his theory, which resembled the racial stereotype of Carothers' "African mind" (WU 2021, position 3594).

There was also a very strong scientific concern in placing psychiatric research in the realm of the hard sciences, trying to reach an exact classification of symptoms. The criticisms that Freud suffered during his time with the "discovery of the unconscious", and even after his death in 1939, are emblematic examples. Although Freud adopted a universalistic theory based on the Oedipus Complex, he was widely criticized for his "unscientific" discoveries, since the unconscious could not be validated by

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[4] According to the IPSS, "to develop valid and reliable research instruments for practical use in international psychiatric studies. For this purpose, the selected patients were between 15 and 44 years old, and presented similar symptoms such as: delusions, hallucinations, gross psychomotor disorder, unusual behaviour, social withdraw, "disorders of thinking other than delusions", overwhelming fear, disorders of affect, self-neglect, and depersonalization" (WHO 1973: 399)

neurological and biological examinations. Universalizing theories were not unique to the IPSS. The difference was in the WHO's use of this approach.

Beyond the political aspect of demonstrating the equality of humans, in line with the idea of world citizenship of the United Nations and the WHO, the IPSS was, above all, an effort to create a common psychiatric language that could diminish or exclude global discrepancies in the understanding of mental disorders. In this sense, the new computational and statistical technologies applied to mental health research were fundamental for the standardization and achievement of the results expected by the IPSS (Wu 2021).

For instance, we can cite the USA video-interview technology used by Lin, one of the IPSS's principal investigators. According to Lin, the video could reach better results, being closer to the "truth" due to its capacity to reproduce the reality of patients. Regarding software, we can mention the CATEGO, used by John Wing to categorize symptoms and classify mental disorders, among others such as Spitzer's DIAGNO (Wu 2021). Some of the criticism received was from the Hungarian Dr. L. Angyal during the fourth session of the WHO classification seminar in 1968. "In his view, the 'human brain does not work like a calculating machine', and he suggested developing 'fresh elaboration' and 'the enlarging of the symptoms'" (Wu 2021, position 3749). Analysing the final report of the IPSS, we can state that the participants were aware of some of these challenges:

> „Subsequent videotape studies substantially confirmed these findings, which indicate that the prevailing concept of schizophrenia is much broader in the United States than in Britain, embracing substantial parts of what British psychiatrists would regard as depressive illness, neurotic illness, or personality disorder and almost the whole of what they would regard as mania (Kendel 1971) [...] This study demonstrates that comparing patients from different centres on the basis of local diagnoses alone can be very misleading and that standardization of data collection and diagnostic processes is required" (WHO 1973: 36).

Despite achieving a certain degree of objectivity using recent technological methods, this approach has been criticized for "flattening science by imposing rigid criteria, too inflexible to encompass a wider range or nuance in disease classification" (Wu 2021, position 3785). It was related, as stated by Wu, to a "quasi-utopian scientific internationalism of post-war". The IPSS and the ICD-9 were the most important achievement of the WHO's International Social Psychiatry Project. However, by trying to prove and adopt this universalistic approach using strict measures, the project ended up reducing the participation of different perspectives elaborated in the local research centres or by other individuals connected to the investigation.

This centralized structure of the IPSS and the non-democratic participation of different perspectives was and is criticized by scholars (Wu 2021). Nevertheless, it is understandable why they chose this path. They had a specific goal and a universalist statement to be achieved. The process of selecting experts from other countries and establishing the research centres was not a random choice. During the meetings and discussions before the official launch of the IPSS, there was not only one perspective to be considered. However, the process of deciding the direction of the project was

reducing some disagreements in favour of a unification of the methodology and the way data would be included and analysed (Wu 2021).

There was, however, little freedom and exchange between the project members and the representatives of the research centres in the selected countries. During the first years of the project, some researchers had the opportunity to visit other centres: "Those from Cali visited London, Moscow, and Washington; those from Agra visited Aarhus and London; those from Moscow went to Aarhus, Cali, and London; and those from Taipei visited Cali and Washington" (WHO 1973: 44). Only the psychiatrists in charge had this chance to exchange directly with colleagues in other teams, and for this reason, there was a certain freedom to reformulate some subsidiary aspects of the project. This space of freedom and exchange did not result in severe questioning of the methodology and the goals of the IPSS. The visits were also instruments of control and training, that is, standardization. As stated in the final report, "One of the most important benefits derived from the exchanges of visits was that they contributed to the development of a team spirit among the investigators and led to spontaneous decisions to collaborate among themselves in subsidiary studies" (WHO 1973: 44).

There was an effort to standardize from the moment of selecting the patients who would compose the study.[5] This was fundamental for the achievement of the results expected by the IPSS. The patients had to follow strict criteria regarding personal, demographic, and pathological aspects. By selecting the same individual profile, the project would be looking for a "neutral" sample that could be compared with similar samples from other countries. By selecting "similar subjects", the project could restrict the possibility of having different results and languages for subjective suffering and treatment: if someone did not present the social, symptomatic, and demographic characteristics, they would be excluded.

> „All patients who contacted the selected psychiatric facilities were first seen by a clerk in charge of the administrative arrangements for the study. His task was to fill in the first (demographic) part of the Screen Form and to keep records of patients who were ineligible for the study because they lived outside the catchment area or were outside the age limits of 15 – 44 years, and also of those patients who passed the demographic screen. For the latter patients, the clerk gave the Screen Form to the first psychiatrist or medical officer to examine the patient so that he had the form when interviewing the patient in the ward or outpatient department. This psychiatrist filled in the second part of the Screen Form, indicating whether or not the patient should be included in the study" (WHO 1973: 45).

Another category of exclusion was the neurological examinations. Schizophrenia in the patients analysed should not be a consequence of physical or neurological abnormality. Once again, it is clear that the focus of the IPSS was fundamentally

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[5] A total of 1202 patients were consulted, distributed among the research centres in the nine countries. "811 of the patients have a Centre diagnosis of schizophrenia, 164 of affective psychosis, 29 of paranoid states, 73 of other psychoses, and 71 of neurotic depression; 54 have other diagnoses" (WHO 1973: 399)

based on symptoms, and not on genetic or physiological aspects. Considering the long biological tradition of diagnoses of mental disorders, we have here a diverse psychiatric bias.

> „The Physical and Neurological Examination (PNE) was not among the most important areas of interest in the IPSS because, as specified by the screening procedure, patients showing any physical our neurological abnormalities possibly connected with their symptomatology had to be excluded. Hence it was only used to assess patients with abnormalities unrelated to their mental condition. The schedule could be completed by any medical officer“ (WHO 1973: 78).

The approach of the project was contradictory in some aspects since the supposed "schizophrenia" could present differently in other cultures. By having a very severe exclusion criterion, the project would have eliminated specificity in search of a medico-political standardization. A "schizophrenic person" in each society could present behaviours that would be excluded by the IPSS criteria. Another significant question: "By implication, does the lack of satisfactory diagnostic language in a specific geographical area mean that mental health problems do not exist there?" According to Wu (2021), "This early concern to some degree reflected criticisms later made by a number of scholars, stating that the IPSS did not reflect a uniformity of disease experience cross-culturally, especially outside of hospitals" (Wu 2021, position 4047).

Conclusion

In this paper, our goal was to introduce the concept and the debate related to the decolonization of mental health understood as a historical process that started during the Cold War. Our focus was on the first global project of transcultural psychiatry undertaken by WHO in the 1960s. Throughout the article, we have mentioned some important names, sometimes outsiders to the standard discussions in psychiatry, but who somehow dialogued with these global concerns on mental health and culture. We will leave for future publications the in-depth study of these alternative approaches, such as Western ethnopsychiatry and transcultural psychiatry in Eastern Europe.

The only aspect that can be considered universal among the various sectors of mental health (transcultural psychiatry, GMH, ethnopsychiatry) and within different cultures is the subjective suffering that people cope with. However, the way this suffering manifest cannot be restricted to national or local levels, since the subject is the one who carries this pain, and they make it an individual journey. Thus, there is a subjective dimension of suffering, which makes mental health a challenging field. How to construct nosography and symptoms having all this in mind? If symptoms and nosography embrace the difficulty of being universal, the same can be said of treatments, of "cures" for these "mental disorders". The IPSS was partially aware of it, especially regarding the symptoms of schizophrenia, and the investigators struggled with the attempt to create a universal language for psychiatry.

For some scholars (Gureje & Stein 2014, Patel et. al. 2014, Beneduce 2019, 2011), the diagnoses of mental disorders found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Diseases* (ICD) are not universal. Subjective suffering, on the other hand, is. The big problem, historically and clinically speaking, is how to deal with this "universality" when creating global policies, considering different cultures and economic contexts. Something that both manuals are aware of, especially in recent times on DSM V (2013) and ICD 11 (2019). As Gureje and Stein (2014: 30) state, "Classifying mental disorders is not a precise science. Indeed, classifications have often been constructed to reflect national health preferences and needs".

The major epistemological criticism that the IPSS underwent after its launch was linked to the universalism advocated by the WHO and United Nations, or as Wu (2021) refers to "international scientific utopia". The paths were essentially focused on universal and symptomatic identification in case studies of schizophrenia. As stated by Wu (2021), "In the classification of diseases [ICD-9, 1975)], culture as a determinant of psychopathology was held in abeyance until the next revision of the ICD" (WU 2021, position 4099).

The originality and the major achievement of the WHO via IPSS was not necessarily the identification of a universalism of the human mind, but its medico-political use in favour of a common psychiatric language, of a classification of schizophrenia including its cultural variations. All this is done from a global investigation, involving localities outside Western Europe and the Anglo-Saxon world. However, universalism was not exclusive to the IPSS, nor even to psychoanalysis or other psychiatric approaches. If we consider Freudian propositions about the Oedipus Complex, we can identify a universal mythology of the subject, an aetiology of subjectivity and psychic life. Although Freud was questioned by anthropologists who did not identify the Oedipus Complex in some matriarchal societies, for example, his initial project was based on a universal idea of the psychic structure and mental disorders (neurosis, psychosis, perversion).

Although these are contemporary discussions in the field of psychiatry, psychology, and psychoanalysis, they have not emerged in the last decades. That is the reason why we aimed to focus on their epistemological roots, their global history, their connections and debates undertaken during the Cold War. The decolonization of mental health depends on our idea of colonization and how it has affected the mental health field. Only from there, we can propose a path, a concept of decolonization. In this article, we considered a particular reading of what we call "decolonization of mental health", and from it, we carried out an analysis of some of its theoretical and institutional roots.

It would be impossible to present the totality of this rich global debate on its roots during the Cold War. The choices and limitations of the sources discussed can only present a critical introduction to this historical worldwide concern. With the term "roots", we do not mean that this discussion started necessarily during the Cold War, but that it became a global topic and part of a global project of transcultural psychiatry.

The WHO project opened the way for other investigations of the same type and had significance in the way schizophrenia was handled in the subsequent years

(WHO 1979, Sartorius et. al. 1986). The IPSS sought to create a common language, but also to show that epidemiological research in the field of mental health is possible in cross-cultural contexts. The IPSS was successful in this endeavour. However, in the domain of transcultural psychiatry, it was very limited regarding some topics and achievements.

More than a global transcultural psychiatry project, the IPSS was a work in the field of "cross-cultural psychiatric epidemiology" (WHO 1973: 398). More than a universality of the human psyche, the IPSS proposed and reached a "universality of the symptoms of schizophrenia". Nevertheless, there is an important difference between the global transcultural psychiatric approach from WHO and the other branches of transcultural psychiatry such as Eric David Wittkower (1899–983), Henri Frédéric Ellenberger (1905–1993), Henri Collomb (1913–1979) and so on (Delille 2016, Delille & Crozier 2018, Bullard 2007). The same can be said about ethnopsychiatry. The universalistic way in which the WHO elaborated its cross-cultural project does not necessarily dialogue with other perspectives of transcultural psychiatry at that time.

The epistemological contribution of anthropology was fundamental for transcultural approaches in general, especially in ethnopsychiatry, which embraced with greater intensity the anthropological and singular aspects in clinical and cultural analyses of human mind. However, these appropriations have not occurred equally. There is a diversity of approaches within what we call transcultural psychiatry during the Cold War, whether in Western or Eastern Europe. The IPSS went in a different direction, adopting a global-epidemiological view rather than an anthropological one.

Our goal was to identify, through the analysis of a global cross-cultural project of the WHO, how mental health and culture were managed as a medico-political project that sought a common language for psychiatry. The beginning, still very timid, of a decolonization of mental health through a universalistic approach. My interest was to demonstrate how this universalist epistemology was shaped and focused on a common language for mental health, distancing itself from anthropology and moving toward an epidemiological approach.

The main challenge of the IPSS was to handle data and results to prove an agenda that had been planned before the research began. Even though the universality of schizophrenia played an important role as a critique of colonial psychiatry, the IPSS took a very risky and limited path. The problem is that we are not all the same. There is a subjectivity at stake, diversity, and sometimes very different cultural and social aspects to be taken into consideration. In this sense, the attempt to create a common and universal language for schizophrenia was very limited. This challenge is the same for the manuals of mental health even today: ICD, DSM, etc. What (transcultural) psychiatry has been trying to solve or to cope with is how to incorporate the plurality, the specificity of the psychic experience, in the diagnostic manuals to be used worldwide. This is not, therefore, a finalized debate, but a topic to be explored and discussed.

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DECOLONIZATION OF MENTAL HEALTH? THE EARLY DAYS OF AN ONGOING PROCESS FROM A GLOBAL HISTORICAL PERSPECTIVE

Tiago Pires

Abstract

The main purpose of this paper is to introduce the concept of decolonization of mental health from the study of the beginning of this process during the Cold War. To do so, we have as a topic of discussion the emergence of global and local projects in transcultural psychiatry. As main documentary analysis, we selected the final report of the World Health Organization transcultural project that was conducted between 1965 and 1973 in the Global South and Global North, entitled *International Pilot Study of Schizophrenia* (WHO, IPSS 1973). Our goal is to identify, through the analysis of this global cross-cultural project of the WHO, how mental health and culture were managed as a medico-political project aiming to create a common language for psychiatry through a Universalist epistemology. The WHO was connected to the social concerns of the post-war period by seeking in the epistemology of universality a reason to affirm that we are all equal and avoid future conflicts between nations. World peace, world citizenship, and universalism were important medico-political agendas of the IPSS and especially of the WHO. The "decolonial" aspect would be in the fact that everyone would have the same psychic structure and, therefore, would be on the same level. Even though the universality of schizophrenia played an important role as a critique of colonial psychiatry, the IPSS took a very risky and limited path. The problem is that we are not all the same. There is a subjectivity at stake, diversity, and sometimes very different cultural and social aspects to be taken into consideration. In this sense, the attempt to create a common and universal language for schizophrenia raised questions for some postcolonial and transcultural approaches.

Keywords: Decolonization; Transcultural Psychiatry; Ethnopsychiatry; Global Mental Health.

ДЕКОЛОНИЗАЦИЯ НА ПСИХИЧНОТО ЗДРАВЕ? РАННИЯТ ПЕРИОД НА ЕДИН ПРОДЪЛЖАВАЩ ПРОЦЕС ОТ ГЛОБАЛНА ИСТОРИЧЕСКА ПЕРСПЕКТИВА

Тиаго Пирес

Резюме

Основната цел на този текст е да представи концепцията за деколонизация на психичното здраве чрез изследване върху началото на този процес по време на Студената война. Поради тази причина е въведена дискусията за появата на глобални и локални проекти в транскултурната психиатрия. Като обект на основен документален анализ избрахме окончателния доклад на транскултурния проект на Световната

здравна организация, проведен между 1965 и 1973 г. в Глобалния юг и Глобалния север, озаглавен Международно пилотно изследване на шизофренията (СЗО, IPSS 1973). Нашата цел е да идентифицираме, чрез анализа на този глобален междукултурен проект на СЗО, как психичното здраве и културата са били третирани като медико-политически проект, целящ да създаде общ език за психиатрията чрез универсалистка епистемология. СЗО е обвързана със социалните проблеми на следвоенния период, търсейки в епистемологията на универсалността потвърждение на обстоятелството, че всички сме равни, а също и възможност да бъдат избегнати бъдещи конфликти между отделните нации. Световният мир, световното гражданство и универсализмът са важни медико-политически програми на IPSS и особено на СЗО. По отношение на структурата на психиката, деколониалният подход смята, че всички хора са еднакви, респективно на едно и също ниво. Въпреки че универсалността на шизофренията изиграва важна роля като критика на колониалната психиатрия, IPSS поема по много рискован и ограничен път. Проблемът е, че не всички сме еднакви. Заложени са на карта субективността, разнообразието и различни културни и социални аспекти, които трябва да бъдат взети под внимание. В този смисъл опитът да се създаде общ и универсален език за шизофренията повдига въпроси за някои постколониални и транскултурни подходи.

Ключови думи: деколонизация; транскултурна психиатрия; етнопсихиатрия; глобално психично здраве.

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