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**Prising open the black box: The production of
knowledge on the mental health ‘treatment gap’ in
Africa**

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I, Sara Daniella Cooper, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature

Date

ABSTRACT

In this research I surface the epistemological assumptions underpinning thinking on the apparent high numbers of people with mental illness in Africa not receiving care, known as the ‘treatment gap’. I thus prise open the ‘black box’ of this knowledge, scrutinising its underlying meaning codes and capillaries of power.

I explore knowledge produced on the ‘treatment gap’ at three different sites: 1) Mental health research in Africa published over the last decade; 2) National mental health policies of 14 African countries; 3) Narratives of 28 psychiatrists all working in public mental health care provision in South Africa, Uganda, Ethiopia or Nigeria. For my analysis I develop a theoretical toolbox which draws on concepts from two broad and multidisciplinary fields, namely Science and Technology Studies (STS) and Postcolonial Studies.

What emerged was that knowledge on the ‘gap’ in mental health care is deeply inserted within the episteme of European Colonial Modernity, and thus saturated with Eurocentric tendencies. In particular, two paradigms are playing a fundamental role, those of evidence-based science (including biomedicine) and human rights. I destabilise the inevitability of these paradigms by putting them in historical perspective, and shedding light on the many questionable certainties and binary oppositions upon which they are based. I show how they have become the gatekeepers of knowledge, ultimately occluding ‘other’ ways of knowing which are based upon alternative epistemological codes. The somewhat singular voice of scholarly authority was, however, at times softened by certain quieter and more marginalised voices. These suggested avenues out of which more decolonised, ‘Africa-focused’ models of scholarship might potentially grow. To sum up, I surface particular tensions and hold them up to the light, with the hope of disturbing certain intellectual reflexes and creating a space for potential alternatives. Ultimately, this might help foster different sorts of conversations on the ‘treatment gap’ from those created by current seats of power.

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ABBREVIATIONS

CGMH	<i>Centre for Global Mental Health</i>
DALYs	<i>Disability-Adjusted Life Years</i>
DFID	<i>Department for International Development (UK)</i>
GCC	<i>Grand Challenges Canada</i>
GMH	<i>Global Mental Health</i>
GRADE	<i>Grading of Recommendations, Assessment, Development and Evaluation</i>
HIV/AIDS	<i>Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome</i>
ICD	<i>International Statistical Classification of Diseases</i>
IMF	<i>International Monetary Fund</i>
LSHTM	<i>London School of Hygiene & Tropical Medicine</i>
LMICs	<i>Low-and-Middle-Income Countries</i>
MGMH	<i>Movement for Global Mental Health</i>
MHaPP	<i>Mental Health & Poverty Project</i>
mhGap	<i>Mental Health Gap Action Programme</i>
MoH	<i>Ministry of Health</i>
M&E	<i>Monitoring and Evaluation</i>
NIMH	<i>National Institute of Mental Health (USA)</i>
PANUSP	<i>Pan African Network of People with Psychosocial Disabilities</i>
PHC	<i>Primary Health Care</i>
PRIME	<i>Programme for Improving Mental Health care</i>
RCT	<i>Randomized controlled trial</i>
STS	<i>Science and Technology Studies</i>
UN	<i>United Nations</i>

UNCRPD	<i>United Nations Convention on the Rights of Persons with Disabilities</i>
WHO	<i>World Health Organisation</i>
WISH	<i>World Innovation Summit for Health</i>
WPA	<i>World Psychiatric Association</i>

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Chains of Science

Stand back, and see
These carefully white-free walls
Meticulous choice of musky peach
A cheery colour, studies show Yet
still your right-angled walls Reveal
the white-coat thoughts That frown
upon my mind
My scattered, torn, disordered
mind That, drug-filled,
subdues
To fit your plan.
But think
This mind
That sees the curves in City Hall
Transforming it to Gaudi's shrine
This mind
That plucks stars from rainy skies
And hears the drumbeats in beetles' wings
This mind
Turns the world on its head
Soaks it in life's pleasures and its pains
And wrings them
Dripping
Onto the page
You avidly read
To fill your glass
With Ophelia drowning
Dido burning.
So when you discuss my
diagnosis And debate my coping
skills Remember
That the sprinkled glass
On which I walk through life
Is the story you race home to
read To free you
From your mind in chains of science.

(Stewart, 2014)

1. INTRODUCTION: A KNOWLEDGE PROJECT ON THE MENTAL HEALTH ‘TREATMENT GAP’ IN AFRICA

Introduction

“One of the things a scientific community acquires with a paradigm is a criterion for choosing problems that, while the paradigm is taken for granted, can be assumed to have solutions. To a great extent these are the only problems that the community will admit as scientific or encourage its members to undertake”.

(Kuhn, 1962, p. 37)

This research is an exploration into the knowledge assumptions and politics underpinning contemporary thinking around the ‘gap’ in mental health care in Africa. The apparent high numbers of people with mental illness in Africa who are not receiving care, now formally referred to as the ‘treatment gap’, has become an issue of major concern within the global public health community (Demyttenaere et al. 2004; Dua et al. 2011; Kohn et al 2004; Kessler et al. 2009; Ormel et al. 2008; Patel et al. 2010; Thornicroft, 2007; Wang et al. 2007a,b). This research seeks to prise-open the black box of thinking on this ‘gap’, unearthing and scrutinizing the silent meaning-codes and conventions mediating the knowledge outcomes. It is thus a knowledge project, an intellectual engagement with the themes of epistemology and power. Contrary to what one might assume, however, such a meta-focus project is not an abstract or merely conceptual endeavour. What and how we know fundamentally shape the kinds of questions that we ask and in turn the sorts of solutions we propose. Struggles over meaning are therefore profoundly practical, with very real and material significance.

The idea for this research came out of, frankly, frustration. Prior to beginning this research, I worked as a research officer for the Mental Health and Poverty Project (MHaPP), based in the Psychiatry Department at the University of Cape Town¹. This project, at the time the largest mental health research programme in Africa, sought to develop and evaluate mental health policy, legislation and services within a range of African countries. My main role was to extend the qualitative component of MHaPP.

¹ http://www.who.int/mental_health/policy/development/mhapp/en/

This involved working with researchers primarily in South Africa, Ghana, Uganda and Zambia to conduct and analyse interviews with a range of mental health care stakeholders, and to produce publications and policy briefs based upon our findings. As part of my work, I was also tasked with spending time in the various mental health care facilities of these four countries so as to develop a ‘feel’ for the situation and associated challenges. Whilst working on this project, I was increasingly frustrated with the representational politics of a region that repeatedly gets misunderstood, misrepresented, pathologised, and intervened upon. I became more and more concerned with the processes of knowledge production, and the power dynamics that myself and others were (albeit unintentionally) perpetuating. And I developed a growing sense of dis-ease with the kinds of conceptual paradigms, both in the mental and social sciences, which have outlived their usefulness, and yet still remained central to mental healthcare research and policy-making on the African continent. I realised that my own experiences and practices were being conditioned by these research processes and knowledge systems. So, it felt like it was time, if not already overdue, to start a conversation. And that is what this research is: a step towards opening-up a new kind of dialogue on mental health care in Africa.

Since beginning my PhD research in 2010, projects such as the Mental Health and Poverty Project have multiplied on the African continent, and in other low-and-middle-income regions. We are indeed currently witnessing a strong international crusade to transform the mental health situation in the developing world, a situation which is increasingly being considered an issue of major global health concern (Global Mental Health Group, 2007; Patel et al, 2011). This drive has in turn given rise to a new field of research and practice, known as ‘Global Mental Health’, which is being led by the international psychiatric community, but incorporating a broad coalition of actors and agencies. This field has engendered a new institutional and research landscape, one which is focused primarily on reducing the ‘gap’ in mental health care globally, but particularly in low-and-middle-income countries. Alongside this, there is growing controversy over the conceptualisation, goals and imagined outcomes of this new field of study. There has recently been an explosion of criticism of the Global Mental Health agenda, particularly from the ranks of transcultural psychiatrists and medical anthropologists. In order to contextualise my current research project, and help delineate where I wish to position it, what follows is a brief outline of the terrain of Global Mental Health and associated critiques.

Thereafter, I will describe the broad aims, objectives and scope of my research, followed by a description of the structure of this thesis.

The rise of Global Mental Health

“We have presented the knowledge base and the strategies to improve mental health. Now we need political will and solidarity, from the global health community, to put this knowledge to use. The time to act is now”.

(Global Mental Health Group, 2007, p. 1250).

Over the last decade, the global psychiatric community has increasingly stressed the dire mental health situation globally, and particularly in Africa, highlighting what it perceives to be a number of disquieting features of the current state of affairs (See Cooper et al., 2011 for a comprehensive summary; also see Global Mental Health Group, 2007; Patel et al, 2011). The size of the burden of mental disorders is generating growing alarm (Collins et al, 2011; WHO 2001, 2008). Estimates commonly cited are that more than 13% of the global burden of disease is due to neuropsychiatric disorders, with 70% of this burden understood to lie within low-and-middle-income countries (Lopez, 2006). It is suggested that this burden is likely to rise dramatically in the next decade, with predictions, for example, that depression will become the leading cause of disability worldwide by 2030 (WHO, 2013). Similarly, the insufficient visibility, policy attention and funding available to address this burden is increasingly being highlighted by a range of scholars (for example Jacob et al. 2007; Kohn et al. 2004; Saxena et al. 2007; Horton 2007; Kakuma et al, 2011, WHO, 2011). There is growing documentation of the meagre financial and human resources dedicated to mental health care, especially in Africa. Common statistics mentioned include, for example, that on average African countries spend less than 1% of their national health budgets on mental health (WHO, 2005); that there is one psychiatrist per 2.5 million people, one psychologist per 2 million people and one psychiatric nurse per 500 000 people in Africa (Saxena et al., 2007); that as many as 44% of African countries do not have a mental health policy while 33% do not have a mental health plan (WHO, 2011).

Amongst the various issues being raised, one matter that has received particular attention is what is seen as the exceptionally high levels of people with mental illness

globally, but particularly in low-and-middle-income countries, who are not receiving mental health care (Demyttenaere et al. 2004; Dua et al. 2011; Kohn et al 2004; Kessler et al. 2009; Ormel et al. 2008; Patel et al. 2010; Thornicroft, 2007; Wang et al. 2007a,b). According to the international psychiatric community, despite robust evidence testifying to the effectiveness of a range of interventions for mental illness, the majority of the world's population has no access to these (Patel et al., 2013). This issue is now referred to as the "treatment gap", formally defined as "the difference between the true prevalence rate of mental illness and the proportion who receive any kind of treatment" (Thornicroft & Tansella, 2013, p. 849 see also Chisholm et al. 2007; Patel et al. 2007; Prince et al. 2007; Saxena et al. 2007 for similar definitions of this 'treatment gap'). Startling statistics have been provided in this regard. For example, it is estimated that between 70% and 90% of people in low-and-middle-income countries who need mental health care do not receive it, a figure which is estimated to be closer to 98% in low income countries in Africa (Collins et al, 2011; Lopez, 2006; WHO 2001, 2008). For the global psychiatric community, this 'gap' in mental health care is seen as particularly worrying, given the significant individual and social costs of untreated mental illness. This community suggests, for example, that the global economic costs of mental disorders were \$2.5 trillion in 2010 and project that this is likely to reach \$6.0 trillion by 2030 (Bloom et al, 2011). The large majority of this cost is being attributed to untreated mental health problems.

Moreover, it is commonly asserted that in the absence of sufficient and supposedly appropriate mental health care services, people with mental illness in Africa are experiencing some of the most severe human rights violations. Indeed, disturbing accounts of the maltreatment of people with mental health problems are increasingly being reported, accompanied by graphic images of such individuals being, for example, tied to trees, chained to beds and caged in small cells in the community (Botha et al. 2006; Drew et al, 2011; Hugo et al. 2007; Shibre et al. 2001; Thornicroft, 2006 are examples of these kinds of human rights' reports). Ultimately, psychiatrists are calling this current 'gap' in mental health care a "global health scandal" (Patel & Thornicroft, 2009, p. 1), a "crisis" (Patel et al., 2011, p. 1441) and a "failure of humanity" (Kleinman, 2009, p. 603).

These growing concerns about the mental health situation in low-and-middle-income countries, including those in Africa, crystalized in 2007 with the publication of

first *Lancet* series on mental health (Global Mental Health Group, 2007). Comprising six articles, this series aimed to bring together the evidence pertaining to the burden and impact of mental disorders, the level of resources dedicated to mental health, and known effective treatments and the barriers to scaling them up. The last article of the series made a “call to action” to reduce the gap in mental health care in low-and-middle-income countries, urging people to join “the broad new social movement” to strengthen mental health care in such regions (Global Mental Health Group, 2007, p. 1241). This series coincided with the launch of the Movement for Global Mental Health (MGMH), an international coalition of mental health professionals, civil society activists and global health advocates which has two aims: to close the gap in mental health care for people living with mental disorders and to promote their human rights². As Vikram Patel (2012, p. 9), one of the key architects of the Movement suggests, the Movement seeks to provide a “platform for people to cast aside their differences, to stand shoulder to shoulder, and to advocate for a shared cause”. Today, the Movement has grown to over 3,000 organisations and individuals from more than 100 countries around the world (Clark, 2014).

Since the *Lancet* series and launch of the MGMH, there has been a strong international push to focus the public health spotlight on mental disorders globally, and particularly in low-and-middle-income countries. This has consolidated around what is now referred to as the field of Global Mental Health (GMH) (Patel, 2014; Patel & Prince, 2010). Aligning itself with the wider area of Global Health, Global Mental Health has been described as an “Area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide” (Patel & Prince, 2010, p. 1976). Led by the international psychiatric community, but incorporating a broad coalition of actors and agencies, Global Mental Health has engendered a new institutional landscape. The field has recently established a number of its own research centres, academic units and clinical training programs. Moreover, under the banner of this field, a plethora of journal articles, special series and reports have been published which have inter alia identified global strategies for mental health research (Becker & Kleinman, 2012; Collins et al., 2011; Mari & Thornicroft, 2010; Patel, et al., 2011; Patel & Prince, 2010) and international guidelines and interventions for scaling-up mental health

² <http://www.globalmentalhealth.org>

services (Mental Health Working Group, 2013; Patel & Thornicroft, 2009; PLOS Medicine Editors, 2013; Patel & Saxena, 2014; Petersen et al., 2011).

We have also witnessed an explosion of Global Mental Health intervention programmes, initiatives which have received significant financial backing from a range of prestigious international funding bodies and governments³. For example, the field has gained the backing of the World Health Organization, which has published two world health reports dedicated to Global Mental Health (WHO, 2001, 2010), commenced its Mental Health Gap Action Programme (mhGap) to close the ‘gap’ in mental health care (WHO, 2008), and most recently launched its Comprehensive Mental Health Action Plan as a framework for scaling-up access to mental health services globally and particularly in low-and-middle-income countries (Saxena, Funk & Chisholm, 2013). The latter has been adopted recently by 194 ministers of health globally, who have formally recognised mental health as a global health priority and made a common pledge for action.

Similarly, the US government-funded National Institute of Mental Health (NIMH) has recently launched its Grand Challenges in Mental Health (GCC) initiative. This initiative has inter alia brought together over 400 ‘global experts’ to identify key research concerns and themes for the next ten years which will help reduce the ‘gap’ in mental health care in low-and-middle-income countries (Collins et al, 2011; Patel, 2012). Based on the priorities pinpointed, the Government of Canada has provided \$32 million to over 60 projects in Africa, Asia and South and Latin America to expand access to mental health care⁴.

Ultimately, Global Mental Health has increasingly captured the imagination of a wide range of stakeholders, from consumer and civil society groups, to national policy makers to international donors and development agencies. Indeed, a recent google search for ‘Global Mental Health’ on November 1st 2009 identified approximately 62300 related sites, of which over 85% of them were registered since

³ Large funding organizations and governments include, amongst others, the World Health Organization (WHO), the US National Institutes of Mental Health, the UK’s Department for International Development, the Wellcome Trust and Grand Challenges Canada. See <http://www.centreforglobalmentalhealth.org/projects> for a summary of the kinds of research projects and interventions being funded.

⁴ www.grandchallengesgmh.nimh.nih.gov

2008 (Patel & Prince, 2010). This increasingly powerful field has, however, also caught the attention of a number of critical scholars, who are raising strong concerns about this growing area of research and practice.

The rise of critique

“We need to challenge the relentless self-aggrandisement of the Western mental health industry, forever claiming that yet more funding is required to tackle ‘massive’ unmet mental health needs. This is an industry out of control, risking hubris and arguably deserving it. Not just ‘mental health’ but the whole industry and its pharmaceutical motor is being globalised...”

(Summerfield, 2012, p. 528)

Thus, alongside the development of Global Mental Health, we are also witnessing growing controversy over the conceptualisation, goals and imagined outcomes of this field. Indeed, a range of critical views have recently been expressed, particularly from the ranks of transcultural psychiatrists and anthropologists. These have been articulated in a number of recent published articles, along with the publication of three special issues dedicated to ‘critical perspectives on Global Mental Health’ - two in *Transcultural Psychiatry* in 2012 (Campbell and Burgess, 2012) and another in 2014 (Kirmayer and Pedersen, 2014), and one in *Disability and the Global South* in 2014 (Mills and Fernando, 2014). As will be touched upon below, the kinds of arguments being made have strong remnants of earlier critiques of psychiatry itself, particularly those associated with Britain’s ‘anti-psychiatry’ movement of the 1960s and 1970s (e.g. Crossley 1998; Rogers & Pilgrim, 2005 for overviews of this movement) and the Mental Health Users/Survivor Movement of the 1970s and 1980s (Crossley & Crossley, 2001; Rogers and Pilgrim, 1991 for summaries of this movement). Although diverse and varied, the critiques being made about Global Mental Health can usefully be divided into two major and interrelated clusters of critique. I refer to these as the biomedical and cultural critiques.

The first major constellation of critique of Global Mental Health pertains to what is seen as the biomedical framework in which the field is situated, and associated biological determinism. This kind of critique is being made by a plethora of scholars (see for example Campbell and Burgess, 2012; Fernando, 2011; Ingleby, 2014; Jain & Jadhav, 2009; Kirmayer & Pedersen, 2014; Kirmayer & Swartz, 2013; Mills, 2014; Read, 2012; Suffling et al., 2014; Summerfield, 2004, 2008, 2012, 2013;

White & Sashidharan, 2014a,b). These individuals are suggesting that implicit in the arguments being put forward, and in the research and interventions that have followed, is the assumption that mental disorders are biologically grounded entities with stable features and singular courses and outcomes. They argue that, although Global Mental Health recognises that the manifestations and triggers of mental disorders may vary across cultures and may be mediated by social determinants, ultimately it is assumed that they have a common biological basis. A number of problems and negative consequences of this assumption have been highlighted.

Many scholars (for example Fernando, 2011; Ingleby, 2014; Summerfield, 2004, 2008, 2012, 2013; White & Sashidharan, 2014a,b) have questioned the legitimacy of this biological assumption, suggesting that evidence for the physical foundations of most mental illnesses remains fairly weak. This kind of critique indeed echoes what was at the intellectual core of Britain's 'anti-psychiatry' movement. Commonly associated with the works of Cooper (1968), Laing (1967) and Szasz (1971), this movement interrogated the notion of mental illness being a brain disease and emphasised the weak construct validity of diagnostic categories within psychiatry. Relatedly, the 'anti-psychiatry' movement also criticised psychiatry's tendency to medicalise mental illness and create disease mongering, an argument which is being similarly made by many critics of Global Mental Health (for example Mills, 2014; Summerfield, 2004, 2008, 2012, 2013). For example, Derek Summerfield, one of Global Mental Health's most ardent critics, argues that the "mental health industry" is "out of control", triggering an "epidemic of psychiatric diagnosis" (Summerfield, 2012, p. 528). For him, Global Mental Health tends to reify subjective consciousness through a mechanistic focus on 'symptoms', which ultimately pathologises normal responses to life's challenges and medicalises everyday life experience.

Moreover, other critics of Global Mental Health have proposed (for example Clark, 2014; Jain & Jadhav, 2009; Kirmayer & Swartz, 2013; Mills, 2014; Read, 2012; Swartz, 2012) that in regarding mental distress as a biomedical pathology, the field relies upon and promotes interventions centered on the individual, such as medication or simple behavioural interventions. For some (for example Campbell and Burgess, 2012; Jain & Jadhav, 2009; Kirmayer, 2006; Kirmayer & Swartz, 2013; Mills, 2014; Swartz, 2012; White and Sashidharan, 2014a) this tends to divert attention away from the social, political and economic drivers of human distress, and

the need for more complex interventions which tackle the structural determinants of mental illness. For other critical scholars (for example Read, 2012; Suffling et al., 2014; White and Sashidharan, 2014b), Global Mental Health's strong focus on increasing access to psychotropic medication has meant that the field tends to gloss over the limitations of such treatments, and the ambivalent attitudes they provoke in those who take them. These critics emphasise that evidence on the efficacy, tolerability and cost-effectiveness of psychotropic treatment remain patchy and contested, limitations which tend to be muted in the push to scale-up mental health care services. Moreover, some of the most vocal critics of Global Mental Health (Summerfield, 2014, p. 409; see also Fernando, 2011) have suggested that this uncritical promotion of psychotropic medication, or what is referred to as the "pharmaceuticalisation of everyday distress", is deeply embroiled with the economic agendas of the pharmaceutical industry. Again, this particular theme has strong remnants of the British 'antipsychiatry' movement of the 1960s and 1970s (for example Rogers & Pilgrim, 2003). As Ingleby (2014, p. 210) argues when talking about Global Mental Health:

The key to understanding the dominance of biological models lies in the adage 'follow the money'. Most recent research in psychiatry has been financed by the pharmaceutical industry, which is only concerned with treatment. After all, reducing mental disorders by tackling their causes would in no way serve the industry's financial interests. Thus, as well as manipulating published results, the pharmaceutical industry has distorted psychiatry's knowledge base by financing a mountain of evidence on pharmacological treatments which it is impossible for other approaches to rival in quantity.

A second and interrelated cluster of critique of Global Mental Health is what Kirmayer and Pedersen (2014) refer to as the "cultural critique". According to Kirmayer and Pedersen, this form of critique has raised a number of concerns about what is seen the inappropriate exportation of a supposedly Western, biomedical model of mental illness, and the consequent neglect and demonization of more local and culturally-relevant ways of approaching mental illness. For example, many services users and associated representative organizations (for example Gikonyo, 2014; Lee, 2014; Ibrahim, 2014; Timimi, 2011; PANUSP, 2014) argue that Global

Mental Health has insufficiently consulted with local communities and particularly individuals and families actually affected by mental illness in low-and-middle-income countries. They suggest that the methods for establishing priorities, research themes and modes of intervention are dominated by a small consortia of psychiatric ‘experts’ drawn mainly from the geopolitical North and as such, tend to reflect the interests and values of Western psychiatry. These individuals and groups have thus strongly criticised Global Mental Health for disregarding and ultimately silencing their voices. These sentiments indeed strongly resonate with the Mental Health User/Survivor movement of the 1970s and 1980s within Britain, and this movement’s commonplace slogans of “Listen to the voice of the user!” and “Let survivors and consumers speak out!” (Crossley & Crossley, 2001, p. 1477; see also Rogers & Pilgrim, 1991; 2005). For example, the *Pan African Network of People with Psychosocial Disabilities* recently made the following formal statement with regards to the field of Global Mental Health:

There can be no mental health without our expertise. We are the knowers and yet we remain the untapped resource in mental health care. We are the experts. We want to be listened to and to fully participate in our life decisions... We want to speak for ourselves (PANUSP, 2014, p. 385).

This argument, that Global Mental Health is marginalising local voices and ‘exporting’ an essentially top-down Western biomedical model, has also been made by a number of academics (See for example Davar, 2014; Fernando, 2012; Ingleby, 2014; Lang, 2014; Lee, 2014; Mills, 2014; Sax, 2014; Skovdal, 2012; Suffling et al., 2014; Summerfield, 2012; Tribe, 2014). According to these scholars, this exportation is underpinned by an inherent assumption of the universal applicability of biomedical understandings and treatments of mental illness. They rigorously contest this assumption, emphasising that it fails to acknowledge the significant variation of mental illness cross-culturally. For these critics, given the culture-specific nature of mental illness, the kinds of diagnostic tools and interventions being promoted by Global Mental Health are not relevant to ‘non-Western’ societies, ultimately leading to inappropriate diagnoses and the implementation of ineffective solutions. For example Ingleby (2014), Summerfield (2012) and White and Sashidharan (2014a) suggest that Global Mental Health is providing inflated and misleading estimates of the burden of mental disorders in low-and-middle income countries. According to

them, the statistics being cited make sense only when Western psychiatric categories and measures are mistakenly applied.

Other critical voices (for example Davar, 2014; Fernando, 2011; Lang, 2014; Mills, 2014; Sax, 2014; Tribe, 2014) argue that the ‘exportation’ of Western biomedical models works to suppress or even demonise ‘culturally’ established systems of mental health and healing. As Tribe (2014, p. 251) states, “The transfer of western psychiatric ideas and the uncritical generalisation of them around the world not only ignores local realities and cultures, but also works to discredit, replace and make ‘vanish’ ...the rich traditions and cultural heritage of many low- and middle-income countries”. Many critics, for example Fernando (2011), Mills (2014), Summerfield (2012) and Timimi (2011) argue that Global Mental Health’s ubiquitous reports of the malign treatment of the mentally ill in Africa, including graphic images of people in chains at traditional healing camps misrepresents and pathologises local forms of healing. Ultimately, they describe this as a kind of medical imperialism or neo-colonialism. As Summerfield (2013, p. 347) emphasises:

The blithe universalism underpinning Global Mental Health is reproducing the dynamics of the colonial era when it was pressed upon indigenous people that there were different kinds of knowledge and that theirs was second rate. Socio-cultural and socio-political phenomena were framed in European terms and the responsible pursuit of traditional values regarded as evidence of backwardness. Global Mental Health workers are the new missionaries.

Global Mental Health and its discontents: A hostile intellectual climate

“There is the need for sociology of knowledge which is neither uncritically deferential to the sciences nor uncritically cynical about them, and which, rather than competing for control of the territory, cooperates with epistemology to understand the scientific enterprise”

(Haack, 2003, p. 201)

Many Global Mental Health advocates (such as Cohen et al. 2011; Cohen 2012; Patel, Minas et al. 2013; Patel, 2014) have been outraged by the kinds of critiques currently being put forward, and have published a number of fervent responses. They argue that Global Mental Health is pervaded by postcolonial sensibilities to form genuine and reciprocal north-south collaborations. They give examples of

partnerships with ‘traditional’ healers developed as part of their programs that are sensitive to local cultural traditions. They reference the body of literature on socio-economic and cultural determinants of mental disorders produced by leading Global Mental Health researchers, and argue that this has established a socially and culturally sensitive empirical basis to inform their interventions. Ultimately, in response to many of the criticisms of Global Mental Health, key advocate Professor Vikram Patel (2014, p. 10) recently made the following formal statement:

The hard grind of trying to make a difference on the ground, warts and all, may make the discipline more vulnerable to attack from lofty critiques delivered from ivory towers...Thousands of people with mental disorders turn up each day in health centres around the world only to receive inappropriate treatments, or die prematurely, or face discrimination and human rights abuses- we must not allow the false prophets, hiding behind the duplicitous cloak of protecting the ‘natives’ from a profiteering and self-serving ‘Western biomedical imperialism’ to distract Global Mental Health practitioners from their duty and responsibility to reduce this suffering.

In an attempt to address these growing controversies and tensions, the Division of Social and Transcultural Psychiatry at McGill University organised a meeting in July 2012 which brought together key proponents and critics of Global Mental Health (Bemme & D’souza, 2012 provide a summary of the key themes raised at this meeting). Although the goal was to identify areas of consensus, clarify concerns and map potentially common programs of research, the meeting generated considerable anger and resentment on both sides, with many individuals leaving prematurely (Personal communication, Doerte Bemme, December 2012).

One effect of current conversations between Global Mental Health advocates and critics is that all sorts of essentialised categories, damaging polarized forms of thinking and somewhat unnuanced views of power are being produced. For example, according to Bemme and D’souza (2014), Kirmayer and Pedersen (2014) and Kirmayer (2006), arguments on both sides of the divide are tending to reproduce somewhat a reified view of ‘culture’, with very little recognition of the fact that this notion has undergone a long history of problematization and reconceptualization, including calls for its abandonment as an analytic category. Moreover, these scholars

suggest that the debates are generating all sorts of essentialised binary oppositions: the biological versus the socio-economic; nature versus culture; pharmacological treatments versus psychosocial interventions; global versus local; the universal versus the relative; passive critique versus active intervention; the conceptual versus pragmatic. As will be revealed in this thesis, the problems with these kinds of rigid dichotomies, and the assumptions upon which they are based, has been the subject of much critical social theory for many decades now (See for example Craffert, 1997; Good, 1994; Law, 2008a; Mol, 2008).

We are therefore currently facing an intellectual climate within the international mental health arena which is characterised by stark polemics, polarized forms of thinking and widespread denunciations of one side versus another. It is indeed becoming somewhat difficult for people involved not to take sides, and in taking sides, it is hard not to get locked into the constrictive terms of the competing perspectives as they are emerging. For example, throughout my PhD research, I was frequently asked whether I am ‘for-or-against’ Global Mental Health. So often I felt forced to choose, and if I did not, a choice would typically be imputed.

In many ways, the terms increasingly shaping current conversations between critics and advocates of Global Mental Health echo the early ‘rationality debates’ of the 1970s between universal rationalists and cultural relativists (e.g. Feyerabend, 1987; Hollis & Lukes, 1982; Wilson, 1970), as well as the so-called ‘science wars’ of the 1990s between scientific realists and postmodernist critics (Labinger and Collins, 2001). As various philosophers of science have suggested (Green, 2012; Haack, 2003; Latour, 2004; Stengers, 2003; 2008), these kinds of epistemological wars ultimately became trapped in a hermeneutics of polemics and stark choices, making it very difficult for scholars to think outside of the frameworks of established positions, canons and criticisms. That is, while the polemics may have been productive in propelling debate, they tended to obscure emergent spaces, concepts, and fields of inquiry between and beyond divides. And this ultimately set up the conditions in which the much-needed discussions of care and nurture and well-being were ultimately sabotaged.

Thus, when talking about the destructive fallout of the science wars, Isabella Stengers (2008) recently called upon academics to stop developing ever cleverer

denunciations of one side versus the other, and to open-up a dialogue about an ecology of knowledge that might offer researchers a way of moving past damaging polarised forms of thinking. Similarly, Susan Haack (2003, p. 201) emphasised that “there is the need for sociology of knowledge which is neither uncritically deferential to the sciences nor uncritically cynical about them, and which, rather than competing for control of the territory, cooperates with epistemology to understand the scientific enterprise”. Ultimately, ‘cooperating with epistemology’, and ‘opening up a dialogue’ about knowledge is exactly where I situate this PhD.

Positioning this PhD: A focus on knowledge

“So, I think my problem and ‘our’ problem is how to have simultaneously an account of radical historical contingency for all knowledge claims and knowing subjects, a critical practice for recognizing our own ‘semiotic technologies’ for making meanings and a no-nonsense commitment to faithful accounts of a ‘real’ world, one that can be partially shared and friendly to earth-wide projects of finite freedom, adequate material abundance, modest meaning in suffering, and limited happiness”.

(Haraway, 1999, p. 175)

My research is thus a knowledge project, an intellectual engagement with the themes of epistemology and power. As such, it is situated at the ‘meta-level’, concerned with the representational politics of contemporary thinking on the ‘gap’ in mental health care in Africa. Work from such a meta-perspective focuses on the processes, purposes and theoretical lenses that silently mediate the knowledge outcomes. In other words, it is research which is tuned into epistemological questions regarding the nature of the knowledge produced, disentangling the power dynamics at play.

What I am insisting upon through such a meta-level approach is that knowledge is not neutral, but is imbued with power and interests, and that knowledge practices are deeply political. Moreover, one of the key starting premises of my research is that our underpinning knowledge assumptions have profound consequences. Thus, unlike common sentiments amongst many Global Mental Health advocates which tend to view work at a more conceptual level as diverting attention away from the hard work needed ‘on the ground’, my current research is based upon the assumption that what and how we know have significant material effects. Put in a slightly different way, my intention through this epistemological project is not to deny ‘the real’. Rather, my

research begins from a place which recognises, like many Global Mental Health advocates, that mental suffering, for example, is a serious phenomenon in Africa, and elsewhere, causing immense pain and claiming many lives and livelihoods everywhere. Regardless of the labels and the definitions, there is a 'dis' in mental distress.

And yet how this 'dis' is understood and described will also have very real repercussions, shaping the kinds of questions that can be asked, and giving practical expression to the decisions that are made. In other words, as suggested by Weed (1995, 1999), without looking critically at the epistemic grounds of the knowledge we produce and the strategies we propose, the solutions implemented may end up being inappropriate and ineffective. Possibly even more serious, as various scholars have demonstrated (Bowker, 2001, 2005; Haack, 2003; Haraway, 1991; Latour, 1987, 2004; Swartz, 2012), without a critical engagement with the capillaries of power and ideologies implicated (often unknowingly) with the knowledge we develop, well-meaning strategies face the danger of oppressing particular people and voices.

The public health example in Kenya (Minakawa et al, 2008), where bed nets were provided to combat malaria, only to find that the villagers were rather using these for drying and catching fish, is a classic example of how interventions might end up having unintended consequences if they are based upon assumptions which are incongruent with the needs and priorities of those they are seeking to help. Another pertinent example is the case of HIV/AIDS where, as suggested elsewhere (for example Campbell, 2004; Crewe & Aggleton, 2003; Sabatier, 1988; Stillwaggon, 2003), the uncritical use of racial paradigms when collecting and organizing health data in Africa has produced devastatingly racist stereotypes of African people and their sexualities. The point is then, unless we are aware of our tools and concepts and the politics to which they are linked, we will invariably reproduce very real forms of power and orthodoxies that potentially censor thought and subjugate people, rather than supporting them. Thus, as Donna Haraway (1999, p. 175) so eloquently puts it, "We need the power of modern critical theories of how meanings and bodies get made, not in order to deny meanings and bodies, but in order to live in meanings and bodies that have a chance for a future".

My epistemological project is also predicated upon a deep sense of dissatisfaction with the historical and contemporary global inequalities underpinning the context of knowledge production. That is, like many critics of Global Mental Health, and much Postcolonial scholarship more generally (for example Connell, 2007; De Sousa Santos et al., 2007; Smith, 1999; Said, 1978; Spivak, 1990), I recognise that there is still a tenacious endurance of Eurocentric power, whereby experiences within Africa continue to be filtered through an imperial epistemological gaze. The problems and consequences of the dominance of this knowledge order will be unpacked in detail in Chapters Three and Four. Suffice to say here, I join the long list of Postcolonial scholars who are seeking to chip away at the grip of this hegemonic epistemic order. As such, my research is based on an ethics and politics that seeks to imagine a more democratic epistemological world, one which is not organized by axes of domination.

And yet at the same time, my research also starts off from a position which is deeply concerned with some of the central ways in which scholars are attempting to dismantle the continuing dominance of Eurocentric structures of knowledge, including in the realm of mental health. That is, as various critical social theorists have argued (for example Ashcroft, Griffiths and Tiffin, 1995; 1998, Bhabha, 1995; Green, 2012; Mbembe, 2002; Odora Hoppers, 2002), there is a strong and problematic tendency within Postcolonial and anti-imperialist struggles to challenge this hegemony by asserting that Africa has its own unique identities, knowledges and practices which are radically different from those of the so-called 'West'. A project of decolonization then, from such a perspective, is about rejecting structures of thought that originate from the 'West', and at the same time unearthing 'native African' ways of thinking in their original form. This kind of 'Afro-centric' perspective indeed features prominently within many critiques of Global Mental Health, and their ubiquitous talk of the 'exportation' of Western psychiatry and its supposed irrelevance for Africa.

As will be discussed in detail in Chapter Three, such a position tends to be based upon an unadulterated, static and monolithic view of 'Africa', ultimately devoid of outside influence or multiplicity. Ultimately, in seeking to separate myself from this kind of perspective, my research is predicated on the necessity of developing theory, practices and politics which are neither Eurocentric nor Afrocentric. In other words,

seek to reimagine the possibilities for scholarly ways of knowing which are not necessarily dictated to by the epistemological order of European Colonial Modernity, whilst simultaneously recognising that Africa is multiple and dynamic and that there is a constant entanglement between knowledges and identities- both ‘local’ and ‘global’. I will term this kind of scholarship ‘Africa-focused’, the nature of which I will attempt to articulate in Chapter Three.

Aims, objectives and scope

“Knowledge which matters has to be knowledge which is open to its own historicity and spatiality, and open to alternative ontologies”

(Bowker, 2001, p. 10)

The aim of my research is thus to problematize the epistemological assumptions underpinning contemporary thinking on the ‘gap’ in mental health care in Africa. The specific objectives can therefore be summarised as follows:

1. To *surface* and *subject to critique* the dominant structures of knowledge mediating the production of knowledge on the ‘treatment gap’ in Africa;
2. To explore how *theory, policy* and *attendant practice* on the ‘gap’ in mental health care in Africa might be *rearticulated* within a decolonized economy of knowledge.

As a way into investigating thinking in this area, my research analyses knowledge produced on the ‘gap’ in mental health care at three specific sites:

1. Mental health *research* in Africa published over the last decade;
2. The national mental health *policies* of 14 African countries;
3. *Narratives* of 28 psychiatrists who are all working clinically in public mental health care settings in one of four African countries (South Africa, Uganda, Ethiopia, or Nigeria).

These three sources of knowledge constitute portals into dominant kinds of thinking in this area, or what Bowker (2010, p. 146) calls the “formal archive” or “official groupthink”. They were chosen because they each possess a considerable amount of power and influence, as will be described in the next chapter. In sum and taken

together, these particular sources of knowledge provide a picture of the central kinds of thinking in this area. But inevitably a partial picture.

Work at a meta-level requires critical conceptual tools and sharp theoretical devices. I therefore developed a conceptual toolbox, one which extracts and synthesizes various theoretical concepts commonly used within two broad fields of study, namely Science and Technology Studies (STS) and Postcolonial Studies. Using the apparatuses from this conceptual toolbox, my analysis of the three sources of knowledge was guided by the following broad research questions:

1. What kinds of episteme, paradigms and classification systems are underpinning the knowledge produced on the ‘gap’ in mental health care?
2. What epistemological assumptions and relations of power are embedded in these knowledge structures?
3. What are the socio-economic and political origins of these knowledge structures?
4. What alternative and potentially meaningful epistemologies and knowledge politics might exist?

This research thus focuses on unearthing and interrogating the questionable certainties and power dynamics of the dominant structures of knowledge mediating thinking on the ‘gap’ in mental health care in Africa. It explores how such thinking might be reinforcing (albeit unknowingly) some of the ideologies and matrices of power that became embedded in the epistemological order of European Colonial Modernity. I will show how knowledge on this ‘treatment gap’ is indeed deeply inserted within this dominant epistemological order. In particular, I will reveal how such knowledge is being strongly mediated by two particular paradigms of thought, those of evidence-based science (including biomedicine) and human rights. Rather than rejecting these structures of knowledge outright, I will explore how appropriate they might be for thinking about the diverse mental health needs and dilemmas of people on the African continent.

Whilst focusing on destabilising the stranglehold of certain inherited and Eurocentric assumptions, my analysis also searches for, and seeks to harness, potential treasures which may lie hidden in the cracks of the dominant epistemological order. That is, it

attempts to unpack, and where possible foreground, more marginalised epistemologies and knowledge politics, which do not necessarily originate from a European Colonial and Modernist form of consciousness. I will show how the conceptual resources of ethnographic articulations and critical phenomenology, for example, which emerged amongst the softer voices in this research, may embody examples of such ‘other’ ways of thinking. I will explore how the more dominant knowledge claims might be negating authentic dialogue with these ‘other’ kinds of knowledge paradigms and forms of ordering. Ultimately, through my analyses I pose questions around how these more marginalised ways of knowing might enable more decolonised forms of knowledge on the ‘gap’ in mental health care to grow and potentially enter into centres of power and influence. I consistently ask how these alternative epistemologies might transform current conversations on the ‘gap’ in mental health care in Africa. Ultimately my aim is to raise different aspects of these complex questions, rather than to bring them to closure with definitive answers.

Thesis structure

This thesis is structured around a series of peer-reviewed publications and interlinking unpublished chapters. After this introduction, in Chapter Two, I describe the particular empirical methods that I employed to develop the archive of knowledge to be analysed. As indicated above, as a way into investigating thinking on the mental health ‘treatment gap’ in Africa, I chose to look at knowledge produced on this topic at three specific sites: 1) Mental health research in Africa published over the last decade; 2) The national mental health policies of 14 African countries 3) Narratives of a sample of 28 psychiatrists from one of four African countries who are all working in public mental health care settings in their respective countries. In Chapter Two I unpack the search strategies I used to access the research and policies documentary material. I also highlight how a narrative-based approach to interviewing was used in order to tap into the thinking on the mental health care ‘treatment gap’ amongst the psychiatrists, the third source of knowledge included in my knowledge archive. I describe the collection of stories as a particular method of research, along with providing details about who the psychiatrists I interviewed were, how I gained access to them and the nature of the interviews that took place.

Delving into research on the ‘gap’ in mental health care, it became clear that research in this area was divided into two different focuses. The first tended to concentrate on the provision of care and how services should be scaled-up so as to narrow the ‘gap’ in mental health care. The second placed its attention on the uptake of services, or what was commonly referred to as ‘help-seeking behaviour’, and how this can be enhanced so as to reduce the ‘gap’ in mental health care. As I explain in Chapter Two, my analysis of research on the ‘gap’ in mental health care therefore followed this division. In the final chapter, I address this apparent division in research focus, and how it may speak to some of the larger issues that are at stake with knowledge on this topic.

In Chapter Three, I develop the conceptual toolbox that will be used for my epistemological project. My toolbox draws upon various concepts commonly used within two broad and multidisciplinary fields of study, those of Science and Technology Studies (STS) and Postcolonial Studies. Four concepts form the foundation of this toolbox, namely, the notions of an ‘*episteme*’, a ‘*paradigm*’, a ‘*classification system*’ and ‘*black-boxing*’. Taken together, these concepts enable me to identify some of the underpinning structures of knowledge, and understand how these structures are socially constructed, exceedingly powerful and yet ultimately invisible. I then view these concepts through a Postcolonial space of thinking. This serves to ground them within a particular time and space, and thus position the focus of my epistemological project in a very specific way. When viewed from such a perspective, what one sees is that a particular episteme, and associated paradigms and classification system emerged during the era of colonialism and what is understood as European modernity. I refer to this as the episteme of European Colonial Modernity, and unpack one of the most stubborn and powerful forms of classification buried in the ‘black box’ of this episteme. This classification system is one which tends to demarcate the social world into homogenous entities and rigid binary oppositions. In order to destabilise the continued hegemony of this epistemological order, it needs to be rigorously decolonised. Drawing on the ideas of ‘*African Modes of Self-Writing*’ and ‘*Southern Theory*’ I delineate the specific kind of decolonization I seek to undertake through my research. This is one which attempts to shift the privilege granted to Eurocentric forms of meaning-making to more ‘Africa-focused’ models of scholarship. I explore what I mean by the slippery notion of ‘Africa-focused’. That is, the production of knowledge which is centred

upon the needs and dilemmas in Africa, whilst simultaneously recognises that identities and experiences on the continent are inherently complex and varied.

In Chapter Four, I surface and put into historical perspective the epistemological assumptions underpinning two key paradigms of thought which are both deeply inserted within the episteme of European Colonial Modernity, namely those of evidence-based science (including biomedicine) and human rights. I concentrate on these particular paradigms because, as will be later revealed, they are strongly mediating contemporary knowledge on the mental health ‘treatment gap’ in Africa. This chapter therefore provides a historical platform from which to understand this knowledge on the ‘gap’ in mental health care. Rather than being self-evident or inevitable mappings of the world, these paradigms emerged within a very specific social and historical milieu. That is, they arose out of, and provided an ideological basis for, many of the socio-economic forms of organization and capillaries of power characterizing 17th and 18th century Europe. As such, they share many of the same kind of epistemological assumptions, in particular, those of universalism, naturalism, objectivity and rationalism. At the same time, these paradigms are underpinned by many homogenous entities and stark binary oppositions. I explore how, one of the major effects of these assumptions and form of classification, is the way in which they tend to occlude ‘other’ ways of thinking and being from entering the formal canon of knowledge.

Chapters Five to Eight are the analytical chapters of my three knowledge sources, that is, the research, the policies and the narrative interviews. These chapters are structured as a set of individually published, peer-reviewed journal articles. One paper, which is Chapter Five, analyses research on the provision of care and a second paper, Chapter Six, explores the other aspect of the ‘gap’ in mental health care, that of research on the uptake of services (‘help-seeking behaviour’). The policies highlighted both of these components of the ‘gap’, and both aspects emerged as prominent themes in the narrative interviews with psychiatrists. I therefore published one paper which focuses on the policies, to be found in Chapter Seven, and one which concentrates on the psychiatrists’ stories, Chapter Eight.

The first paper, currently published in *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, looks critically at research on the

provision of care and its thinking around how services should be scaled-up so as to narrow the ‘gap’ in mental health care. Using the concept of a paradigm from my conceptual toolbox, I explore how the paradigms of evidence-based science and human rights are strongly mediating research in this area. I destabilise the epistemological assumptions underpinning these paradigms, shedding light on the many questionable and contentious certainties upon which they are based. I show how these paradigms, and associated assumptions, are also marginalizing other, potentially important ways of thinking about the provision of care in Africa which might not originate from European Colonial and Modernist forms of consciousness. In this paper I touch on a few examples of critical ethnographic research which embody ‘other’ ways of thinking about the provision of care, ways which may lie outside of the epistemological codes of evidence-based science and individualised human rights.

The second paper, currently in press in *Transcultural Psychiatry*, problematizes research on help-seeking behaviour and the thinking around how to increase the uptake of services so as to reduce the high levels of untreated mental illness. My analysis draws particularly on the concept of a ‘classification system’ from my toolbox in order to problematize how the classifications within this research contribute to producing the knowledge that they are supposedly designed simply to store. I highlight how this research is being mediated by a particular kind of classification system, one which demarcates the social world into homogenous entities and binary oppositions. As touched upon in Chapter Three, and expanded upon in this paper, this is a very powerful system of classification buried in the ‘black box’ of the episteme of European Colonial Modernity. I highlight the problems with this form of ordering the world, and associated epistemological assumptions. By way of contrast, I explore how two critical ethnographic studies confront help-seeking for mental distress in Africa through alternative forms of classification, which are neither Eurocentric nor Afrocentric. I pose questions around how this kind of research, and associated systems of classification, might transform the ways in which we understand how people do, and potentially could, seek support for mental illness in Africa.

The third paper, currently in press in *Disability and the Global South*, uses the concept of a paradigm from my conceptual toolbox to scrutinise knowledge on the

‘gap’ in mental health care- both the provision and uptake of care- produced by the 14 national mental health policies. To contextualize this analysis, I provide a historic-political account of the emergence of the notion of Primary Health Care (PHC), and its entanglement within the decolonization forces of the 1960s. I unpack how and why this concept was subsequently atrophied within the field of public (mental) health, being stripped of its more revolutionary sentiments from the 1980s onwards. Against this backdrop, I show how, although the 14 national mental health policies are saturated with the rhetoric of Primary Health Care and associated concepts of community participation and ownership, in practice they tend to marginalize local meaning-systems and endorse a top-down framework heavily informed by colonial medicine. The policies thinking around the ‘gap’ in mental health care thus end up reproducing many of the very Eurocentric assumptions that the original Primary Health Care notion sought to transcend. More specifically, like research on the provision of care explored in Chapter Five, the paradigms of scientific evidence and human rights become the gatekeepers of knowledge, legislating what are legitimate forms of knowing, and by extension, valid forms of care. I argue that a greater appreciation of the Primary Health Care concept, in its earliest formulation, offers a potentially fruitful terrain of engagement for developing more contextually-embedded and epistemologically appropriate mental health policies in Africa.

The fourth paper, currently in press in *Culture, Medicine and Psychiatry* provides a critical analysis of the narrative-based interviews that I conducted with the 28 psychiatrists. Again, for my analysis I draw particularly upon the notion of a paradigm. I show how dominant thinking amongst the psychiatrists about the ‘treatment gap’- both the provision and uptake of care- was heavily informed by a biomedical form of thinking. There were, however, cracks in this master narrative, which crystallised in the stories that were told by three particular psychiatrists. I explore how their narratives operated within an alternative paradigm, one which appeared to be informed by the tradition of phenomenology, and in particular the ideas associated with French philosopher Merleau-Ponty. I suggest that this more marginalised thinking may offer important insights into reducing the mental health ‘treatment gap’ in Africa in ways very different from those created by current seats of power.

In Chapter Nine, the final chapter of this thesis, I put the different sources of knowledge in conversation with each other, tying together some of the key themes which emerged in my separate analyses. Here I discuss how, although there were differences between them, the knowledge produced at all of the different locations tended to be underpinned by a similar set of meaning-codes and epistemological politics, ones which are deeply inserted within the episteme of European Colonial Modernity. Across the sources of knowledge analysed there were, however, places where the shrill and somewhat singular voice of scholarly authority was at times softened by a chorus of more marginalised voices. In this chapter I explore the enabling potential of these more marginalised voices for bringing about more ‘Africa-focused’ models of scholarship on the ‘gap’ in mental health care on the continent. As will be revealed throughout, and pulled together in this chapter, developing new and potentially transformative knowledges is, however, a precarious endeavour. Therefore, my modest goal in this final chapter is to surface particular tensions and resonances and hold them up to the light, with the hope of disturbing certain intellectual reflexes and helping to open-up a space for potentially alternative kinds of theories, practices and politics.

2. THE ARCHIVE OF KNOWLEDGE

Introduction

“A formal archive is the current official groupthink of how things should be...it is jussive...deliberately sequential...a bowdlerized, legally aware presentation... But what is told is only ever a small subset of that which is relevant. There is a principle of socio-cultural exclusion in every act of recall”.

(Bowker, 2010, p. 213/214)

In this chapter I describe the empirical methods that I employed to develop my archive of knowledge to be analysed for this epistemological project. As a way into investigating the thinking on the mental health ‘treatment gap’ in Africa, I chose to explore, and put into conversation, knowledge produced on this topic at three specific sites:

1. Mental health *research* in Africa published over the last decade;
2. National mental health *policies* in Africa;
3. *Narratives* of a selected sample of psychiatrists all working clinically in public mental health care settings in Africa.

I envisioned that each of these sources of knowledge would constitute important portals into the dominant kinds of thinking in this area, or what Geoffrey Bowker (2010, p. 146) calls the “formal archive” or “official groupthink”. That is, these three sources of knowledge were chosen because I considered them be sites of power and influence. In the current ‘evidence-based’ knowledge economy, research is playing an increasingly important role in informing policy and practice in the health and social-related sectors (Evans & Benefield, 2001). That is, with the growing need to ensure value for money in relation to measurable outcomes, research is more and more being used “to help determine and justify what worked and why, and what types of policy initiatives are likely to be most effective” (Clegg, 2005 p. 416).

Similarly, national policies are political pronouncements which constitute the official discourse or current received wisdom of the state (Law, 2008b). As Leow (2011, p. 312), puts it, policy documents tend to “personify the intrinsic, dominant ideologies and underlying rules and assumptions in a society”. Finally, Yen and Wilbraham (2003) suggest that psychiatrists are relatively high-up in the professional hierarchy

of public sector mental health care provision, including in Africa, and thus possess immense symbolic, social and material power to regulate and govern understandings and practices surrounding mental illness. As Morant (2006, p. 819) articulates, psychiatrists are:

Society's 'practical experts' charged with the task of deciding who is mentally unwell and how they should be treated... Their work transforms government policy on care of the mentally ill, and expert theories on the treatment of mental health problems into tangible practices that shape the lives of clients and their families.

My selection of these particular sites of knowledge does not, however, represent an exhaustive archive of dominant knowledge in this area. Many other sources could have been chosen, which might have provided alternative sorts of windows and different kinds of pictures. The sources of knowledge included in this project are therefore inevitably specific and partial. But my hope is that my analyses of them are strong and detailed enough to offer insights that may be of a wider significance than the particular. In what follows, I describe the various procedures I undertook to develop each of these three specific sources of knowledge.

Knowledge source one: Mental health research in Africa over the last decade

The first source of knowledge I chose to incorporate in my knowledge archive was research, which has been published over the last decade, on the mental health 'treatment gap' in Africa. Obtaining textual material is not as difficult as negotiating access to people. Texts cannot withhold consent or fail to keep appointments. This is not to say that compiling an archive of documentary material is uncomplicated. A systematic and transparent approach is needed. I began my search by looking broadly at the websites of key organisations known to be working in the areas of Global Mental Health. These included:

The Movement for Global Mental Health⁵; World Federation of Mental Health⁶; World Psychiatric Association⁷;

⁵<http://www.globalmentalhealth.org>

⁶<http://www.wfmh.org/>

World Health Organization's Evidence Resource Centre⁸;
International Observatory on Mental Health Systems⁹;
Society for the Study of Psychiatry and Culture¹⁰;
Centre for Public Mental Health¹¹;
Centre for Global Mental Health¹²
Mental Health Innovation Network¹³.

I also scanned journals which I knew had produced special issues on Global Mental Health research. These included series in the *Lancet* (2007)¹⁴, (2011)¹⁵; *Harvard Review of Psychiatry* (2012)¹⁶; *PLOS Medicine* (2009)¹⁷; *Revista Brasileira de Psiquiatria* (2010)¹⁸; and *International Health* (2013)¹⁹. Furthermore, I conducted on-line searches in Medline and PsychInfo databases using the very broad phrases: “mental disorders”, “mental health”, “Africa” (including the names of all individual countries on the continent), and “treatment gap”. Where applicable, keywords were combined with Medical Subject Headings for the Medline databases and Subject Headings for the PsycINFO database.

From these searches I accumulated a wealth of published research on the mental health ‘treatment gap’ in Africa. I spent some time reading through these articles, and immersing myself in the kinds of themes that were materialising. What very quickly emerged was that research was divided into two main focuses. As I explained in Chapter One, the first concentrated on the inadequate availability of mental health care services, and the consequent need for the widespread scale-up of services. Thus, here the emphasis was on the *provision* of care, and how such scale-up should be operationalised so as to narrow the ‘gap’ in mental health care. The second major focus of research on the mental health ‘treatment gap’ centred on the uptake of

7 <http://www.wpanet.org>

8 http://www.who.int/mental_health/mhgap/evidence/en/index.html

9 <http://www.cimh.unimelb.edu.au/iomhs>

10 <http://psychiatryandculture.org/>

11 <http://www.cpmh.org.za/>

12 <http://www.centreforglobalmentalhealth.org/>

13 <http://mhinnovation.net/>

14 <http://www.thelancet.com/series/global-mental-health>

15 <http://www.thelancet.com/series/global-mental-health-2011>

16 <http://informahealthcare.com/toc/hrp/20/1>

17 <http://www.ploscollections.org/article/browse/issue/info%3Adoi%2F10.1371%2Fissue.pcol.v07.i06>

18 http://www.scielo.br/scielo.php?script=sci_issuetoc&pid=1516-444620100003&lng=en&nrm=iso

19 <http://inthehealth.oxfordjournals.org/content/5/1.toc>

services, or what was commonly referred to as ‘help-seeking behaviour’, and what was seen as the significant underutilization of mental health care services. Thus, here the emphasis was on how to increase the *uptake* of services so as to reduce the high levels of untreated mental illness. This split in focus suggested that I needed to explore each of these specific focus-areas further. Thus, in order to identify additional research related to the *provision* of care, I performed on-line searches in Medline and PsychInfo databases using the key phrases: “mental disorders” OR “mental health” OR psychiatr* AND “Africa” (including the names of all individual countries on the continent) AND “scaling up” OR “care” OR “service” OR “treatment” OR “system”. As before, where applicable, keywords were combined with Medical Subject Headings for the Medline databases and Subject Headings for the PsycINFO database.

In order to identify additional research on the *uptake* of care, I conducted on-line searches in Medline and PsychInfo databases using the key phrases: “mental disorders” OR “mental health” OR psychiatr* AND “Africa” (including the names of all individual countries on the continent) AND “help seeking behaviour” OR “health care seeking behaviour” OR “help seek*” OR “seek* help” OR “seek* treatment” OR “health care access” OR “health care utilization” OR “service uptake” OR “treatment uptake” OR “treatment barriers”. In both cases, the reference lists of all applicable papers were scanned to identify further potentially relevant studies, and I contacted the authors of various papers and enquired whether they knew of any other studies in the area. In addition, I got in touch with people known to be working in the field of Global Mental Health and asked if they could provide me with any relevant references. Some of the papers I found by serendipity.

My accumulation of relevant research was also facilitated by the fact that between September 2011 and February 2015 I was appointed as Website Manager for the Centre for Global Mental Health²⁰, a collaborative initiative between the London School of Hygiene & Tropical Medicine (LSHTM) and the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) at Kings College London (KCL). The primary aim of the Centre is to foster research, advocacy and capacity building in the policy, prevention and care of mental disorders in low-and-middle-income countries.

²⁰ <http://www.centreforglobalmentalhealth.org>

My role within the Centre was to manage and update its website, which involved uploading relevant news and events, as well as keeping the resource databases up to date. As the designated point of contact, the Centre's Management and Steering-group teams and extended networks were encouraged to email me whenever they published new research or gained access to relevant Global Mental Health articles and reports. Ultimately, my role within the Centre was invaluable for the development and accumulation of my knowledge archive, as I was consistently sent relevant articles.

The building of my research archive took place over a three year period. Although I conducted my formal searches of the online databases between January 2012 and June 2012, I continually added to and updated my expanding archive. A list of all the research included in my knowledge archive is provided in appendices four and five. In accumulating this archive of research, I was as 'methodical' and 'explicit' as possible throughout. And yet, the process of finding relevant research in this area was filled with unexpected twists and turns. It was thus characterised by an inherently iterative and flexible process, whereby new studies were uncovered which frequently pointed to new avenues. Some of these I ventured down, whilst others I did not. My search strategies always involved long chains of choices- which search terms to use, which databases to investigate, which inclusion/exclusion criteria to use and which areas to investigate further.

Ultimately, my objective was not to undertake a 'systematic review', a particular kind of methodology that has gained increased popularity with the public health sciences. As suggested by Mullen and Ramírez (2006) and Rosen et al. (2010), such an approach erroneously assumes it possible to obtain an objective and exhaustive summary of all the 'evidence' that is 'out there'. Taking heed of this critique, my aim was thus to collect a wide body of material which could provide a *picture* of the main kinds of research being conducted on the mental health 'treatment gap' in Africa.

By triangulating my search methods and reaching a level of theoretical saturation (Willig, 2001), I am confident that collectively the material accumulated has enabled me to develop a good picture. But also a partial one, with inevitable gaps and omissions.

Knowledge source two: Contemporary national mental health policies

The second source of knowledge I included was national mental health policies in Africa. I had thought that accessing these policies would be a relatively easy task. I was proved wrong. After a week of performing Google searches and scanning Government websites, it became clear that national mental health policies on the African continent are not readily available in the public domain. I therefore emailed Dr. Sebastiana Da Gama, the then Director of the World Health Organization's (WHO) African Regional Office, to enquire whether the WHO had a database of national policies on the continent. After receiving no responses to my three 'friendly reminder' emails, I phoned her, where she informed me that the WHO does not have access to these policies. She indicated that obtaining them would ultimately require negotiating directly with the Ministries of Health in each country. She also provided me with a link to the WHO Mental Health Atlas (WHO, 2011), a document which stipulates which African countries had an officially approved mental health policy in 2010. I was somewhat surprised that the WHO did not have these policies at their disposal, given that this organization has published a number of analyses on the nature of mental health policies in Africa, and how they can be improved (See WHO, 2003; 2009 for examples of such analyses).

The WHO (2011) Mental Health Atlas indicated that 19 African countries had a mental health policy in 2010. See Table 1 below for a list of these countries. I decided to focus on accessing these particular policies. I realised that the contacts I had made during my previous job as a researcher on the Mental Health and Poverty project (MHaPP)²¹ might prove helpful in this regard. As described in Chapter One, I was involved in the qualitative component of this project, which entailed conducting and analysing in-depth interviews with key stakeholders in mental health care in South Africa, Ghana, Uganda and Zambia. My role on this project thus provided me with key professional links, including with individuals working within the various Ministries of Health in Africa.

I therefore emailed, and followed up with many phone calls, the relevant contacts I had, and asked whether they could help me with accessing their own and other

²¹ <http://r4d.dfid.gov.uk/Project/50165/>

national policies on the African continent. Such communications spanned over a year, with my frequently pursuing a long sequence of referrals and extended links. I spent many hours phoning Ministries of Health in different African countries, where frequently I was transferred back-and-forth to different departments and individuals. Often the phone connection was lost, and the process needed to be started all over again from scratch. I was consistently struck by how, in many cases, the Government health officials I spoke to knew that they had a mental health policy, but were unaware of how to retrieve a copy. In certain instances, when the policy was located, it did not exist in electronic form, and thus needed to be photocopied and posted to me as a hard copy. On some occasions, the policy arrived in the mail, but on other occasions it did not. I often wonder, for example, whether Botswana's policy, which was supposedly posted to me twice, is still floating through the postal system on its journey to London. Moreover, I still marvel at my hard copy of Zambia's policy, which is apparently one of the few copies that exist and which was kindly couriered to me in South Africa. This relative unawareness of, and associated difficulties around obtaining, the policies raises all sorts of questions around their real meaning, and the degree of ownership local governments really had in their development. I touch on these issues in my analysis of these policies in Chapter Seven.

My attempts at accessing these policies took place between December 2011 and January 2013, during which time I was able to obtain 12 policies out of the total 19 African countries which had one in 2010 according to the WHO's 2011 Mental Health Atlas. Four of these policies (Nigeria's, Rwanda's, South Africa's and Uganda's) were revised post-2010, and these updated versions were emailed to me by the various contacts I had made through my initial investigative attempts. In addition, in 2012 both Ethiopia and Sierra Leone approved their first national mental health policy. One of my contacts in Ghana, who knew I was collecting these policies, emailed both of them to me in January 2013. I am unaware if other countries, which did not have a policy in 2010, have had one approved since then. Thus, in total, my archive of national mental health policies on the African continent comprises those of 14 countries: Ethiopia (2012); Gambia (2007); Ghana (1996) Lesotho (2005); Liberia (2009); Namibia (2005); Nigeria (2011); Rwanda (2012) Sierra Leone (2012); South Africa (2013); Tanzania (2006); Uganda (2011); Zambia (2005); Zimbabwe (2004).

Table 1: African countries which had a mental health policy in 2010 according to the WHO (2011) Mental Health Atlas

Country	Date approved
Algeria*	2009
Botswana*	2003
Democratic Republic of Congo*	1999
Gambia	2007
Ghana	1996
Guinea*	2000
Lesotho	2005
Liberia	2009
Madagascar*	2005
Mauritania*	2005
Namibia	2005
Nigeria	1991 and revised in 2011
Rwanda	1995 and revised in 2012
Senegal*	2006
South Africa	1997 and revised in 2013
Uganda	2000 and revised in 2011
United Republic of Tanzania	2006
Zambia	2006
Zimbabwe	2004

* indicates those policies I was unable to access

As reflected in this table, I was unable to access the policies of 7 countries which, according to the WHO, had one in 2010. These include those from Algeria, Botswana, Democratic Republic of Congo, Guinea, Madagascar, Mauritania and Senegal. For various primarily linguistical and practical reasons, my numerous attempts to obtain these policies, ultimately failed. As part of my role as Website Manager for Centre for Global Mental, I was tasked with compiling a database of past and current Global Mental Health projects in Africa²². From this work, it became clear that the 14 countries whose policies I was able to access were all involved in at least one major Global Mental Health project. In many cases, the development of these policies were in fact embedded within these research projects, forming an integral part of the projects' interventions. From what I could see, with the exception of Botswana and Guinea, the other five countries whose policies I was unable to access did not have a significant Global Mental Health presence and did

²² A selection of these projects are provided here:
<http://www.centreforglobalmentalhealth.org/projects>

not have any large-scale mental health project taking place. Might the mental health policies from these countries be qualitatively different from those I was able to access? Would their inclusion in my archive of knowledge have produced a slightly different picture of policy thinking? Sadly, these questions can only be posed, ultimately remaining unanswered in this thesis.

Knowledge source three: Psychiatrists' narratives

The third and final source of knowledge included in my archive was in-depth, individual interviews with psychiatrists all working clinically in public mental health care settings in Africa. For these interviews, I used a narrative-based approach in order to hear their stories about the 'gap' in mental health care. In Chapter Eight, where I analyse these stories, I unpack in detail the theoretical underpinnings, and associated assumptions, of a narrative-based form of enquiry. I will not repeat these details here. Rather, in this chapter I focus on providing details about who these psychiatrists were (whilst preserving anonymity), how I gained access to them and the setting and nature of the interviews that took place.

Recruitment and sampling

In total, I interviewed 28 psychiatrists, comprising 19 men and 9 women. Eighteen of these I knew personally and contacted initially by email, whilst the remaining ten psychiatrists interviewed I recruited through snow-balling techniques (Kvale, 1996). As with the policies, gaining access to psychiatrists was facilitated by my previous work with the Mental Health and Poverty (MHaPP) project. As mentioned above, through this project I developed professional links with various mental health care stakeholders, including psychiatrists, working in the public mental health care sector in Africa. I made a list of, and then contacted via email, all of the psychiatrists I knew of (21 in total), and asked whether they would be willing to be interviewed as part of my research. I was struck by the quick responses I received from the majority of psychiatrists I emailed, with so many of them telling me how happy they were that I got in touch and how delighted they would be to be interviewed. Remarkably, 18 of the 21 psychiatrists I initially contacted agreed to be interviewed. I did not hear back from 3 of the psychiatrists I emailed, despite two follow-up emails. I do not know

why they never replied, and whether they might have told different kinds of stories and provided alternative sorts of insights.

Many of the psychiatrists I emailed initially also spontaneously provided me with the names and details of other individuals who might be willing to be interviewed and who they thought I should contact. The friendly and helpful responses I got immediately made me feel uneasy, as given the critical lens of my research, I worried that they might be somewhat unaware of what, exactly, they were signing-up for. Indeed, many of the psychiatrists emphasised in our correspondences how the issue of the ‘gap’ in mental health care in Africa is a really important and pressing matter, and how “fantastic” it was that I was focusing on this topic. Would they have had such positive sentiments if they had known more clearly the nature of my research? Was I deceiving them?

During my email correspondence with one of the Ethiopian psychiatrists, she mentioned that a mental health conference was taking place in Addis Ababa. She explained that a number of psychiatrists from the African continent would be attending, and wondered whether I wished to join. I realised that this would provide a unique opportunity for me to interview some psychiatrists in person, many of whom I had already been in contact with via email. I therefore attended the 4-day conference, and was able to interview a number of psychiatrists in person in Addis Ababa.

Certain characteristics of the psychiatrists are shown in Table 2. Given the small number of psychiatrists in Africa, as outlined below, I have not provided the names of the specific hospitals where they worked in order to ensure anonymity. The commonality between the psychiatrists was that they were all working in Government-funded, public sector and urban-based mental health facilities. Furthermore, all of the psychiatrists were African nationals. Seven of the psychiatrists had undertaken their psychiatric training in Europe, 5 in the United States with the rest having obtained their training in Africa. The psychiatrists from South African were all based in Cape Town, those from Uganda were situated in Kampala, the Nigerian psychiatrists were all working in Lagos and those from Ethiopia were all located in Addis Ababa. Eighteen of the psychiatrists worked in

standalone psychiatric hospitals, while the rest were based in psychiatric units located in general hospitals or clinic-based settings.

The sample of psychiatrists is specific and small, from particular countries on the continent- South Africa, Uganda, Ethiopia and Nigeria. All four of these countries had a national mental health policy and a relatively large proportion of research on the mental health ‘treatment gap’ came out of these countries (as seen in Appendices four and five). As such, I anticipated that speaking to psychiatrists in these particular countries would aid my comparison of the different sources of knowledge. I also focused on these particular countries as I had considerable contacts and connections with people working within mental health care in these settings. Rather than being viewed as a limitation, this prior familiarity may have contributed to the psychiatrists’ tendency to open up and provide rich and detailed stories. Indeed, story-telling as a specific research methodology has been found to be particularly productive when a relationship between ‘interviewer’ and ‘interviewee’ exists before proceeding with the formal interview process (Kvale, 1996; Willig, 2001).

The relatively small size of this sample must, however, be viewed in the light of the paucity of psychiatrists available in Africa. Current available estimates indicate that there are only 22 practicing psychiatrists in Uganda (Kigosi et.al 2010); 40 in Ethiopia (Ethiopian MoH 2012) and fewer than 100 in Nigeria (Issa 2005). The availability of public sector psychiatrists in South Africa is relatively higher, with estimates that there are approximately 0.28 psychiatrists per 100 000 population (Lund et.al 2009). With all of this said, however, I do not wish to suggest that the views expressed by the psychiatrists included in my research characterise the sentiments of all psychiatrists in these four countries, let alone the continent as a whole. The stories that were told were specific and local, about particular sites and situations. However this does not mean that their significance is necessarily restricted to the local. As Mol (2008) and Turnbull (2000) found when using stories as a form of knowledge production, it is somewhat paradoxically because of their specificity and attention to detail that stories have the power to travel, to offer wider insights that may be transported to other contexts.

Table 2: Demographic details of the psychiatrists

Characteristic	Number
Country	
South Africa (Cape Town)	8
Ethiopia (Addis Ababa)	7
Nigeria (Lagos)	7
Uganda (Kampala)	6
Sex	
Male	19
Female	9
Ethnicity	
Black	22
White	6
Place of work	
Standalone psychiatric hospital	18
Psychiatric unit in a general hospital/clinic	10
Place obtained psychiatric training	
Africa	16
USA	5
Europe	7

Interview settings

The interviews with the psychiatrists took place in one of three locations- in their offices at the hospitals where they worked, in the lounge of the hotel where I was staying during my time in Addis Ababa or on the phone. Initially I had been concerned about the public and somewhat casual setting of the hotel lounge. However, very quickly this proved to be useful, as I think the relaxed environment of the hotel lounge, usually accompanied by strong Ethiopian coffee, helped the psychiatrists to talk more freely. In fact, interviewing people in naturally occurring and informal settings has been found to increase their tendency to open-up and share rich details about their lives (Kvale, 1996; Willig, 2001). Similarly, I had been concerned that conducting interviews on the phone would not provide the best medium for story-telling, as it has been suggested that this interview modality frequently leads to less honest and in-depth forms of discussion (for example Kvale, 1996; Trochim & Donnelly, 2007). I came to appreciate, however, that the phone might in actual fact create a kind of barrier, a space of face-less distance, or what Trier-Bieniek (2012, p. 642) refers to as the “sense of anonymity involved with virtual conversation” (See also Block & Erskine, 2012; Mealer & Jones, 2014). Somewhat ironically then, talking on the phone may have helped the psychiatrists feel comfortable to

talk in what emerged as very personal and candid ways. Moreover, these phone-calls usually occurred at the weekend or in the evenings, when the psychiatrists were away from their daily pressures and demands. This too may have helped create a space for the psychiatrists to feel more relaxed and willing to share information. Having previously met most of these psychiatrists in person meant that a degree of familiarity and rapport had already been established prior to the interview, and thus the ‘getting to know you’ kinds of conversations could be avoided. Ultimately, some of the longest and richest interviews I had were with those psychiatrists who I interviewed on the phone.

Whilst in Addis Ababa, I was included in all of the conference dinners and group-tours of the city, where I took part in many informal conversations with the psychiatrists attending the conference. This provided me with invaluable additional insights into some of their thinking. But I was also plagued with a constant sense of unease, always feeling as if I was an under-cover spy. I sweated profusely through-out my time in Addis Ababa, probably a combination of the relentless heat and my persistent anxiety.

For the interviews that took place in hospital settings, I ended up spending a considerable amount of time waiting for the interview to begin. Most of the psychiatrists were delayed for our scheduled interview time, and in Ethiopia, often by over two hours. In fact, I learnt that time operates differently in Ethiopia, possibly a result of the fact that the country is structured around, simultaneously, two different time/date systems, one international and one local. I thus ended up spending much time soaking up the energy of the various hospitals, which so often left me feeling uneasy. I was again and again struck by the extreme poverty, the dire infrastructure and the severe forms of physical and mental disability I saw. The dull stares and whisperings from the various patients I briefly crossed paths with always made me very uncomfortable. In one of the hospitals in Addis Ababa, I was consistently unnerved by the regular power cuts which were always accompanied by fire alarms ringing and piercing yelling, doctors and patients alike. In fact, after my first interview at one of the psychiatric hospitals in South Africa, I felt nauseous and struggled to concentrate. I wondered how I was going to endure this process, and I deliberated about whether an epistemological project such as mine was properly engaging with these impenetrable material realities. But after that first day I became somewhat de-sensitised, with my experiences and concerns somewhat stabilising in my psyche. I wondered about the extent to which the psychiatrists I spoke to had also become inured in some way, maybe as a way of coping.

Accessing the stories

In order to tap into these psychiatrists' thinking on the mental health 'treatment gap', I employed a narrative-based approach to interviewing. As will be explored in detail in Chapter Eight, such a method of enquiry is based on the premise that stories are socially-embedded, primary meaning-making structures. Proceeding from this view, the objective of the interviews was to elicit stories or 'whatever comes to mind'. I began each interview by indicating that I was interested in their understandings of why people who need mental health care may or may not be getting the care that they need. I provided a two-page hand-out (See appendix one) summarising the nature and aims of the study, and a form for them to give their consent to participate in the study (See appendix two). Those whom I interviewed in person signed the form, and I emailed the forms to those I interviewed on the phone for them to read, and before beginning they provided verbal consent. In all cases, I made it clear that they were under no obligation to participate and could terminate the interview at any point. I also assured them of confidentiality and anonymity, and gained permission to audio-record the sessions.

I asked extremely broad and open-ended questions which were structured as 'narrativised' topics or story-telling invitations (Hollway and Jefferson, 2000). These questions included, for example, if they could describe how they came to be working at the hospital, what a typical day involves, what sorts of challenges they face, what kinds of patients they are currently seeing and have seen in the past, incidents with patients they found challenging, positive and/or memorable and any other things they wanted to talk about (See appendix three for the loose interview guide used). Where thoughts were expressed in somewhat general or abstract terms, I tried to anchor these to specific incidents which had actually happened, urging the psychiatrists to describe examples from their daily experiences. Throughout the interviews, I created spaces for extended turns and associative shifts in topic, encouraging one story to lead to others even if they appeared to be non-linear, partial and fragmentary. I ended up asking very few of the questions that I had devised prior to the exchanges, with the majority of psychiatrists telling long stories in response to a few brief questions. I was consistently struck by the psychiatrists' tendency to open up and provide rich and detailed stories, with each interview lasting between 1½ hours to 4 hours. Each interview thus took on a life of its own, characterized by a continual elaboration of

the themes and ideas that *they* presented in *their own* accounts. This was important as I felt that I was gaining access to the participants' own meaning frames, as we followed their own associative trails and unfolding logic (Riessman 2008).

In addition to the issues that I have already mentioned, the psychiatrists' tendency to be forthcoming may also have been facilitated by the fact that I was a PhD student, which created a unique interview dynamic between us. Many of the psychiatrists were supervising their own Masters and PhD students, and I frequently felt as if they positioned themselves as 'the educator' and me as 'the student'. This allowed me to ask for very detailed descriptions and explanations, as I was 'authentically the learner'. Consider the following exchanges:

Psychiatrists: You see, a lot of people are aware of the problem, but are just not doing anything about it....But I think it's the whole bystander thing.

Sara: bystander thing?

Psychiatrist: I'm sure you came across this term in social psychology, maybe in your undergraduate years? Anyway, how I like to explain it to my students...is that... You really should look into this concept as it could be very useful for your research...

Another interview exchange ended as follows:

Psychiatrists: So how many other psychiatrists are you planning on interviewing?

Sara: I'm hoping to interview maybe about 30 psychiatrists in total.

Psychiatrists: Wow. That is a lot. I don't know much about the kind of methodology you are using, but I imagine you might find it is very scattered, with people going all over the place...and very broad kinds of themes coming up...my colleagues and I actually recently did some more qualitative-type research and we found it very useful to...I'd be happy to show you some of our stuff...

Thus, as reflected in these two excerpts, many of the psychiatrists perceived me as a kind of colleague, but particularly, a more junior colleague, one whom they could 'teach' and 'show' things. If I did not comprehend something, frequently they took the time to explain it to me slowly and meticulously, using examples from their lives

so that I properly understood. Ultimately, this was very helpful for obtaining details and example-rich narratives, which proved significant for making sense of their thinking. I transcribed all of the interviews myself in full. After each interview, and during my time in Addis Ababa, I also performed intensive journaling, jotting down some of my post-interview thoughts and observations. I would regularly consult these journal entries, noting issues that needed to be followed up in future interviews.

A note on ethics

Formal ethical approval to conduct my research was obtained from both the London School of Hygiene & Tropical Medicine's [Ethics reference no. 6310] and the University of Cape Town's [Ethics reference no. 162/2013] ethical review boards, and my research adhered to all formal research ethics practices. And yet in unveiling the epistemological politics embedded in the knowledge produced, I fear I have not done justice to the multifaceted identities the researchers, policy-makers and psychiatrists have, and the difficult circumstances in which they work and seek to improve. Through the stories I was told by the psychiatrists, I was consistently moved by the amount of time and energy these psychiatrists put into trying to help their patients. And spending time in the various hospitals, I was made acutely aware of how they are attempting to do this within dire contexts characterised by minimal resources and limited support structures. Similarly, many of the researchers whose works I have included I know personally and have even worked with on previous occasions. I am always struck by how many of them have a genuine and relentless desire to improve the lives of those with mental health problems in Africa and elsewhere. Ultimately, whilst writing, and reading through this thesis, I have been plagued by feelings of guilt. In taking a critical approach to this research, I have not meant to trivialize or demonize who these individuals are, and the work that so many of them tirelessly do. At the same time, however, I have not been able to ignore the many meaning-codes that lurked in the shadows of the stories I heard and texts I read, ones which were implicated with particular forms of power. Holding these shadows up to the light is ultimately a slippery ethical and political endeavour, one which carries both perils and possibilities.

Conclusion

Research is a messy business that often involves a great deal of improvisation and continual reassessment. Adequately capturing this ‘mess’ is not easy, and largely discouraged when writing research methodologies. Indeed, when talking about the prevailing preoccupation with “methodological cleanliness”, John Law (2004, p. 3) articulates:

Sometimes I think of it as a form of hygiene. Do your methods properly. Eat your epistemological greens. Wash your hands after mixing with the real world. Then you will lead the good research life. Your data will be clean. Your findings warrantable. The product you will produce will be pure. Guaranteed to have a long shelf-life.

This research project was far from clean: Policies never arrived; search strategies for documentary material consistently changed; phones played up; tape-recorder batteries went dead; interviews were delayed or rescheduled or even cancelled; and many tricky ethical and personal concerns emerged and were never quite resolved. Writing about ‘what I did’ after these were done has made things appear a lot more ordered and planned. They were not. However, a consistent set of research practices has endured through this project, practices that involve the methodical and transparent collection of information, deep reading and adaptation of theoretical concepts and texts, and intense reflection on purposes and interests, both my own and others.

3. THE CONCEPTUAL TOOLBOX

Introduction

“Only by making the rules of the playground visible and negotiable might myriad ways of seeing, knowing and being be able to bloom”

(Bowker, 2001, p. 10)

As I have been describing, this research is concerned with the production of knowledge on the mental health ‘treatment gap’ in Africa. It is thus an epistemological project, focused on problematizing the nature of the knowledge produced in this area. A knowledge project such as this is therefore less concerned with the actual content of an area of interest, and more on the deep knowledge assumptions that mediate the way in which problems get framed and solutions get determined. Ultimately, it is research which is tuned into epistemological questions regarding the conventions of meaning-making that lie *behind* the knowledge that is produced, disentangling the power dynamics at play.

In this chapter I develop a conceptual toolbox for this task, one which extracts and synthesizes various theoretical resources being used widely within two broad fields of study, namely Science and Technology Studies (STS) and Postcolonial Studies. STS is an interdisciplinary field which is informed by a range of theories and standpoints, inter alia Wittgensteinian philosophy, post-structuralism, Foucauldian critical theory, symbolic interactionism, semiotics, feminist epistemology, actor network theory amongst many others (Bauchspies et al. 2006; Labinger & Collins, 2001; Pinch, 2001; Restivo, 1995). The intellectual landscape of this field is thus inherently varied, comprising a number of diverse theoretical and methodological positions. However, as suggested by various scholars (Biagioli, 1999; Bauchspies et al. 2006; Bowden, 1995; Callon, 1995; Hackett et al., 2008; Law, 2008a; Sismondo, 2004), a common thread that holds the fabric of STS together is a unified concern with the representational politics of scientific knowledge and practice. That is, there is a shared focus on the social, historical, political, economic, cultural and/or material foundations of science, including medical science. Indeed, a number of scholars have looked critically at the medical sciences from a STS perspective (for example Berg &

Mol, 1998; Casper & Berg, 1995; Elston, 1997; Levine, 2012; Mol, 2008, 2002; Mol et al., 2010; Moser, 2005; Stengers, 2008), and others have focused specifically on the mental health sciences (for example Moser, 2008; Pols, 2004; Stengers, 2003).

Postcolonial Studies is likewise a multi-disciplinary intellectual enterprise that has a similar interest in the basis of knowledge structures and the representational work that knowledge does. However, this field tends to anchor such a concern to a particular set of historical power struggles and their geopolitical consequences. More specifically, Postcolonial Studies seeks to problematize the unequal relations between the geopolitical North and South that were historically construed by European colonialism and modernity (Ashcroft, Griffiths and Tiffin, 1995, 1998; De Sousa Santos et al., 2007; Moore-Gilbert, 1997; Said, 1978; Spivak, 1990). The field thus directs its critique towards the relationship between colonisers and colonised, and the epistemological and cultural effects this relationship have had on the production of knowledge (Ashcroft, Griffiths and Tiffin, 1995, 1998). Like STS, various scholars have engaged with the medical sciences through a Postcolonial lens (for example Butchart, 1998; Comaroff, 1993; Comaroff & Comaroff, 1992; King, 2002), including the mental health sciences in particular (for example Barrett, 1996; Fanon, 1963; Holdstock, 2000; McCulloch, 1995; Swartz, 1986; 1998; Vaughan, 1991).

Despite the overlapping interests of these two fields, according to various scholars (Anderson, 2002; Anderson & Adams, 2008; Harding, 1998; McNeil, 2005), they have thus far sustained somewhat of a limited formal engagement with each other. There have been a few recent attempts to put these two intellectual traditions in dialogue with each other. For example, two special issues (Anderson, 2002; McNeil, 2005) have been published recently in an effort to outline what they refer to as “postcolonial technoscience”. This has been defined as research which is tuned into “both the impact and legacies of formally deposed imperial regimes and to new forms of exploitative global relations...and the importance of acknowledging such relations in the context of STS” (McNeil, 2005, p. 107). Thus, proceeding from this view, I attempt to undertake a careful and in-depth conversation between these two fields of study. Ultimately, it is hoped that this will provide a potentially productive intellectual space for engaging with the nature of knowledge on the mental health

Four concepts form the core of my conceptual toolbox, namely, those of an ‘*episteme*’, ‘*paradigm*’, ‘*classification system*’ and ‘*black box*’. These concepts have been defined in varying ways and used within a number of different contexts within both STS and Postcolonial studies. I thus describe how I will use these concepts, particularly in relation to each other, and articulate how they might usefully buttress one another. I explore how taken together, they enable one to identify some of the underpinning structures of knowledge, and understand how these structures are socially constructed, exceedingly powerful and yet ultimately invisible.

I then view these concepts through a Postcolonial space of thinking, which serves to ground them within a particular time and space, and thus position the focus of my epistemological project in a very specific way. That is, one which seeks to contribute towards decolonising the episteme of European Colonial Modernity. I draw upon the ideas of ‘*African Modes of Self-Writing*’ and ‘*Southern Theory*’ in order to articulate the specific kind of decolonization I seek to undertake through my research. This is one which aims to shift the privilege granted to Eurocentric forms of meaning-making to more ‘Africa-focused’ models of scholarship. I define what I mean by the slippery notion of ‘Africa-focused’. That is, scholarship which is centred upon the needs and dilemmas in Africa, whilst simultaneously recognises that identities and experiences and knowledges on the continent, as with elsewhere, are complex and heterogeneous.

The underpinning structures of knowledge: Episteme, paradigms, classification systems and black boxes

“...And what of the left handers in the world of right-handed magic, chronic disease sufferers in the acute world of allopathic medicine, the vegetarian in MacDonaldis?”

(Bowker & Star, 1999, p. 9)

Four concepts, an ‘*episteme*’, a ‘*paradigm*’, a ‘*classification system*’ and a ‘*black box*’ form the foundation of my theoretical toolbox, notions which I shall now explore. The concept of an episteme is commonly associated with the French philosopher and social theorist Michel Foucault. Foucault was particularly interested in the historical configurations of knowledge/power structures, and the forms of regulation such structures exercise. In his *The Order of Things*, he moves

language, literature, paintings, economics and more, from the 16th to the 19th centuries, in an attempt to explore the ways in which ‘things’ were ordered- the “pure experience of order and of its modes of being” (Foucault, 1970, p. xxiii). Here he highlights how a major change took place in Western systems of thought between the Classical age of the seventeenth century and the modern era beginning during the eighteenth century. Introducing the notion of an episteme, Foucault explains that each period was characterized by a distinct “epistemological field” or “discursive formation” that shaped the “conditions of possibility of all knowledge, whether expressed in a theory or silently invested in a practice” (ibid, p. 267). Each of these eras thus comprised of a whole ensemble of unspoken rules that governed what were thinkable and acceptable. In other words, each of these periods comprised a distinct episteme. In his subsequent book, *The Archaeology of Knowledge* Foucault (1972, p.212) provides a more explicit definition of an episteme. He writes:

An episteme may be suspected of being something like a world-view, a slice of history common to all branches of knowledge, which imposes on each one the same norms and postulates, a general stage of reason, a certain structure of thought that men [sic] of a particular period cannot escape- a great body of legislation written once and for all by some anonymous hand...the episteme makes it possible to grasp the set of constraints and limitations which, at a given moment, are imposed on discourse.

Therefore, as depicted here, an episteme is a historical a priori that grounds the modes of knowing of an era. It is a set of assumptions that structures the ways in which people think, understand, and act in the world at any given time (Dreyfus, & Rabinow, 1983). Each episteme prescribes rules for ordering our knowledge and practices, and thus configures the conditions of possibility within a particular epoch. An episteme therefore serves as a kind of all-pervasive space in which the thoughts and practices of an age inhabit, be they philosophical, scientific, social, political or artistic and so forth (Turnbull, 2000). As Foucault (1972, p. 212) goes on to assert:

By episteme, we mean, in fact, the total set of relations that unite, at a given period, the discursive practices...the way in which each of these discursive formations...are situated and operate...the lateral relations that may exist

between epistemological figures in so far as they belong to neighbouring, but distinct sets of practices.

Thus, an episteme creates structural relations between different schools of thinking and acting in a given time. What this definition implies is that an episteme is made-up of many distinct “discursive formations”, which are united through an equivalent set of underpinning assumptions. These more specific ‘discursive formations’, or what can be understood as paradigms, are thus connected through their collective insertion within the same episteme. I thus buttress the notion of an episteme with the concept of a paradigm, in order to further develop my conceptual toolbox.

In his ground-breaking book, *The Structure of Scientific Revolutions*, Thomas Kuhn (1962) focused on understanding how changes in scientific knowledge come about. His key argument is that, contrary to popular belief, transformations in scientific theory do not follow a logically determinate procedure, and cannot be accounted for solely by cognitive changes. Rather, such transformations are complex social processes that emerge out of changing intellectual circumstances and possibilities (Zammito, 2004). In making this argument, Kuhn invokes the notion of a paradigm, a concept which he illustrates by the following story:

An investigator who hoped to learn something about what scientists took the atomic theory to be, asked a distinguished physicist and an eminent chemist whether a single atom of helium was or was not a molecule. Both answered without hesitation, but their answers were not the same. For the chemist the atom of helium was a molecule because it behaved like one with respect to kinetic theory of gases. For the physicist, on the other hand, the helium atom was not molecule because it displayed no molecular spectrum. Presumably both men were talking of the same particle, but were viewing it through their own research training and practice (Kuhn, *ibid*, p. 51).

For Kuhn, these scientists see things differently because they live and work in different worlds, or within different paradigms. They understand a helium atom differently because they are inserted within particular disciplines that each have their own agreed upon ways of understanding and handling scientific objects. As Kuhn (*ibid*, p. 46) argues:

Scientists...never learn concepts, laws and theories in the abstract and by themselves. Instead, these intellectual tools are from the start encountered in a historically and pedagogically prior unit that displays them with and through their appliances.

Thus a paradigm, according to Kuhn, constitutes a world view or what he also calls a “disciplinary matrix”, a kind of constellation of communal commitments and presuppositions. Conjointly, these elements set the terms, or provide “abstracted rules” (ibid, p. 47) around what counts as significant questions, what modes of analysis are appropriate and what kinds of solutions are acceptable. As Kuhn (ibid, p. 108) explains:

As a vehicle for scientific theory, the paradigm functions by telling the scientist about the entities that nature does and does not contain and the ways in which those entities behave. That information provides scientists not only with a map, but also with some of the directions essential for map making. In learning a paradigm, the scientist acquires theory, methods and standards together usually in an inextricable mixture.

A paradigm therefore serves as a conceptual prism through which people make sense of the world (Zammito, 2004). Or put slightly differently, only that which ‘fits’ with the ideas of the accepted paradigm make sense and thus acquire significance. That which does not ‘fit’, the anomalies, might go unnoticed or be displaced, until one day they might potentially fit into a new paradigm (Turnbull, 2000). Thus, for Kuhn, ‘normal science’ takes place when scientific puzzle-solving occurs within the terms of a shared paradigm, in other words, it is “research firmly based upon one or more past scientific achievement, achievements that some particular scientific community acknowledges for a time as supplying the foundation for its further practice” (ibid, p. 10). ‘Revolutionary science’ occurs when anomalies accumulate and are increasingly deemed to be significant: “the tradition-shattering complements to the tradition-bound activity of normal science” (ibid, p. 12). This might provide the impetus for a major crisis and with it a paradigm shift, bringing about a new paradigm whose consolidation signals the return to normal science and its associated puzzle solving.

My conceptual toolbox can therefore be thickened by placing Kuhn's paradigm and Foucault's episteme in conversation with each other. A paradigm can be thought of as the distinct set of assumptions that structure the production of knowledge within a particular discipline or school of thought. Different paradigms might have different sets of rules governing what is thinkable and sayable. And yet these varying paradigms, with their own specific communal commitments, will all still share a similar epistemological and metaphysical space. In other words, they will be connected through their collective insertion within the same episteme. In the same way as an episteme is made up of a number of interrelated paradigms, a paradigm can also be thought of as having various connected components or knowledge structures. A classification system can be understood as one such 'smaller unit', amongst many others. I thus come to the third key concept of my theoretical toolbox, the notion of a classification system.

The idea of classification systems, and how such systems shape our knowledge of the world, has received much attention from scholars Geoffrey Bowker and Susan Leigh Star. In their *Sorting Things Out*, they explore the role of categories in shaping the modern world (Bowker & Star, 1999). For these scholars, systems of classification are essential, without which any attempt at understanding the world would be inconceivable. Such systems are therefore necessary and unavoidable. But this does not mean that they are given or innocent, as is commonly assumed. As Bowker and Star assert (ibid, p. 10), a classification system is "a spatial, temporal, or spatio-temporal segmentation of the world... a set of boxes (metaphorical or literal) into which things can be put to then do some kind of work". What these scholars are therefore insisting is that classifications create boxes, and it is the design of these boxes- their size, shape, quantity, site and substance- which mediates what can be put into them. They go on to emphasize that, "Many scholars see categories and classification as coming from an absent sense of 'mind', little anchored in the exigencies of work or politics" (ibid, p. 286). For these scholars then, although classification systems are frequently assumed to be inevitable, in fact much effort goes into their construction and maintenance. This work that is involved with their development is always imbued with particular ideological positions, interests and values.

The example of the International Statistical Classification of Diseases and Related Health Problems (ICD), as described by Bowker and Star (*ibid*, pp. 107-134), is very illuminating in this regard. They demonstrate how, as social and political mores shift and change, so too do categories of disease entities. New ‘diseases’ are frequently being ‘discovered’ and classified within the ICD, with others being determined as no longer illnesses after all and consequently eliminated as valid disease categories. The ICD thus constantly negotiates and redefines the boundaries of illness categories. Indeed, as outlined in detail elsewhere (Smith, Bartlett, King, 2004), the specific case of homosexuality, which until the mid-1980s was categorized as a medical condition, most aptly captures the political nature of illness classifications. It is not difficult to see how this official medical diagnosis occurred within the context of powerful socio-political forces that were against variations from the traditional heterosexual dyad that prevailed for much of the 20th century (Smith, Bartlett & King, 2004).

Taking the notions of an episteme, a paradigm and a classification system together provides a useful framework for thinking about the underpinning structures of knowledge. What all of these concepts imply is that the production of knowledge is not merely a descriptive practice, one which generates supposedly inevitable mappings of the world. Rather, at the heart of all three concepts is the idea that knowledge is fundamentally social and political and historical, deeply contingent upon the context in which it is produced. How we understand phenomena, solve problems and categorise entities are intrinsically moulded by a deep and shared ensemble of unspoken assumptions that are accepted within a given moment of time. What these concepts therefore suggest is that understanding the nature of knowledge necessitates that we surface the episteme, and associated paradigms and classification systems, and unpack their underpinning politics and assumptions.

What makes knowledge structures such elusive entities for analysis, however, is that they are as invisible as they are powerful (Bowker & Star, 1999). The episteme in which we operate, and associated paradigms of knowledge and classification systems become so taken for granted and natural, so intrinsically accepted as ‘given’, that almost by definition their underlying scaffolding disappears (Foucault, 1970, 1972). In other words, all of the rules and assumptions and values and politics that shape how we see and think in the world, become deeply buried, or sealed up in what

Bruno Latour (1987, 1999) has called the ‘black box’, the fourth fundamental concept of my conceptual toolbox.

In his *Science in Action*, Latour (1987) explores the activities of scientific ‘fact-making’, unpacking how scientific ‘facts’ become accepted as incontrovertible ‘givens’. Here he constructs the notion of the ‘black box’, referring to entities whose constitution are so completely taken for granted, so assumed to be real, that their inner workings need not be examined nor questioned. These inner workings are all the interests and politics and values and rules inscribed in the construction of knowledge, which I have been describing above. Once something becomes a ‘black box’, or ‘black boxed’, we stop scrutinizing how it came to be, or who and what participated in its construction. It becomes a “closed” and “tightly sealed” file imbued with a spurious quality of self-evidence (ibid, p. 23). In his *Pandora’s Hope*, Latour (1999, p. 304) enlarges on the process of ‘black-boxing’ as:

The way scientific and technical work is made invisible by its own success. When a machine runs efficiently, when a matter of fact is settled, one need focus only on its inputs and outputs and not on its internal complexity. Thus, paradoxically, the more science and technology succeed, the more opaque and obscure they become.

What this opaqueness enables, according to Latour (1999, p. 304), is a focus on “inputs and outputs” and not on the complex processes that produce these effects. In other words, all of the meta-narratives and politics through which the ‘fact’ was produced and is maintained are concealed. The logic and consequences of the knowledge produced thus become deeply hidden. And lest this sounds too conspiratorial, we have to understand that this process is normalised and archived in such a way as to be inherited and accepted as common-sense reality. It is here that ‘black boxes’ become so very powerful, as by making their inner workings invisible, they create the illusion, or “god-trick” that they represent self-evident truths, a kind of “nature has spoken” (Haraway, 1999, p. 177). This will invariably censor certain kinds of thought and oppress particular people, albeit unknowingly. Thus, according to Latour (1999, p. 29) we need to “reopen the black box, break it apart and reallocate its components”. We need to delve into the archives of epistemic, paradigmatic and classification design, making them visible, unpacking their

assumptions and power relations and thinking about their implications. It is ultimately about making some of the most routine and accepted knowledge claims “strange” (Collins, 2001, p. 159), destabilising their apparent stability and piercing their self-evident logic.

Thus, in terms of my specific topic of the mental health ‘treatment gap’ in Africa, what my analysis so far suggests is that knowledge in this area, and the solutions being proposed, are neither neutral nor given. Rather, such thinking is being shaped by a whole ensemble of unspoken knowledge assumptions and politics within the mental health sciences specifically, and society more generally. Such thinking is deeply embedded within a variety of accepted norms around what count as significant kinds of questions, what modes of analysis are appropriate for answering these questions and what sorts of solutions are acceptable. Unpacking these taken-for-granted thus requires making visible the dominant paradigms and classification systems structuring knowledge on the mental health ‘treatment gap’. It necessitates unearthing the hidden assumptions and capillaries of power that are embedded in such organizing frameworks. It involves problematizing which views about Africa, mental distress, care, dignity, human behaviour and progress (to name just a few) are inserted into these larger explanatory metanarratives. Ultimately, it requires asking what other, potentially productive ways of thinking and choices are being obscured by these understandings.

By prizing open the black boxes of knowledge on the mental health ‘treatment gap’ in this way, making the silent codes and conventions that guide the knowledge outcomes visible, this research becomes a form of epistemological politics; in other words, a struggle over meaning. Yet the very real practical and material significance of an epistemological project such as this cannot be overstated. As suggested by Krieger (2000), work at an epistemological level is indeed somewhat uncommon within the public health sciences, frequently dismissed as abstract and inappropriate given the urgency of pressing health issues. However, examining the assumptions embedded in our work is profoundly practical. This is because knowledge is not only constructed, but also constitutive. Through our knowledge producing practices, we bring very ‘real’ things into being. This is indeed the perspective of various STS scholars working within a post-structuralist albeit materially-oriented mode of thinking (see for example Haraway 1991, 2008; Latour, 2004; Law, 2008a; Law

Urry, 2004; Mol 1999, 2002; Moser, 2008). According to such thinking, the episteme, paradigms and classification systems in which we work have very real force in the world. As Lien and Law (2011, p. 68) assert, “Social structures are being generated at the same time and in the same moment as scientific (or other) forms of classification or knowledge: the social and the natural classifications are being enacted together in material practices”.

Thus, from this perspective, the ‘real’ and the representational, the material and the semiotic are dialectically intertwined (Jensen & Bowker, 2005). Knowledge structures simultaneously represent and enact realities. Indeed, this is what Kuhn was getting at when he ascertained that after a paradigm shift occurs, scientists work in a different world. The world after Copernicus or Einstein changed, or as Kuhn (1962, p. 111) puts it, “What were ducks in the scientist’s world before the revolution are rabbits afterwards”. Bowker and Star also provide a useful example in the case of mental illness to illustrate the real, material force of our classificatory practices:

Consider the case where all diseases are classified purely physiologically. Systems of medical observation and treatment are set up such that physical manifestations are the only manifestations recorded. Physical treatments are the only treatments available. Under these conditions, then, logically schizophrenia may only result purely and simply from a chemical imbalance of the brain. It will be impossible to think or act otherwise (1999, p. 49).

Our knowledge structures are therefore powerful entities that influence both representations and realities. They valorise some points of view and obscure others, privilege certain kinds of truths and silence others. At the same time, they also bring certain worlds into being and make it difficult for others to come into existence. Ultimately, those anomalies, which cannot be encapsulated within the structures of our paradigms and classification systems, are excluded from our knowledge archive and in turn our potential ways of being in the world. As such, the underpinning knowledge assumptions structuring thinking on the mental health ‘treatment gap’ will invariably have very real and material consequences. They will provide a lens through which the issues are being framed, and thus mediate the kinds of solutions that will be determined. They will help shape the nature of the services that are developed, the kinds of health campaigns that are implemented and the

behaviours that are advocated. Ultimately, unless we look critically at what lies behind the thinking of these initiatives, they might prove to be ineffective (however this is defined) and have unintended negative consequences.

The dominant episteme: European Colonial Modernity

“‘When I use a word’, Humpty Dumpty said, in rather a scornful tone, ‘it means exactly what I choose it to mean- neither more nor less’.

‘The question is,’ said Alice, ‘whether you can make words means so many different things.’

‘The question is,’ said Humpty Dumpty, ‘which is to be master- that’s all’”

(Carroll, 1872, p.72)

Thus far, I have developed my conceptual toolbox by incorporating and relating the notions of an episteme, paradigm, classification system and black boxing. I have explored how, in conversation with each other, these concepts help one to understand how the underpinning structures of knowledge are socially constructed, powerfully constitutive and yet ultimately invisible. Now, if we look at these concepts through a Postcolonial space of thinking, what we see is that a particular episteme, and associated paradigms and overarching classification system, emerged during the era of colonialism and what is understood as European modernity. I will refer to this throughout as the episteme of European Colonial Modernity. This episteme increasingly came to govern the structures of thought amongst both the colonists and colonised (Ashcroft, Griffiths and Tiffin, 1995, 1998; Moore-Gilbert, 1997). In other words, beyond its economic and political dimensions, colonialism also had a strong epistemological dimension. It was thus characterised by both physical forms of exclusion, oppression and discrimination, as well as more subtle forms of cultural and epistemological domination.

In the next chapter, I explore in detail the nature and historical constitution of two particular paradigms of thought which are deeply inserted in the episteme of European Colonial Modernity. These are the paradigms of evidence-based science (including biomedicine) and human rights. In this current chapter, I would like to touch on one of the most stubborn and powerful forms of classification buried in the ‘black box’ of this episteme. This is a broad system of classification which tends to demarcate the world into homogenous entities and stark binary oppositions: ‘Africa’ versus ‘Europe’, ‘traditional’ versus ‘modern’, ‘primitive’ versus ‘civilized’, ‘belief’

versus 'knowledge', 'subjective' versus 'objective'. As most pertinently demonstrated by Edward Said (1978) in his *Orientalism*, through the metalanguage of colonialism and modernity, imaginary lines were drawn and monolithic categories were constructed. Through this logic, entities in one column were designated as inherently superior or essentially progressive, whilst those in the other column were relegated as innately inferior or naturally subsidiary. The value judgements and assumptions underpinning these designations were, however, ultimately 'black-boxed' in the normalised categories of science, objectivity, progress, knowledge and so forth.

As suggested by various Postcolonial scholars (Chakrabarty, 2000; Comaroff & Comaroff, 2012; Quijano, 2000; Said, 1978), this kind of classification system, and associated hidden assumptions, was intimately embroiled with modernist Europe's attempts to delineate its own contemporary identity, and to produce, define, and contain non-European difference. From the eighteenth century onwards, there was a mounting belief in the exceptionalism and uniqueness of contemporary Europe, inherently different from its own previous eras. Not only essentially dissimilar to however, but also inherently better than, its past. As Enlightenment scholar, Immanuel Kant famously asserted, the Enlightenment was "man's final coming of age...the emancipation of the human consciousness from an immature state of ignorance and error" (cited in Wilson, 2004, p. 649). In other words, as highlighted by Festa & Carey (2009), modernist Europe's contemporary institutions, practices, and conceptual schemes- an industrial capitalist economy, a liberal nation-state, positivistic scientific methods, human rights principles or various ensembles of these things - were increasingly understood as essentially modern, inevitably progressive and inherently superior.

It was through this same logic that Enlightenment Europe also depicted and created the colonial 'Other' (Festa & Carey, 2009; Iggers 1982). Eighteenth century Europe began to understand itself as holding a superior position, not only in relation to its own past, but also in relation to other contemporary societies. These other, non-European societies were increasingly characterised as embodying more rudimentary organizational stages of development, and thus occupying a retarded temporal space within the evolutionary chain (Smith, 1999). They were assumed to be the primitive

version of Europe, similar to what Europe was before it evolved into the era of modernity (Oguejiofor, 2007). As Quijano (2000, p. 221) succinctly states:

All non-Europeans could be placed vis-à-vis Europeans in a continuous historical chain from 'primitive' to 'civilized', from 'irrational' to 'rational', from 'traditional' to 'modern', from 'magic-mythic' to 'scientific'; in sum from non-Europeans to something that could be, in time, at best Europeanized or 'modernized'.

Therefore, in legitimizing tropes of otherness and polarizations of difference, this form of classifying the social world served to unambiguously distinguish Europe from its 'other', and validate its supposed "positional superiority" (Said, 1978, p.7). Moreover, as suggested by various scholars (Chakrabarty, 2000; Comaroff and Comaroff, 2012; Quijano, 2000), this system of classification contained a strong normative stance, implying that European modernist ways of knowing and being were those to which *all* of humanity should aspire. Ultimately, to become modern, was to become European, or rather as Aníbal Quijano (2000, p. 221) puts it, "Europeanised". This normative position was indeed deeply entangled with European imperialist ends, providing the ideological justification for Europe's appropriation of other territories and peoples (Dussel, 2000; Oguejiofor, 2007; Quijano, 2000, 2007; Said, 1978; Smith, 1999). As Enrique Dussel (2000, p. 472) in his *Europe, Modernity and Eurocentrism* suggests:

The modern, European civilization casts itself as a superior, developed civilization. The aforementioned superiority makes the improvement of the most primitive, coarse people a moral obligation...insofar as barbaric people oppose the civilizing mission, modern praxis must exercise violence...understood as an inevitable action in order to destroy the obstacles impeding modernization.

Thus, under the guise of the 'civilizing mission', this way of ordering the social world was used to validate colonialism as a supposedly moral endeavour aimed at modernizing non-European populations and helping to liberate them from their supposed backwardness. Ultimately, such enterprises were cast as merely helping

non-European societies develop apparently more modern and progressive ways of knowing and being.

Despite the end of formal colonial rule however, many have argued (Connell, 2007; Smith, 1999; Said, 1978; Spivak, 1990) that conventional knowledge of the world today continues to be filtered through this epistemological order and associated way of ordering the social world. That is, although political power was ostensibly transferred to the formerly colonised, it “did not transform the structures of domination - that is, the institutional and cultural contexts of Western hegemony in the global international order, and African [and Third World] marginalisation within it” (Grovoqui, 1996, p. 2).

For example, in her *Southern Theory* (2007), Raewyn Connell highlights how there are still deep global inequalities within the context of knowledge production. She demonstrates how scholars in the geo-political South continue to operate within an academic terrain dominated by the form of ordering the social world originating from the geopolitical north during European modernity and colonialism. As such, Connell argues, there is still a stubborn endurance of Eurocentric power, whereby experiences within Africa continue to be filtered through the structures of knowledge formed by the episteme of European Colonial Modernity. Along similar lines, in her *Decolonizing Methodologies*, Linda Tuhiwai Smith (1999) argues that the episteme of European Colonial Modernity established a positional authority of Western ways of ordering the world. She suggests that this epistemological order continues to have a tenacious hold today, still powerfully conditioning the possibilities for contemporary subaltern scholarship. In other words, the experiences of the previously colonized continue to be the subject of an orientalising gaze, and understood through classifications developed to understand and define the realities of modernist and colonial Europe. As Smith (ibid, p. 199) ascertains:

It is still difficult for the heirs of the colonizers and the colonized alike to think outside of the categories and bodies of knowledge formed by the epistemological order of colonialism... or even to make out whether one speaks from within, outside of, or at all without colonial discourse.

These kinds of arguments about the continued dominance of the episteme of European Colonial Modernity, and associated classification system, have been made in relation to the mental health sciences more specifically. Many scholars have argued that since their emergence, and continuing into the present, the mental health sciences have been constituted predominantly out of knowledge and theories which originate from the geopolitical north. For example, during the colonial and early postcolonial period, critical psychiatrists such as Collomb (1975), Fanon (1963) and Lambo (1981) argued strongly against the intrinsically Eurocentric nature of psychiatry, and its reproduction of a hegemonic imperial cultural order. For example, Collomb (1975, p. 106) through his vision of a ‘une psychiatrie africaine authentique’ challenged young African psychiatrists of his day to free themselves from the constraints of Western psychiatric models by developing local solutions which fitted with Africa’s own social and cultural resources. Similarly, Franz Fanon through his ‘psychiatry of liberation’ consistently spoke about the universalizing trends of psychiatry, and argued for its ‘decolonisation’, along with the African psyche (Vergès 1996).

More recently, a number of African scholars have spoken about the “cultural colonialism” (Mkhize, 2004, p. 26) of the contemporary mental health sciences and their continued “cultural one-sidedness” (Louw, 2002, p. 1) and “Westocentric” nature (Holdstock, 2000, p. 10). It is emphasized (for example Barrett, 1996; Danziger, 1997; Hook, 2004; Inglby, 1981; Staeuble, 2006; Swartz, 1998; Yen & Wilbraham, 2003) that so many of the theories and concepts of the mental health sciences still reflect a particularly Eurocentric epistemological structure of human existence and understanding. Ultimately, as Stam (2004, p. 24) succinctly puts it, the mental health sciences continue to embody “scientized and institutionalized variants of the eighteenth century colonial moral language”.

Many problematic effects of the continued hegemony of this epistemological order, including within the field of mental health, have been highlighted. It is suggested that this dominance perpetuates the legacies of colonialism and of racism, and buttresses certain kinds of privilege. Indeed, for many critical Postcolonial scholars (for example Mignolo, 2007; Nandy, 1989; Quijano, 2000, 2007; Sardar, 1998; Smith, 1999), uncritically accepting the authority of this epistemological order is to inhabit a particular political philosophy, one which they identify as an extension of

colonialism. At the same time, the continued supremacy afforded to this episteme means that ‘other’ kinds of knowledges, which do not necessarily share the same epistemological space, are so often marginalised or excluded (Ashcroft, Griffiths and Tiffin, 1995; Moore-Gilbert, 1997; De Sousa Santos et al., 2007, Spivak, 1990, 1995). This exclusionary logic will be unpacked in greater detail in the next chapter.

Ultimately, this epistemological order, which will continue to exert its powers in more or less productive ways, needs to be subjected to rigorous critique. In other words, in order to destabilise its continued dominance, and enable ‘alternatives’ to potentially grow, the intellectual heritage of modernity and colonialism needs to be decolonized (Appiah, 1995; Mignolo, 2007; Nandy, 1989; Said, 1978; Spivak, 1990, 1995; Turnbull, 2000). Or as Water Mignolo (2007, p. 469) puts it, we need to “unveil the totalitarian complicity and seeming historical inevitability of the rhetoric of modernity and the logic of coloniality in order to open up space for the possibility of ‘another world’ in which many worlds can co-exist...”.

Decolonising the episteme: The rise of an ‘indigenous knowledge’ movement

“There should be no room for cultural arrogance. Africans are neither Americans nor Europeans...African people should be treated within the framework of their own culture and belief systems”.

(Mosotheo et.al, 2011, p.447).

Such a project of epistemic decolonization has been interpreted and approached in a range of diverse and at times opposing ways. One particularly influential strand, from which I wish to separate my research, has been referred to as ‘indigenisation’ or the ‘indigenous knowledge movement’. According to various critical Postcolonial theorists (Ashcroft, Griffiths and Tiffin, 1995, 1998; Green, 2012; Odora Hoppers, 2002), this movement has sought to challenge the continuing dominance of Northern structures of knowledge by asserting that Africa has its own ‘indigenous’ knowledge systems - or perhaps, multiple ones - which are independent from ‘Western’ knowledge structures. As suggested by these scholars, a project of decolonization from this kind of indigenous perspective, requires discarding structures of thought that originate from the West, and at the same time unearthing ‘native’ ways of thinking in their original form.

These sentiments are clearly discernible within many of the critiques of contemporary Global Mental Health, as alluded to in the previous chapter. Here there is a common tendency to speak about the “dubious enterprise” of Global Mental Health which is “imposing” Western psychiatry whilst “suppressing indigenous healing systems and knowledge” and “disrespecting the wisdom of traditional cultures” (Fernando, 2011, p. 22; see also Davar, 2014; Fernando, 2012; Ibrahim, 2014; Ingleby, 2014; Lang, 2014; Lee, 2014; Mills, 2014; Sax, 2014; Summerfield, 2012 who all make this kind of argument). Thus, ‘Western’ psychiatric models tend to be construed within these critiques as essentially malign, and with relatively little to offer for people in Africa. Strong calls are therefore being made for the rejection of such supposedly ‘alien’ models and the development of mental health theories and practices which are based upon apparently ‘traditional’ African values and systems of healing.

As emphasised by Connell (2007), this kind of ‘indigenous knowledge’ movement is an understandable retort to the consistent hegemony of structures of thought which depend on the epistemological order of the geopolitical north. However, the problems and potential dangers of this kind of ‘Afrocentric’ perspective are manifold. Such an approach tends to produce a view of Africa as essentially static and monolithic, ultimately outside of influence and multiplicity. It is premised on an idea of Africa’s distinctiveness from Europe, and that there are essentially ‘pure’ and ‘authentic’ African identities and system(s) of knowledge, which may be unearthed and revived. Yet as various critical Postcolonial scholars have argued (Ashcroft, Griffiths and Tiffin, 1995, 1998; Bhabha, 1994, 1995; Connell, 2007; Mbembe, 2002; Smith, 1999), this current of thought tends to obscure the inherent fluidity, diversity and interdependence of identities and knowledges.

For example, Homi Bhabha ascertains that different cultures and knowledges, including those in Africa, are complex and diverse, having assimilated and mutated over centuries. He thus argues against the notion of a “primordial unity or fixity” of identities and knowledge systems, the “inherent originality or purity” that can be unearthed and reclaimed (Bhabha, 1995, p. 208). Along similar lines, Achille Mbembe (2002, p. 254) suggests that calls for indigenization or what he terms “nativist currents of thought” claim “that Africans have an authentic culture that

confers on them a peculiar self irreducible to that of any other group”. This results in an emphasis on establishing a unique “African science,” an “African democracy,” an “African language” which, according to Mbembe (ibid, p. 255), is premised upon a mythologised view of a “unique African identity” and an “authentic African interpretation”. For him, ‘authentic’ or ‘pure’ kinds of identities and knowledges do not exist. Rather, there is an inherent contingency, entanglement and malleability between knowledges, a constant melange of cross influences and currents- global and local. As he articulates:

To be sure, there is no African identity that could be designated by a single term or that could be named by a single word or subsumed under a single category. African identity does not exist as a substance. It is constituted, in varying forms, through a series of...mobile, reversible, and unstable practices (ibid, p. 272).

Therefore, according to scholars such as Bhabha and Mbembe and others, this indigenization approach becomes a new kind of essentialism, whereby although seemingly at loggerheads with Eurocentricity, is in fact structurally very similar. That is, both Euro- and Afro-centric modalities of thought have a single, monolithic benchmark by which to judge and value the world and they share a view of history that denies change and multiplicity, as well as the movement of people and things in more than one direction. Although calls for indigenization may have changed the content, the Eurocentric system of classification system, with its stark demarcations and homogenous entities, remains firmly intact. As Mbembe (2002, p. 256) asserts, “nativist currents of thought draw their fundamental categories from the myths they claim to oppose and reproduce their dichotomies”. Thus, according to both Bhabha (1994, 1995) and Mbembe (2002) and others, this ultimately limits the possibility of an effective subversion of the inherited Eurocentric knowledge archive.

Such an approach is not only misguided, but might also have potentially dire consequences, as the case of HIV/AIDS in South Africa most pertinently shows. As Green (2012) and Colvin (2012) both suggest, here supposed ‘African medicine’ was constructed as the antithesis of ‘Western science’, undergirding the state’s policy to deny HIV-positive people antiretrovirals, which cost millions of South Africans their lives. These kinds of sentiments are clearly discernible within certain critiques of

Global Mental Health, and particularly the suggestion that psychotropic medications are essentially ‘Western’ and thus inappropriate for the people in Africa. Ultimately this argument could have similarly detrimental repercussions as the case of HIV/AIDS.

Contributing to decolonization: Transcending both Afro- and Euro-centricity

“Can we have social theory that does not claim universality for a metropolitan point of view, does not read from only one direction, does not exclude the experience and social thought of most of humanity, and is not constructed terra nullius?”

(Connell, 2007, p. 47).

So, the question is, how might we think about challenging the unequal nature of the global knowledge economy, whilst simultaneously appreciating the inherent complexity and synchronicity of people and things in numerous directions? That is, how to contribute towards decolonising the episteme of European Colonial Modernity, without recourse to a stance of indigeneity and Afro-centrism? Achille Mbembe (2002) has coined the now catch term, “*African Modes of Self-Writing*” which might be helpful in this regard. This phrase acknowledges the need for people in Africa to find their own styles and theories which are not necessarily defined by the modernist vision and the legacy of colonialism. For Mbembe (ibid, p.242), such modes of creating knowledge need to fit with ‘African’ realities, and be shaped by these. However, such meaning-making needs to simultaneously appreciate that there is an inherent heterogeneity of “African imaginations” which come forward as “multiple, disparate but often intersecting knowledges and practices”. In other words, it is about “opening up the way for selfstyling” on the continent, in a manner which recognises African knowleges and traditions as diverse, complex, global and cross cutting (ibid, p. 242).

Along similar lines, Raewyn Connell’s (2007) notion of ‘*Southern Theory*’ might also be useful for thinking about how we might destabilise the unequal nature of the global knowledge economy in ways which refuse both Afro- and Eurocentricity. Connell (ibid, p. 47) asks: “Can we have social theory that does not claim universality for a metropolitan point of view, does not read from only one direction, does not exclude the experience and social thought of most of humanity, and is not

constructed *terra nullius*?”). What Connell is suggesting by *terra nullius*, that is, ‘the silence of the land’, is the problem with the disregard for context within dominant social theory. Thus, according to her, approaches to knowledge production need to take place and context seriously, appropriately entangling theory with the realities, lexicons and matrices of particular, situated contexts. Importantly, however, a focus on ‘the particular’ needs to avoid geographical essentialism based on local/global conceptual binaries. For her, such provincializing ignores the zones of engagement and connectedness between supposedly ‘local’ and ‘global’ knowledges and actors. Instead, Connell argues for what she calls ‘Southern theory’, which is predicated on “relations- authority, exclusion, inclusion, hegemony, partnership, sponsorship, appropriation- between intellectuals and institutions in the metropole and those in the world periphery” (ibid, p. viii–ix).

What scholars such as Mbembe and Connell are therefore suggesting is that there is an urgent need for boundary pushing within the modes of creating knowledge, modes which shift the privilege granted to Eurocentric forms of meaning-making to more ‘Africa-focused’ models of scholarship. This shift is not, however, about overthrowing one monolithic benchmark or conceptual orthodoxy and uprooting another. Rather, it is about an opening up and a loosening. That is, it necessitates loosening the *inevitability* of the inherited European archive of knowledge by unravelling its contours and revealing its weaknesses. Importantly, this does not mean necessarily rejecting such structures of thought. Indeed, for scholars such as Mbembe and Connell, knowledge, wherever and by whomsoever it is produced, is potentially available for transgressive, emancipatory and counter-hegemonic use. But such structures of knowledge cannot remain black-boxed entities. They need to be opened-up, their meanings unpacked, and their politics re-thought. Ultimately, it requires asking in which context and for whom such structures of thought might or might not be appropriate and worthwhile ways of thinking and living. As Mignolo (2007, p. 499) argues, “Emancipating projects, as devised in Europe in the eighteenth century, can be kept alive, but they must be ‘extracted’ from their appropriation by the rhetoric of modernity to justify the logic of coloniality”.

At the same time, developing more ‘Africa-focused’ models of scholarship also necessitates exploring what ‘other’ kinds of epistemologies and knowledge politics, which do not necessarily originate from European colonial and modernist forms of

consciousness, might be possible and potentially transformative. Importantly, this is not about unearthing or retrieving a lost purity, but requires thinking about how theories and practices might be centred upon and appropriate to the needs and dilemmas in Africa, whilst recognising that these are complex and varied in different parts of the continent and Diaspora.

My research will thus scrutinise how knowledge on the mental health ‘treatment gap’ in Africa might still remain bound to Eurocentric content and orientation. That is, I will interrogate how such knowledge might be reinforcing (albeit unknowingly) some of the ideologies and matrices of power that became embedded in the epistemological order of European Colonial Modernity. I will show how such thinking on the ‘gap’ in mental health care is indeed deeply inserted within this knowledge order, and associated classification system and paradigms of evidence-based science and human rights. Rather than rejecting these structures of knowledge outright, I will explore how appropriate they might be for thinking about the diverse mental health needs and dilemmas of people on the African continent.

At the same time, throughout this research, I will also unpack and where possible foreground ‘other’, potentially transformative forms of meaning-making. I will show how the conceptual resources of ethnographic articulations and critical phenomenology, which emerged amongst the softer voices in this research, may embody examples of such ‘other’ ways of thinking. I will explore how the more dominant knowledge claims might be negating authentic dialogue with these ‘other’ kinds of knowledge paradigms and forms of ordering the world. I will pose questions around how these marginalised ways of knowing might enable more ‘Africa-focused’ forms of scholarship on the ‘gap’ in mental health care to grow and potentially enter into centres of power and influence. Ultimately, I ask how these alternative epistemologies might transform current conversations on the ‘gap’ in mental health care in Africa.

Importantly, I will constantly raise different aspects of these complex questions, rather than bring them to closure with definitive answers. Sadly, there are no ready answers, and any attempt to provide them would be to proclaim some newly captured moral high ground. This risks setting up a new kind of knowledge orthodoxy which I have been arguing against. My challenge is therefore more modest, one which is

conditioned by a constitutive limit. That is, I attempt to surface particular tensions and resonances and hold them up to the light, with the hope of disturbing certain intellectual reflexes and opening-up a space for potentially new imaginings. This is what Donna Haraway (1992, 1999) suggests is at stake for ethical, responsible and self-reflexive research. That is, research whose “images are not the products of escape and transcendence of limits...but the joining of partial views and halting voices into a collective subject position that promises a vision of the means of ongoing finite embodiment, of living within limits and contradictions” (Haraway, 1999, p.182). For Haraway then, this disposition of limitedness is, somewhat paradoxically then, the basis of our accountability, the way in which “we might become answerable for what we learn how to see” (ibid, p. 177). Ultimately, a limited and ambivalent perspective, rather than the all-seeing eye of finality, can be held responsible for both its possibilities and perils.

This posing of questions and searching for alternatives is, fortunately, enabled by the fact that knowledge structures are invariably unstable. Despite their power, they are also vulnerable. Although the core argument holds- that black boxes seal-up the constructedness of coded assumptions and their consequences- the black box is indeed somewhat of a blunt analytical instrument. This is because neither the ordering nor the order is ever closed. Paradigms can change, entities can be classified differently and knowledge structures can at times contest the dominant order. Knowledge inevitably comprises sites of potential discrepancy, lack of ‘fit’ and seepage into and out of the black box. As Bowker and Star (1999, p. 161), assert:

Black boxes may be opened and closed as circumstances and structural conditions change...the box, if you will, is neither clearly closed nor completely black.

Black and white are therefore notorious in their concealment of grey, and thus partial visibility is a more likely condition. This is ultimately why a project of delving into the nature of our accepted codes and assumptions is so challenging, and yet also potentially so transformative.

4. THE PARADIGMS OF EVIDENCE-BASED SCIENCE AND HUMAN RIGHTS: A HISTORICAL PERSPECTIVE

Introduction

“Ideas neither descend from a timeless heaven nor are they grounded in the necessities of ‘nature’, but develop out of the imaginations and intellects of historical human beings”

(Foucault, 1984, p. 42)

In the previous chapter, I suggested that during the era of European colonialism and modernity, a particular epistemological order emerged and increasingly came to govern the ways of thinking amongst both the colonists and colonised. I termed this epistemological order the episteme of European Colonial Modernity, and touched upon one of the most stubborn and powerful forms of classification buried in the ‘black box’ of this episteme. In this current chapter, I develop this analysis further, by looking at the historical constitution of two particular paradigms which are deeply inserted in this episteme. These are the paradigms of *evidence-based science (including biomedicine)* and *human rights*. In particular, I surface, and put into historical perspective, the epistemological assumptions underpinning these paradigms of thought.

I concentrate on these two particular paradigms as, deeply intertwined, together they capture many of the fundamental contours of the episteme of European Colonial Modernity. Moreover, as will become clear, these paradigms are playing a fundamental role in shaping contemporary knowledge of the mental health ‘treatment gap’ in Africa. This chapter therefore provides a historical platform from which my subsequent analyses of this knowledge can be understood. It is important to highlight from the start why I speak about ‘the paradigms of evidence-based science (including biomedicine)’ rather than referring to biomedicine as its own, distinct paradigm. As I will show, biomedicine lives within, and ultimately arises out of, the broader paradigm of evidence-based science. What is now commonly referred to as ‘biomedicine’ or the ‘the biomedical model’ can thus be conceived of as the scientific paradigm of modern medicine.

Rather than being self-evident or inevitable mappings of the world, these paradigms arose out of, and in turn provided an ideological basis for, many of the socio-economic forms of organization and capillaries of power characterizing 17th and 18th century Europe. These paradigms are thus intimately entangled with each other, and with the context in which they emerged. For the purpose of analysis, I discuss each of these paradigms separately. Drawing on the works of key historians of science and Postcolonial scholars, I explore their origins and some of their main knowledge assumptions. Moreover, I unpack how both their roots and underpinning epistemologies were dialectically intertwined with the socio-economic and political forces of 17th and 18th century Europe. A lot has been written about the dominance of these paradigms during the 19th and 20th centuries, and why they gained such a formidable force during this time (see for example Armstrong, 1983; Comaroff, 1993; De Sousa Santos et al., 2007; McCulloch, 1995; Turner, 1995). Although I touch on this later period, my focus in this chapter is on the 17th and 18th centuries. That is, I explore how the tenaciousness of these paradigms have much earlier roots, a power and influence which was strengthened further and ultimately consolidated in subsequent centuries.

Although there are obvious differences between them, I demonstrate how both paradigms share a number of underpinning epistemological assumptions, in particular, those of naturalism, universalism, objectivity and rationalism. Moreover, both paradigms are strongly mediated by stark binary oppositions, indeed the powerful form of classification I explored in the previous chapter. Drawing on the concept of “epistemic violence” (Spivak, 1990, 1995), I argue that a major epistemological effect of these paradigms, and associated assumptions and form of ordering, is the way in which they tend to occlude other ways of thinking and being from entering the formal canon of knowledge. I argue that this exclusionary logic was deeply embroiled with Enlightenment battles over the authorisation of knowledge and attempts to develop boundaries of socio-economic and political legitimacy. Although emanating over four hundred years ago, the forms of exclusion produced by these paradigms still retain their power today. This will become a common thread that will run through my subsequent analyses of knowledge on the mental health ‘treatment gap’ in Africa.

The paradigm of evidence-based science

“‘You are to be in all things regulated and governed’, said the gentleman, ‘by fact. We hope to have, before long, a board of fact, composed of commissioners of fact, who will force the people to be a people of fact, and of nothing but fact. You must discard the word Fancy altogether. You must use mathematical figures which are susceptible of proof and demonstration. You can only form the mind of reasoning animals upon facts. This is the new discovery. This is fact. This is taste’”

(Dickens, 1854, p. 18)

Central epistemological assumptions

From the middle of the 16th century to the early decades of the 17th, Western Europe witnessed an explosion of scientific discoveries and innovations. This era, now termed the Scientific Revolution, saw an infinite number of breakthroughs in the natural sciences (Henry, 2004; Israel, 2001; Knellwolf, 2004). During this time, the finite spherical and earth-centred universe was replaced by Copernicus’s notion of a sun-centred solar system in an infinite expanse of space. Galileo’s pioneering laws of planetary motion were advanced, and Newton developed his innovative theory of gravitation. These evolutions in the fields of cosmology and physics were accompanied by numerous innovations in human anatomy and physiology including, for example, Harvey’s epochal theory of the circulation of blood and the pumping action of the heart.

For the purposes of this chapter, what was significant about this period was that it saw the emergence of particular ways of thinking about the world, and how it can be known. More specifically, it was during this period that the principles and methods of science were born and consolidated. According to various historians of the science (Henry, 2004; Israel, 2001; Knellwolf, 2004; Stewart, 2004), both the origins and fundamentals of this new philosophy of science can be thought to lie in the works of Francis Bacon, Rene Descartes and Isaac Newton. I thus briefly touch on the central ideas of these three scientists, as this will shed light on some of the key underpinning assumptions of the scientific paradigm of thought.

Francis Bacon (1561–1626), commonly referred to as the ‘father of the experimental method’ was the first to articulate the empiricist philosophy of science (Stewart, 2004). For Bacon, ideas should not be upheld because of religious doctrines, but should be determined through rigorous, empirical methods. That is, all knowledge claims should be based upon generalizations of observable facts and technical rules. More specifically, he proposed that through direct manipulation and observation, in the form of an experiment, one can gain an understanding of the workings of nature in a supposedly objective fashion (Knellwolf, 2004). Thus, for Bacon, in order to obtain valid knowledge about the world, “all that was required of the scientist was to follow procedure correctly” (Dickson, 1979, p. 12).

Drawing on these ideas, Rene Descartes (1596-1650), French scientist and founder of the so called ‘mechanical philosophy’, proposed a second method for achieving what he perceived as legitimate knowledge. Descartes, like Bacon, wished to free himself from the current religious criteria of validity, and thus embarked on a general reformation of how truth can be obtained (Henry, 2004; Stewart, 2004). Whereas Bacon focused on the generalizations of observations and facts, Descartes proposed the value of reason as the locus of legitimate knowledge (Schouls, 2004). In developing his Cartesian epistemology, Descartes argued that the world could be divided into two realms (Henry, 2004). The first realm comprises of the hard and machine-like regularities that operate in terms of mathematical laws of cause and effect, while the second encompasses human sensibilities and subjective judgements. He thus formulated a new kind of radical dualism between the objective and the subjective, between logical reason and irrational feelings, between mind and body. According to Descartes, it is the first realm which holds the key to the acquisition of valid knowledge (Knellwolf, 2004). In other words, according to Descartes, legitimate knowledge is that which is built upon the supposedly objective and rational deductions of the mind, deductions which should be detached from the corporeal and the emotional.

These ideas of Bacon and Descartes culminated in Isaac Newton’s (1643- 1727) theory of mechanics and gravitation, a theory which was increasingly seen to provide a comprehensive scientific explanation of the physical universe (Henry, 2004).

Newton shared Descartes’ view of the mechanistic nature of the universe, but tempered this with a Baconian concern for matters of fact and avoidance of

speculation. He thus combined the rational, mechanical approach of Descartes with the strict empirical procedures of Bacon (Murdoch, 2004). According to Newton, the physical universe consists of discrete, solid objects of moving matter that influence each other through material forces. The motions of these objects, and their effects, are in turn governed entirely by stable laws of nature. The universe as a whole, Newton thus asserted, behaves deterministically and that the motions of all physical objects can, in principle, be calculated objectively by a finite number of mathematical formulae (Henry, 2004).

Despite their differences, these three scientists were united on a number of fronts, commonalities which embody some of the core contours of the scientific paradigm. All three sought to challenge theological understandings of reality by proposing a world-view which deferred to science as the ultimate basis for truth (Stewart, 2004). All three scientists assumed that physical nature was a rational sphere, operating according to orderly and universal principles of cause and effect (Murdoch, 2004). For all three of these scientists, these natural laws and principles are in turn knowable through the principles and methods of science. In other words, by following a standard logic- observation, experimentation, measurement and/or deduction- we can come up with explanatory models that objectively capture what is 'out there'. Although they disagreed over whether 'truth' was to be derived deductively from self-evident first principles or by observation and experiment, there was ultimately a shared assumption that 'truth' and 'certainty' could be acquired through human reason (Henry, 2004). In other words, scientific rationality, rather than the religious, the spiritual, the emotional, held the key to greater understanding. As such, together these scientists formulated a particular style of thinking about the way in which of phenomena operate, and how these workings can be legitimately known.

As the 17th century unfolded, this particular style of thought had a profound effect on thinking not only within the physical sciences, but also within the intellectual and social world more generally (Israel, 2001, 2006). It was increasingly believed that if phenomena in the physical realm were governed by natural and universal principles, then surely the social world would be regulated by a similar set of rules and conventions (Fitzpatrick, 2004). There was indeed growing optimism in science as the guarantor of knowledge, with the expectation that by imitating the methods and principles of the natural sciences, the social world could be grasped and positively

directed (Knellwolf, 2004; Wilson, 2004). It was increasingly believed that it was just a matter of bringing such methods and thinking to bear on other aspects of human affairs. As Enlightenment philosopher Marquis de Condorcet (1795, cited in Henry, 2004, p. 24) enquired rhetorically,

The sole foundation for the belief in the natural sciences is the idea that the general laws directing the phenomena of the universe, known or unknown, are necessary and constant. Why should this principle be any less true for the development of the intellectual and moral faculties of man than for the other operations of nature?

In a similar regard, Rene Descartes also confidently asserted (cited in Henry, 2004, p. 28):

Those long chains of deductive reasoning... of which geometricians make use in order to arrive at the most difficult demonstrations, had caused me to imagine that all those things which fall under the cognizance of men might very likely be mutually related in the same fashion, and that, provided that we... always retain the order which is necessary in order to deduce the one conclusion from the other, there can be nothing so remote that we cannot reach to it, nor too recondite that we cannot discover it.

Proceeding from these kinds of sentiments, from the late 17th century society increasingly came under the sway of scientific rationality. And what was most significant about this time, was the way in which the principles and methods of science came to take on a normative stance, the benchmark for all forms of knowledge and ways of thinking. As Henry (2004, p. 10) argues, from the mid-17th century, “scientific knowledge acquired the cultural kudos in the West...science began to be recognized as the supreme cognitive authority, the intellectual system to which all others should defer”. Thus, during this time, previous beliefs were steadily questioned in light of the new principles of science. There was a growing renunciation of mythological and religious cosmologies, which were replaced with the new trinity values of observation, experimentation and calculation (Wilson, 2004). That is, conceptions of truth, and the criteria for judging what is true, were more and more governed by the principles of science. For knowledge to acquire

value as ‘truth’ it was increasingly believed that it had to constantly strive to become ‘scientific’, to construct and organize concepts according to certain rigorous criteria of scientificity. Radical and unequivocal separations were made between the ‘scientific’ and the ‘non-scientific’, the ‘rational’ and the ‘irrational’. And all that was seen to be outside of science was increasingly deemed “inadequate, illegitimate or nonsensical or superstitious” (Henry, 2004, p. 10). Ultimately, as articulated by Israel (2001, p.3), “After 1650, everything, no matter how fundamental or deeply rooted, was questioned in the light of scientific reason”.

The emergence of biomedicine

Medical practitioners were particularly inspired by the achievements of those working in the natural sciences, and increasingly sought to understand the body through similar methods and principles (Harrison, 2004). As such, from the late 17th century a new scientific approach to medicine began to emerge, one which crystalized towards the end of 18th century. This scientific paradigm of modern medicine is now commonly referred as ‘biomedicine’ or the ‘the biomedical model’ (Armstrong, 1983), the central tenets of which I will briefly unpack. Drawing heavily on the ideas of Bacon and Descartes and later Newton, medical practitioners of the late 17th century began to think of the body as if it were a machine, capable of mechanistic explanation and manipulation (Good, 1994; Nettleton, 2006; Russell, 2013). And like the supposedly orderly and predictable ‘nature’ of other entities, it was increasingly assumed that so too was disease a natural reality; an invariant biological object with a stable, discrete and universal identity (Armstrong, 1983; Gordon, 1988; Kirmayer, 1988). Such mechanical imagery is clearly depicted in the following 17th century text written by one of the early anatomists who tried to understand the workings of the human body:

Whoever examines the bodily organism with attention will certainly not fail to discern pincers in the jaws and teeth: a container in the stomach: water-mains in the veins, the arteries and other ducts; a piston in the heart; sieves or filters in the bowels; in the lungs, bellows; in the muscles, the force of the lever; in the corner of the eye, a pulley, and so on (cited in Russell, 2013, p. 9)

Like those working in the physical sciences who were seeking to separate themselves from spiritual understandings of reality, from the late 17th century medical practitioners also sought to distinguish disease from theological metaphysics (Good, 1994; Gordon, 1988). That is, rather than seeing disease as sin, the outcome of misfortune or ‘divine punishment’, it was increasingly understood as mechanism: “not prayer, but ‘looking and seeing’ what is wrong in the body machine and repairing” was regarded as key (Gordon, 1988, p. 24). Similarly, drawing on Descartes’ mind-body dualism, clinicians began to distinguish between a person’s mind and the material and mechanical operations of the body. That is, ideas, emotions, beliefs and values- matters of the mind- were more and more seen as of secondary importance when it came to understanding and fixing body-machines (Good, 1994; Kirmayer, 1998; Nettleton, 2006). Furthermore, during this time, there was a growing expectation that the mechanical functioning of the body and by extension, the natural laws of its dysfunctions, would eventually be identifiable, explainable and repairable through scientific endeavour (Russell, 2013). Thus, from the late 17th century, clinicians increasingly sought to understand the workings of the body according to scientific principles and methods, and to discover the laws that governed the operations of disease (Harrison, 2004).

Towards the end of the 18th century, with the newly discovered pathological anatomy, medicine was thought to have found these natural laws. Or as Harrison (2004, p. 57) puts it, from this time, medicine was seen to have acquired a supposed “objective real, and at last an unquestionable foundation for the description of disease”. Commonly associated with the work of French physician Xavier Bichat (1771-1802) and his ‘tissue pathology’, the discovery of the autopsy and pathological anatomy gave rise to the claim that disease existed in the form of localised lesions inside of the body (Armstrong, 1983, 1984; Sullivan, 1986). In other words, particular tissues within the interior of the body were identified as the original sites of disease. As Mark Sullivan (1986, p. 335) articulates:

Before the autopsy revealed the lesion as the disease, diseases were identical to their symptoms. After the autopsy became the definitive way to confront disease, it was no longer necessary to define disease in terms of its most common symptoms... The symptoms now point to the lesion alone. The

lesion becomes the necessary and sufficient condition for the presence of disease.

Thus, according to Sullivan (1986) and Armstrong (1983, 1984), with the autopsy, it became possible to make inferences from inner lesions back to outer symptoms and vice versa. Following Michel Foucault's analysis of the rise of the 'medical gaze', Sullivan suggests that this fundamentally transformed the way in which disease was understood, and the nature of clinical inquiry. That is, with the discovery of lesion at autopsy, disease could now be identified as a supposedly purely natural phenomenon within the biological body, totally independent of the patient's awareness of it. Disease was thus increasingly seen as separate from patients' experienced sense of it. As Sullivan (*ibid*, p. 335) highlights:

By revealing the lesion at autopsy, it becomes possible for the physician to identify disease in a way totally independent of the patient's experience of it. Disease thus begins to be autonomous from patients' experienced sense of disability.

In other words, disease was understood as real, biological disorder, prior to and independent from the subjective experience of it. Illness, on the other hand, was seen to represent the patient's personal experience of distress. And these two aspects of distress were increasingly afforded a different status. That is, the patient's subjective account of illness was deemed unreliable and essentially irrelevant to the physician's biomedical diagnosis of supposed 'real disease'. In other words, the patient's personal awareness of distress was subordinated to supposedly objective evidence of disease acquired through visual inspection and pathological inquiry modelled after the autopsy. According to Sullivan (*ibid*, p. 337):

As the ultimate source of medical knowing shifted from clinical language to visibility at the autopsy, the epistemological status of patients' reports of symptoms changed...Symptoms were now data to be used in the search for the identity of the disease rather than constituting that identity themselves.

A similar argument is made by David Armstrong (1983, 1984), who also draws on Foucault's notion of the rise of the 'medical gaze' in the late 18th century. According

to Armstrong, at this point, the focus of the clinical exchange was increasingly placed on the physical anatomy of the patient in order to localise and identify the pathological lesion within the inner spaces of the body. As a result, signs were distinguished from symptoms, with the former conceptualised as the prime source of knowledge within the clinical inquiry; the final arbiter of clinical truth:

Sign and symptom were separated: the symptom might well remain silent, the truth of the disease was contained only in what the doctor found, in the form of the sign. Symptoms, what the patient said, could provide a guide or a hint or a suspicion of which organ or system might be involved but were only preliminaries; the core task of medicine became not the elucidation of what the patient said but what the doctor saw in the depths of the body (Armstrong, 1984, p. 738).

Thus, according to Armstrong, as clinical inquiry sought to anticipate anatomical inquiry, for example through greater reliance upon techniques of physical diagnosis and laboratory investigation, the patient's capacity for self-knowledge and interpretation was isolated away from the body. Or as Sullivan (1986, p. 344) puts it, "The activity of self-interpretation or self-knowledge is eliminated from the body... The body known and healed by modern medicine is not self-aware".

This biomedical understanding of disease, and the nature of clinical inquiry, thus produced, and increasingly came to rely upon an additional kind of binary opposition, over and above the mind-body split. Sullivan (1986) refers to this as the 'epistemological dualism' which lies at the heart of biomedicine. That is, medical science increasingly made distinctions between disease and illness, and relatedly, between that of physician as active knower and patient as passive known. Within this way of thinking, subjective awareness of illness was seen as meaningful only so far as it helped point to the underlying disease entity; if no such empirical referent could be found, such personal opinions were conceived as essentially irrelevant. 'Real pathology', on the other hand, reflected natural, disordered physiology (Armstrong, 1983, 1984; Good, 1994; Gordon, 1988; Sullivan, 1986).

Moreover, from this perspective, medical scientific techniques, such as direct observation and laboratory results, were seen as able to provide objective and

accurate knowledge of the reality of pathology (Armstrong, 1983, 1984; Good, 1994; Sullivan, 1986). In other words, medical knowledge and practice was conceived of as reflecting the facts of nature; the straight-forward and transparent depiction of the universal workings of disease. Put slightly differently, the validity and rationality of medical science was seen as dependent upon the causal-functional integration of biological systems (Good, 1994). Ultimately, 'rational' ways of thinking and behaving were understood to be those which are oriented to identifying and treating the underlying mechanisms of real pathology. Such an approach to knowing and being was seen as providing the means for a definitive, rational and natural science of disease, and of medicine. As Bichat in his *Anatomic Generale* put it (cited in Sullivan, *ibid*, p. 341):

Medicine has for a long time been excluded from the exact sciences; it will have a right to be associated with them at least as regards the diagnosis of disease when one shall have combined everywhere with vigorous clinical observation the examination of the alterations suffered by our organs... of what value is clinical observation if one is ignorant of the seat of evil?

Understanding the growing sway of scientific rationality

The question is how this scientific paradigm gained such a powerful influence on society so quickly after its emergence, and importantly, how it acquired such a normative position with regards to knowledge production, including within medicine? The efficiency of scientific rationality, which had led to all kinds of ground-breaking understandings and discoveries, including in relation to disease, is undeniably a contributing factor. Yet the authoritative stance that science increasingly came to occupy cannot be understood solely as the consequence of its proficiency. Various historians of science (Israel, 2001, 2006; Knellwolf, 2004; Murdoch, 2004) have demonstrated how its growing hegemony in the late 17th and 18th centuries was also intimately linked to a number of complex social, religious and economic forces and interests. These provided a fertile ground for the widespread acceptance of, and increasingly normative status afforded to, scientific modes of thinking.

At the time when the scientific paradigm emerged, Western Europe was experiencing a number of significant religious, economic and political changes. As clearly articulated by Jonathan Israel in his *Radical Enlightenment* (2001) and *Enlightenment Contested* (2006), 16th and 17th century Europe was ravaged by strife and chaos in the name of religion, notably the Thirty Years War (1618-48) on the continent and the English Civil Wars of the 1640s. People were deeply affected by the horrors of these wars, which had produced immense human suffering- food and resource scarcities, disease, violence, material destruction and loss of life. These conflicts also gave rise to a growing crisis and confusion in religious thought, and an increased schism within western Christendom between Catholicism and Protestantism. This period was thus characterized by a growing questioning of, and rebellion against, the authority of the Roman Catholic Church, and the simultaneous widespread suppression of such dissidence.

Within this context, there was a desire for the end of tyrannical ecclesiastical hierarchies, and for a philosophy that would bring some form of direction and clarity to the growing sense of uncertainty (Israel, 2001, 2006; Knellwolf, 2004). It was increasingly believed that there must be a better way to live than under the dominion of oppressive religious authorities. The emerging philosophy of science, which was explicitly seeking to free itself from theological doctrines, was alluring. Relatedly, scientific modes of thinking were thought to have found order within the changing world of nature and time, which would have also been appealing. Bacon had indeed compared science to a harp, the sounds of which would “quieten beasts” and thereby maintain “society and peace...but if these instruments be silent, or that sedition and tumult make them not audible, all things dissolve into anarchy and confusion” (cited in Israel, 2006, p. 198). Science was seen as possessing the ability to harmonize society and sedate social conflict. Thus, as Israel (2006, p. 201) argues “Amid so great a crisis gripping religion and religious authority in western Europe, it was only to be expected, given the recent stunning advances in astronomy, physics, and mathematics, that theologians and philosophers should turn to a new source- science- for help, confirmation, and support”.

The growing acceptance and popularity of scientific thinking was also deeply entwined with the economic changes that were occurring in Europe during the 17th and 18th centuries, or as Habermas puts it, “from the very beginning an intimate

relationship existed between scientific philosophy and the bourgeois revolution” (cited in Arslan, 1999, p. 201). During the 17th and 18th centuries, the continent was engaging in widespread colonial expansion, conquering first the Americas and then other regions of the world. This was in turn giving rise to a climate of economic competition and commercial exchange, with Europe accumulating all kinds of new commodities, mineral riches and land (Israel, 2001, 2006; Murdoch, 2004). Relatedly, during this time, the beginnings of industrialization started to take shape, first in England and later spreading to the rest of Europe. It was a time in which transport links were improving, new forms of mechanisation were developing, and towns were growing and becoming cities. Europe during the 17th and 18th centuries was thus witnessing a major growth in empire and commerce, ultimately giving rise to a growing industrial, capitalist economy (Israel, 2001, 2006; Murdoch, 2004).

This new wave of commercial and economic development within Europe was producing profound shifts in social hierarchies and forms of organization, and in particular, the ascendance of a new and powerful entrepreneurial class (Israel, 2001, 2006). This wealthy class was increasingly placing value on the secular ideals of material wealth, commercial growth and individual freedom, ideals which were coming into conflict with the ideologies of the church and feudal hierarchies (Murdoch, 2004). This rapidly growing bourgeoisie resented the power and wealth of the church and feudal lords, which were seen as hindering their more secular interests of material progress, and increasingly sought ways of acquiring greater power and autonomy within the socio-economic and political realms (Festa & Carey, 2009). Science, including biomedicine, was seeking to undermine the credibility of the church, and was thus seen by the bourgeoisie as a crucial means through which they could liberate themselves from social and economic forms of submission. Ultimately, science, with its ideals of discovery, progress and reason, was believed to hold key intellectual insights for economic advancement and greater socio-political freedom (Murdoch, 2004).

Therefore, by the time the scientific paradigm emerged in the mid-17th century, there was growing dissatisfaction with theological dogmatism and tyrannical hierarchies in Europe. Moreover, profound socio-economic shifts were taking place during this time, with the continent changing into a society increasingly dominated by commercial power structures and interests. Late 17th and 18th century Europe was

therefore characterised by the growing desire for new kinds of thinking and authorities. The principles and methods of science held the key to legitimizing and consolidating these transformations and sentiments. However, as suggested by Arslan (1999), Festa & Carey (2009) and Wilson (2004), for this to be possible, science needed to become the authoritative, even sole criterion of truth claims. Put somewhat crudely, the methods and principles of science needed to become a new kind of orthodoxy, the benchmark to which all other ways of knowing and being should defer. Rigid distinctions needed to be made between the ‘scientific’ and the ‘non-scientific’, and thus the ‘rational’ and the ‘non-rational’; the ‘legitimate’ and the ‘illegitimate’. Ultimately, these kinds of stark delineations, and the values imbedded within them, were intimately entangled with efforts to undermine the legitimacy of ecclesiastical doctrines and weaken the monolithic hold of the Christian Church and feudal hierarchies.

As the 19th century unfolded, these socio-economic and political changes taking place in Europe were consolidated, and the paradigm of science played a fundamental role their solidification. As will be expanded upon below, 19th century Europe saw the decline of feudalism and royal absolutism and the birth of the modern, nation and industrial state. From this point, the church was separated from the state, and activities previously undertaken within the sacred sphere were increasingly subsumed under bureaucratic institutions and practices related to the nation-state (Miller & Rose, 1990; Rose, 1993; Scott, 1998; Turner, 1995). During this time, the social prestige afforded to science expanded considerably.

In summary, with the formation of the new state, together with the associated maturing industrial and capitalist economy, there was growing state concern around how to introduce greater control and management of individuals (Armstrong, 1983; Miller & Rose, 1990; Rose, 1993; Turner, 1995). That is, the regulation of populations, or in Foucault’s words, ‘the governmentality’ of people- their wealth, their health, their means of subsistence, their customs and habits and so forth- increasingly emerged as political objectives of the state (Foucault, 1984). As Scott (1998, p. 77) emphasizes, “Early modern European statecraft required knowledge of, and access to, a previously opaque society... not only the new forms of thought, but also novel procedures of documentation, computation and evaluation”. Here the emerging scientific bodies of knowledge (medicine, criminology, penology,

sociology, psychology, education, etc.), and associated institutions (the asylum, the clinic, the prison etc.), held a special place. Conceived of as knowing the mechanisms by which individuals and populations functioned, such apparatuses were seen to provide the means for their governmentality, a role which they increasingly came to occupy (Armstrong, 1984; Rose, 1993; Turner, 1995).

The increased authority afforded to science, and particularly biomedicine during the 19th and 20th centuries, was also intimately entangled with the growth of Empire. During this time, the colonial endeavours of the preceding centuries expanded considerably, with Europe violently invading, occupying and annexing countries in Africa. Biomedicine occupied a special place within these endeavours, or as Comaroff (1993, p. 306) puts it, the “development of colonialism in Africa as a cultural enterprise was inseparable from the rise of biomedicine as a science”. If lay people in Europe were increasingly seen to hold frequently erroneous subjective understandings about illness, the beliefs of people in Africa were understood to personify the height of irrationality and degeneration (McCulloch, 1995; Vaughan, 1991). As such, medicine within the colonies in Africa was characterized, at least in part, by a struggle between rational Western biomedicine and primitive traditional therapeutics (Comaroff, 1993; Comaroff & Comaroff, 1992; King, 2002; Vaughan, 1991). In its imaginary, ‘Western’ biomedicine embodied the highest form of rationality, in contrast to the supposed backward and superstitious nature of indigenous medical beliefs and practices. Thus, during the 19th and 20th centuries, there was a strong focus on supposedly medically ‘modernizing’ populations within Africa. Such ‘modernization’ entailed denigrating and attempting to drive out primitive traditional therapeutics, via export of biomedical theories and practices. This process was ultimately constructed as a humanitarian endeavour, essentially freeing backward societies from the grip of irrational forms of thinking and being.

There was thus a dialectical interplay between 19th century biomedicine and the colonizing project in Africa, or in Comaroff’s (1993, p. 306) words, “they were cut from the same cultural cloth”. That is, when the colonists tried to ‘domesticate’ the realities of supposedly primitive Africa, they drew heavily upon biomedical icons and practices to impose their domination. Biomedicine was therefore intrinsic to the operation of colonial power, providing the legitimacy of science to colonial ideologies (Comaroff, 1993; McCulloch, 1995; Vaughan, 1991). At the same time,

colonial endeavours in Africa also provided biomedicine with an essential empirical ‘laboratory’ and a supposedly natural rationale for its emerging vision of the body and its ailments. Indeed, the ‘African’ mind and body captured the imagination of colonial medicine, increasingly becoming prime ‘objects’ of study for British medical practitioners (Butchart, 1998; Holdstock, 2000; McCulloch, 1995; Swartz, 1986). Thus, as Vaughan (1991, p. 201) puts it, “Colonialism provided much ‘raw material’ on which the new scientific biomedicine drew for the elaboration of its theories, and also provided a ‘surgery’ for the evolving practice of medicine”.

Colonial activities therefore provided further power and authority to the emerging biomedical sciences in Europe. In summary, 19th century biomedicine and the ideology of imperial control buttressed each other, ultimately verifying and strengthening the other through the categories and metaphors of a mutually sustaining vision. As Comaroff (1993, p. 324) succinctly articulates:

Medicine both informed and was informed by imperialism, in Africa and elsewhere. It gave the validity of science to the humanitarian claims of colonialism, while finding confirmation for its own authority in the living laboratories enclosed by expanding imperial frontiers.

The paradigm of human rights

“Rights are too often treated as a kind of god-term. Rights clearly have historical roots...and need to be understood in light of their place in the order of existence”

(Frohnen & Grasso, 2009, p. 1)

As I have been suggesting, during the 17th and 18th century, Europe was being strongly influenced by scientific rationality, with this mode of thinking laying the seeds for a number of other forms of knowledge about the social world. One such structure of thought, which drew heavily on the new principles of science, was the paradigm of human rights. According to various historians on this subject (Frohnen & Grasso, 2009; Hunt, 2007; Stearns, 2012), both the origins and fundamentals of the notion of human rights can be seen to lie with the works of three particular Enlightenment intellectuals: John Locke (1632-1704), Jean-Jacques Rousseau (1712-78) and Immanuel Kant (1724-1804). I thus briefly touch on the central ideas of

these three intellectuals, as this will shed light on some of the key underpinning assumptions of the human rights paradigm of thought.

Central epistemological assumptions

Central to the political philosophies of both English philosopher John Locke and French philosopher Jean-Jacques Rousseau was the notion of a ‘state of nature’, and associated ideas of ‘natural law’ and ‘natural rights’. For these intellectuals, the state of nature is one in which people enjoy “perfect freedom” and in which “all men by nature are equal” (cited in Gorman, 2003, p. 56/57). According to them, there are no divine rights that only the privileged few possess; rather, everyone is equal and no one is above the law of nature. As Locke states: “It is evident that all human beings- as creature belonging to the same species and rank and born indiscriminately with all the same natural advantages and faculties- are equal amongst themselves” (cited in Stearns, 2012, p. 58). In a similar manner, Rousseau proclaimed:

Man is born free; their liberty belongs to them, and no one but they has the right to dispose of it...To renounce liberty is to renounce being a man, to surrender the rights of humanity and even its duties...Such a renunciation is incompatible with man's nature; to remove all liberty from his acts is to remove all morality from his acts (cited in Fudjack, 2001, p. 7).

Thus, for these philosophers, the natural order of things is one in which people are inherently free and equal, possessing certain natural rights which cannot be denied, abrogated or transferred from one individual to another. In further elaborating the ‘nature’ of these innate rights, the notion of human autonomy emerged as central (Hinkelammert, 2004; Mahoney, 2007; Tierney, 2005). That is, for Locke and Rousseau, people were seen to be naturally endowed with the inalienable rights of self-ownership, self-determination and self-mastery. For example, according to Locke, in the state of nature, everyone “is bound to preserve himself” possessing the “liberty of acting according to his own Will”. For him, this is the “foundation” of all that belongs to oneself, “the fence” to one’s self-preservation and the “law of nature...which willeth the peace and preservation of all mankind” (cited in Gorman, 2003, p. 56/57). Furthermore, for these intellectuals, people’s corporal integrity and autonomy are intimately entangled with the property rights of individuals. As Locke

famously declared “every man has a Property in his own Person. This no Body has any Right to but himself” and thus “every man, hath by Nature a Power...to preserve his Property, that is, his Life, Liberty and Estate, against the injuries and Attempts of other Men” (cited in Frohnen & Grasso, 2009, p. 43). Indeed, Locke took this idea further by asserting that in the state of nature, the world belongs to humankind equally, and thus every individual has the right to unlimited accumulation of resources:

God, who hath given the world to men in common, hath also given them reason to make use of it to the best advantage of life, and convenience. The earth, and all that is therein, is given to men for the support and comfort of their being. And though all the fruits it naturally produces, and beasts it feeds, belong to mankind in common, as they are produced by the spontaneous hand of nature...yet being given for the use of men, there must of necessity be a means to appropriate them some way or other before than can be of any use, or at all beneficial to any particular man (cited in Hinkelammert, 2004, p. 15).

Further still, for Locke, this unrestricted entitlement to accrue resources also endows people with the “private right” to procure human labour in exchange for money:

It is plain, that men have agreed to disproportionate and unequal possession of the earth, they having by a tacit and voluntary consent found out a way, how a man may fairly possess more land than he himself can use the product of, by receiving in exchange for the overplus, gold and silver, which may be hoarded up without injury to anyone, these metals not spoiling or decaying in the hands of the possessor (cited in Hinkelammert, 2004, p. 17).

According to Locke and Rousseau, people possess these inherent rights and freedoms, including property rights, because of the intrinsic rationality of humanity. In the words of Rousseau, “The freedom then of man, and liberty of acting according to his own will, is grounded on his having reason, which is able to instruct him in that law he is to govern himself by, and make him know how far he is left to the freedom of his own will” (cited in Gorman, 2003, p. 57). People were therefore understood to be endowed with natural entitlements for no other reason than their inherent capacity to reason. And for these philosophers, it is this ability to reason that

should guide people in their establishment of fundamental moral principles and ethical laws. Put slightly differently, for Locke and Rousseau, morality could be objectively determined through none other than human reason.

This primacy afforded to reason, in understandings of both human ‘nature’ and ethical laws, was further consolidated by the thinking of German philosopher Immanuel Kant. Drawing on the works of Locke and Rousseau, Kant believed that individuals possess what he called the “innate rights” of equality, freedom and dignity (cited in Mahoney, 2007, p. 34). Moreover, like Locke and Rousseau, Kant asserted that people possess these ‘innate rights’ because they hold a natural ability to reason. As Kant writes: “Man regarded as a *person*, that is, as the subject of a morally practical reason... possesses a *dignity* (an absolute inner worth) by which he exacts respect for himself from all other rational beings of the world” (cited in Mahoney, 2007, p. 34). Kant asserts further:

Now, I say, man, and in general, every rational being exists as an end in himself and not merely as a means to be arbitrarily used by this or that will...Beings whose existence does not depend on our will but on nature, if they are not rational beings, have only a relative worth as means and are therefore called “things”; on the other hand, rational beings are designated “persons” because their nature indicates that they are ends in themselves....Such an end is one for which no other end can be substituted, to which these beings should merely serve as means. For without them, nothing of absolute worth could be found (cited in Cheah, 1997, p. 243).

In other words, according to Kant, what gives human beings their unique dignity and worth is their innate capacity to exercise reason. Moreover, like Locke and Rousseau, Kant believed that universal and objective ethical laws could be developed by applying this human reason. In seeking to develop a solid foundation on which to build a supposedly universal theory of ethics, or what he called “the supreme principle of morality”, Kant argued that “the ground of obligation must be looked for...solely *a priori* in concepts of pure reason” (cited in Mahoney, 2007, p. 33, his emphasis).

For all three philosophers, however, people may not always think and act according to reason, and as such, may not inevitably realise their natural rights and freedoms. As Rousseau explains, what reason requires is “intelligible and plain” but he holds that “self-love will make men partial to themselves and their friends; and, on the other side, ill-nature, passion and revenge will carry them far too in publishing others” (cited in Gorman, 2003, p. 58). Similarly, Locke asserted, “Were it not for the corruption, and vitiousness of degenerate Men” there would be no need for people to leave the state of nature and by mutual agreement develop a means in which they can “unite for the mutual Preservation of their Lives, Liberties and Estates, which I call by the general Name, Property” (cited in Mahoney, 2007, p. 19). For these intellectuals then, there is a need for a legitimate political authority which can act as the protector and enforcer of people’s natural rights and universal entitlements. As Locke emphasized, “The law of Nature would, as all other laws that concern men in the world, be in vain if there were nobody that in the state of Nature had a power to execute that law” (cited in Gorman, 2003, p. 57). Thus, according to Locke, Rousseau and Kant, there is a need for a ‘social contract’ in which each individual resigns his power to a socio-political organisation which has a common established law and judicature. As Rousseau explains:

Just as nature gives each man absolute power over all his limbs, the social pact gives the body politic absolute power over its members... What man loses by the social contract is his natural liberty and an unlimited right to everything he tries to get and succeeds in getting; what he gains is civil liberty and the proprietorship of all he possesses... We might, over and above all this, add, to what man acquires in the civil state, moral liberty, which alone makes him truly master of himself; for the mere impulse of appetite is slavery, while obedience to a law which we prescribe to ourselves is liberty (cited Mahoney, 2007, p. 16).

As such, according to these three philosophers, by developing a legitimate body politic, we are compelled to abide by the moral laws that we prescribe to ourselves, and in turn, we become masters of our property and of ourselves. For them, through this arrangement, genuine human freedom becomes possible. According to all three of these philosophers, the kind of political organization that can ensure this is one founded on the principle of consensus decision-making, in other words participatory

democracy (Franke, 2008, 2011, 2013; Gorman, 2003; Mahoney, 2007). In other words, establishing the conditions under which human freedom is possible, wherein it becomes possible to determine the rights that humans may appropriately claim of one another in a truly universal and objective form, means forming a political regime ordered around sovereign, nation-states. This form of political organization, which Kant defines as a “moral requirement” can thus provide “the sum of laws which need to be promulgated generally in order to bring about a rightful condition” (cited in Franke, 2013, p. 371).

Pulling these various ideas together, it is clear that these three philosophers’ thinking on human rights shared a number of underpinning assumptions (See Pannikar, 1984 and Sardar, 1998 for comprehensive summaries of these shared epistemologies). Their thinking is all premised on the notion of a universal human nature that is inevitably shared by all people. This ‘nature’ is one in which human beings are essentially independent entities, endowed with an inherent rationality and self-interested drive. The human being is thus fundamentally the individual, and human rights are there primarily to protect the autonomy of individuals, including their individual property rights. At the same time, this human ‘nature’ is conceived of as essentially different from, and superior to, other living beings. Unlike other beings, we have certain intrinsic rights and entitlements because we are born with dignity but, more importantly, because we possess the innate rational capacity needed to reaffirm such dignity. Moreover, for all three philosophers, universal and objective ethical laws can be determined by this innate ability to reason, in other words, moral principles and actions should be derived solely through human reason. At the same time, their thinking presupposes a socio-political order based on liberal democracy, which is lauded for its supposed intrinsic ability to objectively protect and enforce the independent rights of individuals. That is, the sovereign nation-state is recognised as the inevitable means for achieving otherwise unreachable rights and freedoms.

What is particularly significant about this interrelated set of assumptions is the quality of normativity and inevitability it tends to embody. People are assumed to be *naturally* autonomous and *innately* rational, and the sovereign nation-state is seen to be a *universal inevitability*. Indeed, for these philosophers, people who defy their supposedly ‘inherent’ way of being and who ‘refuse’ to live by this apparently preordained political order, have defied the laws of human nature and have in turn

rebelled against humankind. For Rousseau, such individuals can be justifiably forced to do so: “If anyone refuses to obey the general will he will be compelled to do so by the whole body; which means nothing else than he will be forced to be free” (cited in Mahoney, 2007, p. 16). For Kant, such individuals “have only a relative worth...and are therefore called ‘things’” (cited in Cheah, 1997, p. 243). Similarly for Locke, such individuals are no more than objects, or what he terms “noxious creatures” that should be annihilated:

In transgressing the law of nature, the offender declares himself to live by another rule, than that of reason and common equity...and so he becomes dangerous to mankind... being a trespass against the whole species, and the peace and safety of it, provided for by the law of nature... Besides the crime which consists in violating the law and varying from the right rule of reason, whereby a man so far becomes degenerate, and declares himself to quit the principles of human nature, and to be a noxious creature (Locke, 1690, cited in Hinkelammert, 2004, p. 6).

More still:

[Upon renouncing] reason, the common rule and measure...hath by the unjust violence and slaughter he hath committed upon one, declared war against all mankind, and therefore may be destroyed as a lion or a tiger, one of those savage wild beasts, with whom men can have no society nor security (Locke, 1690, cited in Hinkelammert, 2004, p. 6)

Epistemological assumptions in socio-economic and political context

It is thus clear that the paradigm of human rights drew heavily on the kind of scientific rationality that was gaining currency at the time. Like the supposed ordered and universal ‘nature’ of the physical world, human nature was assumed to essentially rational and inevitably common to all people, everywhere. And like the laws of the physical realm, it was assumed that universal moral principles too could be objectively and unequivocally determined through none other than reason.

This new paradigm of human rights was also deeply influenced by, and in turn provided legitimacy to, the new socio-political and economic structures that were coming into being. As I have been describing, 17th and 18th century Europe was witnessing growing hostility towards religious and aristocratic dogmas, and the steady weakening of the monolithic hold of the Christian Church. During this time, extensive debates were occurring around what might constitute legitimate forms of governance. It was a time when all sorts of new ideas were emerging about popular sovereignty and the absolute will of the people, as opposed to royal absolutism and religious authority. The notion of human rights clearly drew heavily upon, and provided further currency for, these sentiments (Franke, 2008, 2011). Rather than deriving from divine rights and the will of God, human rights discourse emphasised that moral and ethical principles arose naturally from human reason. Furthermore, human rights discourse asserted explicitly that the fulfilment of these natural rights and freedoms necessitates a particular form of political authority, one based on ‘collective will’, rather than on divine rights and traditions. In emphasising the equality of individuals, their natural rights and their power to establish and change political authority, the notion of human rights helped validate the breaking with aristocratic and religious government and the tradition of divine right (Frohen and Grasso, 2009; Hinkelammert, 2004; Mahoney, 2007).

Moreover, the assumptions embedded within the paradigm of human rights reflected, and in turn helped further consolidate, the growing capitalist economy and increasingly powerful bourgeoisie (Bates, 2012; Haskell, 1985; Manoka, 2009). At the heart of Locke, Rousseau and Kant’s theorising of human rights was a particular concern with the economic freedom of individuals, and their rights to accrue private property, resources and employment. Such thinking clearly reflected the functioning of the growing commercial market and the ideals of the entrepreneurial class of 17th and 18th century Europe. Not only did the paradigm of human rights reflect such interests, it also codified some of the most fundamental elements of modern capitalism. Indeed, the feudal relations of production had a very particular ideology which helped to sustain them. This involved interpreting social relations as having a divine origin, with each individual performing a specific function ascribed by God. As Larrain (cited in Manoka, 2009, p. 447) puts it, in feudalism:

Ideology assumes a religious form; the justification of personal dependence is found in a sacred order which is revealed by God and which consequently cannot be altered by man. Personal dependence upon, and loyalty to, the landlord is spontaneously expressed in the ideological submission to God, from which all subordination is modeled.

The paradigm of human rights provided a new form of ideology which helped to justify the changes in relations of production from a feudal-based system to a capitalist one. In emphasising the inherent freedom and equality of all individuals and of the market, human rights discourse ‘naturalised’ the existence of private property and wage labour. Ultimately, as Manoka (2009, p. 448) argues, “The ideology of freedom and equality embodied in the notion of rights has developed historically in an organic relationship with capitalism”.

The paradigm of human rights was also intimately entangled with 17th and 18th century European colonial endeavours in the Americas and the Far East, especially India, and later in Africa. As Hinkelammert (2004, p. 4) outlines, prior to the 17th century, European expansion was justified by the divine rights of the monarchy, however, “since the bourgeois revolution had eliminated the divine right of kings... the urgency for a new political theory was evident”. The paradigm of human rights ultimately provided this new ideology, which was increasingly used to justify European expropriation of the other territories and populations as a humanitarian endeavour. As highlighted above, through its assumptions of naturalism and universalism, human rights discourse implies that people who defy their supposedly ‘inherent’ way of being have rebelled against the natural order of nature. According to Locke, for example, these individuals and populations are “degenerate” and “wild beasts” who have assaulted “the entire species” and have thus become a “danger to mankind” (cited in Hinkelammert, *ibid*, p. 4). As such, they can be compelled, justifiably, to be transformed, or even annihilated. In other words, for Locke, who had indeed invested much of his fortune in the English slave trade: “in waging an unjust war against humankind” such offenders can be “destroyed as a lion or a tiger” and “their goods or services can be appropriated as reparations for the losses suffered by the conqueror” (cited in Hinkelammert, *ibid*, p. 5). Thus, ultimately, drawing heavily on this way of thinking, the European invasion and conquering of foreign territories could now be vindicated as an apparently legitimate political action in the

name of peace; the loyal application and restoration of the supposed ‘natural’ order of things. As Hinkelammert (2004, p. 2) describes:

The Spanish based the conquest of America on the denunciation of the human sacrifices committed by aboriginal American civilizations. Later, the conquest of North America was argued for based on the violations of human rights on the part of Native Americans. The conquest of Africa was justified by the denunciation of cannibalism, the conquest of India by the denunciation of widow immolation, the destruction of China by the opium wars was equally based on the denunciation of the violation of human rights in China. The West conquered the world, destroyed cultures and civilizations... all of this was done in in the name of preserving human rights and restoring the natural laws of reason.

It is thus clear that the paradigm of human rights was thus deeply embroiled with the socio-economic and political changes that were taking place within 17th and 18th century Europe, possessing a dialectical relationship with the decline of religious and aristocratic authorities, the rise of the liberal nation-state, the growth of modern capitalism and the expansion of empire. The interconnected relationship between these different factors culminated in the major changes that occurred at the end of the 18th century, when the momentous American and French Revolutions took place. These revolutions simultaneously gave birth to the modern nation-state and the ultimate decline of feudalism, royal absolutism and religious authority. They also gave rise to the official legal endorsement of human rights principles (Hunt, 2007). Drawing heavily on the works of Locke, Rousseau and Kant, *The American Declaration of Independence* (1776) stated:

We hold these truths to be self-evident, that all men are created equal, that they are endowed...with certain inalienable Rights, that among these are Life, Liberty and the Pursuit of Happiness...that to secure these rights, governments are instituted among men, deriving their just powers from the consent of the governed (cited in Stearns, 2012, p. 75).

Similarly, France’s *Declaration of Rights of Man and the Citizen* (1789) asserted that “Men are born and remain free and equal in rights”, and assigned sovereignty to the

nation whose sole purpose was to protect the “rights to liberty, property, security and resistance to oppression” (cited in Hunt, 2007, p. 21).

Conclusion

In this chapter I have surfaced, and put into historical perspective, the epistemological assumptions underpinning two particular paradigms of thought—those of evidence-based science (including biomedicine) and human rights. I have attempted to destabilise the self-evidence of these ways of thinking by showing how, rather than being inevitable mappings of the world, they arose out of a very specific social and historical milieu. The growing strength afforded to these paradigms was intimately entangled with the way in which they provided an ideological basis for the many socio-economic and political changes taking place in 17th and 18th century Europe. As these changes were consolidated in the subsequent centuries, so too was the tenacity of these ways of thinking. In the chapters which follow, I show how these paradigms are playing a fundamental role in shaping knowledge on the ‘gap’ in mental health care in Africa. This current chapter has concentrated primarily on the historical constitution of these paradigms and associated assumptions. In the subsequent analyses, I destabilise the underpinning assumptions I have surfaced in this chapter further, by shedding light on the many questionable certainties upon which they are based.

Although there are obvious differences between these two paradigms, what I have tried to reveal in this chapter is that they are both underpinned by a shared set of epistemological assumptions. These assumptions merge around a now familiar group of abstractions, in particular, those of naturalism, universalism, objectivity and rationalism. That is, these paradigms are united in their understanding of the world as a rational and invariant sphere, one which operates according to orderly and discrete principles of cause and effect. That is, both are premised on the notion of an inherently universal ‘nature’ (social, physical, biological etc.) that is ‘out there’ and available for mechanistic explanation and manipulation. Furthermore, both assume that the ‘nature’ of this world and its inhabitants are objectively knowable through scientific rationality. In other words, both paradigms are based upon the assumption that ‘truth’ and ‘certainty’ can be acquired through none other than the principles and methods of science. So, for example, the body and its dysfunctions are assumed to be

accurately knowable and treatable through medical science. Moreover, supposedly universal ethical laws are understood to be objectively and definitively determinable through logic and reason. Ultimately, according to both of these paradigms of thought, logical and rational forms of thinking and being, rather than the religious, the spiritual, the emotional and so forth, hold the key to greater understanding and better ways of living.

These kinds of assumptions underpinning both paradigms also coalesce around a particular way of ordering the social world, one which is based upon homogenous entities and stark binary oppositions. That is, they produce and rely on rigid demarcations between the rational and the irrational; the moral and the immoral; the objective and the subjective; knowledge and belief; body and mind; disease and illness; material and spiritual. Moreover, through this logic, entities in one column are designated as *inherently* superior or *essentially* progressive, whilst those in the other column are relegated as *innately* inferior or *naturally* subsidiary. Ultimately, the value judgements underpinning these designations become ‘black-boxed’ in the supposedly progressive language of science and human rights.

As I suggested in the previous chapter, this overarching system of classification is indeed one of the most stubborn and powerful forms of classification buried in the episteme of European Colonial Modernity. As highlighted in the preceding chapter, and contextualised further in this current chapter, this way of ordering the social world was intimately entangled with modernist Europe’s attempts to delineate its own contemporary identity, and to distinguish itself, unequivocally, from both previous eras and other societies. Such efforts ultimately depended upon stark demarcations between the legitimate and illegitimate; the rational and the irrational; the natural and the unnatural; the moral and the immoral; the modern and the primitive. In other words, by legitimizing tropes of otherness and polarizations of difference, this form of ordering helped to unambiguously distinguish certain ways of thinking and being as inevitably superior in comparison to others. Not surprising, those institutions, practices, and conceptual schemes that were constructed as supposedly the most advanced were exactly those that were coming into being within 18th century Europe- an industrial capitalist economy, a liberal nation-state, positivistic scientific methods, biomedical techniques, human rights principles or various ensembles of these things.

In short, this way of classifying the social world into rigid demarcations, and the values embedded in these binaries, was deeply embroiled with 17th and 18th century struggles in Europe over the authorisation of knowledge, and attempts to develop boundaries of socio-economic and political legitimacy. Ultimately, this form of ordering was part and parcel of battles to loosen the power of religious and aristocratic authorities, to separate church and state, to consolidate an industrial capitalist economy and to expand European empires. The question is whether we really need to continue to fight those battles that took place in Europe so long ago, in this way.

In addition to the material and physical forms of exclusion, oppression and discrimination this form of ordering and associated assumptions has generated in the past and continues to produce today, it also has significant epistemological consequences. One of the major epistemological effects is the way in which it tends to negate its 'others'. That is, through this system of classification and associated assumptions, the paradigms of evidence-based science and human rights imply that the only worthy ways of thinking and being in the world are those which originate from their own epistemological codes (Connell, 2007; De Sousa Santos et al., 2007; Mignolo, 2007; Nandy, 1989; Quijano, 2000, 2007; Smith, 1999). Only understandings of disease as natural, disordered physiology are seen as legitimate. Only the techniques and principles of medical science are understood as being appropriate ways of depicting and treating the workings of disease. Only the idea of human beings as rational and self-determined individuals is understood as valid. Only systems of justice and morality which are derived through reason and enforced through a democratic nation-state are conceived of as acceptable. Ultimately, 'other' ways of thinking and being, which are based upon alternative epistemological assumptions and politics, are deemed inevitably irrelevant, inferior, irrational and/or illegitimate.

This kind of epistemological exclusion or silencing that is produced by the paradigms of evidence-based science and human rights is what is meant by Gayatri Chakravorty Spivak's (1990, 1995), often used phrase "epistemic violence", or what others have termed "epistemicide" (Harding, 1998). Spivak poses the now much publicized question "Can the Subaltern Speak?" which for her is really a question

about who is heard, and what enables us to be heard and to hear. As she (1990, p. 59/60) puts it:

For me, the question ‘Who should speak?’ is less crucial than ‘Who will listen?’ ‘I will speak for myself as a Third World person’ is an important position for political mobilization today. But the real demand is that, when I speak from that position, I should be listened to seriously, not with that kind of benevolent imperialism...

Spivak is arguing that the subaltern seldom speaks and is rarely properly heard. If they talk at all, they are heard only if they speak through the voice of the inherited modernist and colonial archive. In other words, unless one speaks through the dominant and entrenched language of European modernity and colonialism, one will not be heard. Thus, one of the real epistemological dangers with the kinds of paradigms I have explored in this current chapter is the way in which they occlude other, potentially important and meaningful ways of thinking and being, from entering the citadel of knowledge.

In the chapters that follow, it will become clear that this exclusionary logic is playing out profoundly in the production of contemporary knowledge on the mental health ‘treatment gap’ in Africa. That is, a key thread running through my analyses is the way in which the two paradigms explored in this chapter are foreclosing other, potentially meaningful, ways of thinking about mental health care in Africa. The argument I will make throughout these analyses is that these kinds of paradigms of thought may be important and meaningful in Africa, and thus should not *inevitably* be rejected. Yet what I will again and again problematise is their *hegemony*, the way in which they become the gatekeepers of knowledge, ultimately policing the boundaries of legitimate forms of knowing, and by extension, valid forms of care and well-being.

5. RESEARCH PAPER ONE

Prising open the ‘black box’: An epistemological critique of discursive constructions of scaling up the provision of mental health care in Africa

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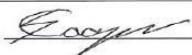
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Abstract

Global Mental Health research is increasingly highlighting the high levels of untreated mental illness in Africa and calling for the scaling-up of services in order to redress this situation. A particular model of care is being strongly advocated for such scale-up, and a recent explosion of research is providing guidelines for its implementation. This article seeks to open up the ‘black box’ of international research on scaling up the provision of mental health care in Africa, unearthing the hidden assumptions and power dynamics underpinning the knowledge produced. It insists that gaining a better understanding of care provision demands that we not only fill the gaps in knowledge but also problematize the assumptions upon which existing knowledge is based. This article demonstrates how two interrelated paradigms are strongly mediating research in this area – those of ‘scientific evidence’ and ‘human rights’. Drawing on theory and research from Science and Technology Studies (STS) and Postcolonial Studies, it demonstrates how these paradigms are both underpinned by several contentious epistemological assumptions, assumptions which are deeply inserted within the epistemological order of Western modernity and colonialism. The main argument is that through their shared ideological undertones of ‘objectivity’, ‘universalism’ and ‘rationalism’, these paradigms are potentially marginalizing other possibly important ways of thinking about care in Africa, ways which might not originate from colonial and modernist forms of consciousness. This article makes a plea for a more inclusive and plural archive of knowledge on scaling up mental health care in Africa, one which is more hospitable to diverse epistemological politics and moral landscapes.

Keywords: Africa, care provision, epistemological assumptions, mental health research, Postcolonialism

Introduction

We have presented the knowledge base and the strategies to improve mental health. Now we need political will and solidarity, from the global health community, to put this knowledge to use. The time to act is now. (Global Mental Health Group, 2007: 1250).

... we mistook the map for the territory, and re-imprisoned ourselves in our unbearable wrongness of being ... (Wynter, 2006: 107).

Over the last decade, the mental health situation in Africa has gained renewed attention as an important public health concern within the global arena (Global Mental Health Group, 2007). One issue of particular concern is what is understood as a considerable number of people with mental health problems on the continent not receiving care, now referred to as the mental health ‘treatment gap’ (Petersen et al., 2011; World Health Organization, 2001). This issue has in turn given rise to a ‘broad new social movement’, led by the international psychiatric community but incorporating a broad coalition of actors and agencies, which is focused on narrowing this ‘gap’ (Horton, 2007: 806). Within this movement, there is a significant degree of consensus that increasing the levels of mental health care in Africa requires the scaling-up of services by implementing a particular model of care. Such a model, it is emphasized, involves the deinstitutionalization of mental health care by integrating it into primary health settings and developing community-based forms of care (Patel et al., 2011; WHO, 2008). In light of this consensus, a strong recent focus of global mental research has been on investigating, and providing guidelines around, exactly what kinds of mental health care interventions should be implemented within primary health care and community settings (Patel and Thornicroft, 2009; WHO, 2010).

Now, the content of this particular model of care, and the guidelines around its implementation, has generated a fair degree of debate, with various scholars raising concerns about its appropriateness for African countries. For example, it has been suggested inter alia that such an approach may be associated with an increased burden on households (Breen et al., 2007), may create new resource challenges (Kigozi, 2007), may exacerbate already over-burdened health systems and associated stressors for health workers (Breier et al., 2009; Petersen, 2000) and may marginalize

patients with chronic mental illnesses (Swartz and MacGregor, 2002).

Notwithstanding the importance of these issues, what has received far less attention, if any at all, is the epistemological assumptions underpinning this model of care and associated implementation guidelines.

In light of this silence, this article seeks to problematize discursive constructions of scaling up the provision of mental health care in Africa. It attempts to open up the ‘black box’ of research in this area, unearthing the hidden assumptions and capillaries of power embedded in the knowledge produced (Latour, 1999). This article is insisting that gaining a better understanding of service provision in Africa demands that we not only fill the gaps in knowledge, but that we also look critically at the assumptions upon which existing knowledge is based. Such assumptions, which are frequently deeply hidden and taken-for-granted, have profound practical and political consequences, helping to shape the kinds of questions that can be asked and thus the solutions that can be generated (Bowker and Star, 1999). As such, unless we examine the structures of knowledge mediating contemporary knowledge on mental health service provision, current strategies being proposed and implemented to address the ‘gap’ in care might prove to be ineffective and inappropriate (Mol et al., 2010). Possibly even more serious, without a critical engagement with the ideologies implicated with the knowledge produced, well-meaning strategies face the danger of oppressing particular people and subjugating certain voices, rather than supporting them (De Sousa Santos et al., 2007). When talking about the current movement for Global Mental Health, Vikram Patel stresses that although the movement ‘advocates a certain *function* (i.e. healthcare has to follow a set of values and aspirations), the *form* can take many different shapes’ (his emphasis, cited in Bemme and D’souza, 2012: 6). This article is insisting, however, that it is the actual function, the values and aspirations which need to be opened up for greater scrutiny and debate.

In the first part of this article, I demonstrate how two interrelated paradigms are explicitly shaping thinking around mental health care provision in Africa – those of scientific evidence and human rights. Drawing on recent international research on the scaling-up of mental health care in Africa, I highlight how rationales for the particular model of care being advocated are being informed strongly by these two structures of thought. Similarly, I show how these two specific paradigms are also

mediating research on how this particular model of care should be implemented. In the second part of this article, I draw on theory and research coming out of Science and Technology Studies (STS) and Postcolonial Studies, in order to turn my gaze onto each of these paradigms separately. I demonstrate how despite their appearance and widespread acceptance, these structures of knowledge are neither neutral nor given, but underpinned by several contentious epistemological assumptions. In particular, I highlight how, although there are obvious differences between them, both possess deep ideological undertones of universalism, objectivity and rationalism. As such, I reveal how they share a very similar epistemological space, both forming an integral part of the intellectual heritage of Western modernist and colonial thought. The key argument of this article is that the dominance of these paradigms, and the associated epistemological space they occupy, may be preventing other, potentially important ways of thinking about mental care health in Africa from contributing to the formal canon of knowledge. When talking about the ‘fascinating pair’ of evidence-based medicine and medical ethics, Annemarie Mol et al. (2010: 12) enquire whether it might be possible to ‘venture into the enormous space left open between these alternatives’. This article seeks to contribute to such debates by exploring how research on the provision of mental health care in Africa might better ‘venture’ into this ‘space’.

It is important to emphasize from the start of this article that I am not suggesting that the dominant model of care being proposed is flawed and inevitably should be discarded. Nor am I implying that the notions of scientific evidence and human rights are necessarily ‘wrong’ and meaningless. What I am arguing against, however, is the hegemonic way in which the paradigms of scientific evidence and human rights, and associated epistemological assumptions, are mediating research on the scaling-up of the provision of mental health care in Africa. This article attempts to shed light on the dangers of single voices and hegemonic perspectives when thinking about mental health care provision. More specifically, it seeks to show how such hegemonic thinking may be foreclosing other, potentially important, ways of constituting knowledge about mental health care in Africa, which may not originate from a Western modernist and colonial form of consciousness. I provide certain examples of potential ‘alternative’ kinds of knowledges and ways of knowing. The focus of this article is, however, not on these possible alternatives per se, but rather on how greater research into these kinds of alternatives, is ultimately being curtailed. It is

thus a plea for a more inclusive and plural archive of knowledge in this area, one that is more hospitable to diverse epistemological politics and moral landscapes. Most certainly, current demands of the global knowledge economy pose several challenges to developing such an archive of knowledge, something which is indeed appreciated by various Global Mental Health care researchers and which I briefly consider in the conclusion of this article.

Scaling up mental health care in Africa: Scientific evidence and human rights

While there must always be space for discourse and conflicting ideas, these must be based firmly on an equal commitment to science and to the right of people who are demonstrably unwell to receive care.

(Patel, in press)

In 2001, the WHO dedicated its World Health Report to mental health, a report which has been described as a ‘landmark document’ in the field of international mental health (Eaton, 2009: 14). Highlighting the high levels of untreated mental illness in low-and-middle income countries, the report proposed a particular model of care as the means for narrowing this ‘gap’. As stated in the report,

The key message to governments is that mental asylums, where they still exist, must be...replaced with well-organized community-based care and psychiatric beds in general hospitals (WHO, 2001: 4).

In justifying this particular recommendation, the report highlights that this proposal is ‘based on a respect for human rights’ (WHO, 2001: 65) and the fact that ‘there is now a strong evidence base, derived from a number of controlled studies, demonstrating the effectiveness of de-institutionalization, the development of community-based services, and integration into the overall health system’ (WHO, 2001: 105). This report marked the beginning of a strong international research movement focused on transforming mental health care provision in low-and-middle income countries, including in Africa. Drawing upon, and elaborating, the key message of the WHO report, a plethora of articles and special issues dedicated to mental health have subsequently been published in a range of high-profile scientific journals, including two series in both *The Lancet* (Global Mental Health Group, 2007; Patel et al., 2011) and *PLoS Medicine* (Patel and Thornicroft, 2009; PLOS

Medicine Editors, 2013), series in *Revista Brasileira de Psiquiatria* (Mari and Thornicroft, 2010) and *Harvard Review of Psychiatry* (Becker and Kleinman, 2012), as well as papers in *Nature* (Collins et al., 2011), *JAMA* (Patel and Prince, 2010) and *New England Journal of Medicine* (Patel and Saxena, 2014) among others (see Petersen et al., 2011, for reviews of some of this work). In line with the WHO report, across this body of work there is a considerable degree of consensus that African countries need to transform their mental health care systems by deinstitutionalizing them and integrating them within both community and primary health care settings.

As with the WHO report, rationales for this recommendation are situated within two particular paradigms: those of scientific evidence and human rights. In terms of the former, there is a tendency across this body of work to cite a host of clinical trials which, it is argued, have shown the efficiency, clinical effectiveness and cost-saving nature of this model of care. Outlining the results of such studies in a fair degree of detail, it is ascertained that there is now a ‘strong scientific evidence base’ (Eaton et al., 2011: 1592) and a ‘robust body of scientific evidence’ (Patel and Saxena, 2014: 499) which testifies to the ‘clinical and cost-effectiveness’ of this model of care (Lund and Flisher, 2009: 1040; Patel, 2012: 7). It is asserted that ‘high-quality scientific studies’ (Thornicroft and Tansella, 2013: 12) have shown that such a model of care ‘improves the processes and outcomes of health care’ (Dua et al., 2011: 2), ‘improves clinical outcomes with decreased costs’ (Wiley-Exley, 2007: 1232) and ‘produces large treatment effect sizes’ (Patel and Prince, 2010: 1976). Ultimately, it is argued that a ‘growing evidence base’ (Lund et al., 2012: 1; Patel and Prince, 2010: 344) is demonstrating that such a model of care ‘yields better access to care, better physical as well as mental health outcomes, and improved overall cost-effectiveness than institutional care’ (Patel et al., 2013: 2) and that ‘large custodial psychiatric hospitals squander resources on ineffective and inappropriate interventions’ (Patel et al., 2007: 1000).

In addition to appeals to science, arguments for the deinstitutionalization and integration of mental health are also strongly drawing upon the rhetoric of human rights. There is widespread agreement across this body of research that such a model of care provides an ethical basis of care that resonates with United Nations (UN) human rights conventions, in particular the UN Convention on the Rights of Persons with Disabilities (UNCRPD) (see particularly Drew et al., 2011; Lund et al., 2012;

Petersen et al., 2011). For example, drawing on this convention, it is argued that this model of care ‘supports the notion that people should have equal access to services in their own locality and in the least restrictive environment’ (Mari and Thornicroft, 2010: 210), fosters the ‘importance of self-determination and the rights of people with mental illness as persons and citizens’ (Thornicroft et al., 2010: 68) and ‘promotes independent living in society in accordance with articles 19 and 25 of the CRPD’ (Drew et al., 2011: 1670).

It is thus clear that two particular conceptual frameworks – scientific evidence and human rights – are strongly shaping rationales for why the particular model of deinstitutionalization and integration of mental health care should be adopted by low- and-middle income countries, including those in Africa. The importance of these specific paradigms was crystallized in the now widely cited 2007 *Lancet* series on Global Mental Health (Global Mental Health Group, 2007). Consisting six articles, the series sought to document the burden of mental disorders and review the ‘evidence’ of effective treatments and barriers hindering their implementation. In summarizing the series as a whole, the final article made a ‘call to action’ to scale up services for people with mental disorders by developing packages of mental health care interventions to be implemented within community and primary health care settings. It emphasized that such scaling-up should be based upon the principles of scientific evidence and human rights, which according to Patel and Prince (2010: 2) have now become the ‘twin principles ... widely adopted as a focus of action in Global Mental Health’. This final article also made a plea for more research to support such scaling-up efforts, research which it emphasized should focus on exploring the specific content of these ‘packages’ of mental health interventions.

In response to this plea, we have indeed witnessed a recent explosion of research investigating ‘what’ specific mental health care interventions should be deinstitutionalized and integrated within primary health care and community settings. And the paradigms of scientific evidence and human rights are strongly mediating such research. For example, between 2008 and 2011, the World Psychiatric Association (WPA) appointed a Task Force to oversee a series of studies to explore what kinds of community-oriented forms of mental health care should be developed in Africa (Mari and Thornicroft, 2010; Thornicroft et al., 2010). In describing the overarching conceptual framework for these studies, Thornicroft et al. (2010: 69)

emphasize how the guidelines produced were ‘written to explicitly align with the requirements of the UNCRPD and associated treaties and conventions’. It is stressed further that the main principles to guide community-based services should be ‘the protection of human rights as ratified by the relevant UN conventions’ and ‘on the grounds of cost-effective and evidence-based mental health systems’ (Mari and Thornicroft, 2010: 211).

Similarly, between 2009 and 2010, a set of studies, published as a series in *PLoS Medicine*, sought to explore which specific ‘evidence-based interventions’ should be delivered within primary health care settings (Patel and Thornicroft, 2009). Six mental disorders were chosen: alcohol use disorders, attention-deficit hyperactivity disorder, dementia, depression, epilepsy, and schizophrenia. Each study examined evaluations of pharmacological and psychosocial treatments for one of these six disorders. The ‘evidence’ reviewed across the studies included generic measurable outcomes that indicated that an intervention enhanced detection, prevented/delayed relapse, reduced costs, increased availability and improved health and social outcomes. As such, the ‘evidence’ reviewed only included quantitative data, derived from systematic reviews, statistical meta-analyses and randomized controlled trials. Other kinds of evaluations, say of a more qualitative nature, were therefore elided from the data collection phases.

Drawing upon and expanding these studies, in 2010 the WHO launched its Mental Health Gap Action Programme (mhGAP), their flagship project in mental health care (WHO, 2008). As part of the programme, the mhGAP Intervention Guide was developed, a kind of ‘what to do’ manual for the management of mental disorders by health workers in primary health care settings (WHO, 2010). In developing this guide, the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach was employed, a methodology for synthesizing scientific evidence on the effectiveness of clinical interventions, in order to produce clinical practice guidelines (Dua et al., 2011; Guyatt et al., 2008). Employing this methodology, groups of ‘priority’ mental conditions were identified, on the basis of their association with elevated mortality/morbidity rates, high economic costs and considerable human rights violations in accordance with the UNCRPD. Common measurable outcomes were decided upon, including social and health-related outcomes, negative effects of the intervention, economic impacts and barriers

impeding implementation. A hierarchy of study designs was developed, which only included quantitative research, and considered non-randomized controlled type studies (e.g. observational, cohort, case–control studies) only if they met certain scientific criteria (Guyatt et al., 2008). The evidence from this research was then synthesized and produced into a step-by-step decision-making protocol, which outlines the specific scenarios health workers in primary care settings may face and associated actions to be taken. Ultimately, it is emphasized that these guidelines are ‘grounded on the best available scientific and epidemiological evidence’ (WHO, 2008: 4) and thus provide ‘the ingredients for scaling up mental health services in LMICs’ (Petersen et al., 2011: 319). When talking about the mhGAP Intervention Guide, Patel and Eaton (2010) assert that:

There are two major principles which should underpin policies: improving access to evidence-based care and respecting the human rights of affected persons. Whereas the principles concerning human rights are comprehensively addressed in international instruments such as the United Nation’s Convention on the Rights of People with Disabilities (CRPD), until now we have not had internationally accepted guidelines on the former ... This has now changed. (p. 343).

What has now changed, according to scholars such as Patel and Eaton, is that ‘The mhGAP provides a robust foundation for scaling up by answering the key question of what should be scaled up’ (Patel, 2012: 8). Ultimately, it is argued that ‘The mhGAP guidelines should become the standard approach for all countries and health sectors; irrational and inappropriate interventions should be discouraged and weeded out’ (Patel et al., 2011: 1442). This appeal that the mhGAP become the ‘standard approach’ is being responded to widely. A burgeoning body of large-scale studies are currently being proposed and executed to scale up the mhGAP Intervention Guide in African countries, studies which are being backed by significant amounts of funding from a variety of international governments and funding agencies (including the National Institute of Mental Health, Grand Challenges Canada, Wellcome Trust, Department of International Development, UK).²³ Ultimately, as Patel (2012: 8) emphasizes, ‘The roadblocks now lie on the path between knowing what works (as

²³ See <http://www.centreforglobalmentalhealth.org/projects> and Patel (2012) for summaries of such projects.

synthesized in the mhGAP-IG) and how it will be delivered “to scale” – that is, to entire populations’.

To sum up, I have demonstrated how scientific evidence and human rights are central players in defining the scope and nature of contemporary research on mental health care provision in Africa. These paradigms are explicitly informing rationales for the model of deinstitutionalization and integration of mental health care. They are also mediating research, and associated guidelines, on what specific kinds of interventions should be integrated within primary health care and community settings. In the sections to follow, I delve into each of these paradigms in more detail, exploring some of their underpinning and deeply hidden epistemological assumptions. Although I consider each paradigm separately, my analysis hopes to reveal how they are in fact structurally very similar, both strongly reflecting the epistemological order of Western modernity and colonialism.

Scientific evidence

They said ... that he was so devoted to Pure Science ... that he would rather have people die by the right therapy than be cured by the wrong.

(Lewis, 1926: 137)

The idea that clinical practice and medical interventions should be based on ‘scientific evidence’ emerged in the 1980s with the rise of what is now referred to as ‘evidence-based medicine’ (Timmermans and Berg, 2003). Criticizing what was seen as the common usage of subjective judgements and anecdotal impressions, the proponents of ‘evidence-based medicine’ asserted that medical practice must be based rather on scientific evidence (Sackett et al., 1996). The notion of ‘scientific evidence’, and by extension, ‘evidence-based’ medicine, is underpinned by a set of now well-known positivist assumptions, with an emphasis on empiricism, rationalism and objective enquiry. At the heart of these notions is the assumption that there is a predictable and transparent ‘reality’ that is ‘out there’, one which operates on the basis of rational and universal principles of cause and effect (Timmermans and Berg, 2003). It is assumed further that this ‘reality’ can be known, objectively, through the principles and methods of science and, in particular, a well-designed randomized clinical trial (RCT). In other words, by following a specific logic – observation, experimentation, measurement and deduction – it is assumed that the

methods of science are able to generate the most impartial and incontrovertible form of evidence (Montgomery, 2006; Moser, 2008). Put in a different way, it is assumed that knowledge which is valid and meaningful includes those aspects of ‘reality’ which are directly observable and measurable as tangible indicators and outcomes (Mol, 2006).

The notion of scientific evidence, and relatedly ‘evidence-based medicine’, is therefore underpinned by very explicit assumptions about the nature of ‘reality’ and how it can be legitimately known. These conjectures are indeed deeply rooted within the epistemological order of Western modernity and colonialism, an order in which scientific modes of thinking became crystallized as the supposed paragon of investigative virtue and the guarantor of universal truths (De Sousa Santos et al., 2007; Stengers, 2003, 2008; Turnbull, 2000). As John Henry’s (2004: 10) analysis of some of the key tenets of Western, modernist thought demonstrates, from the mid-17th century, ‘scientific knowledge acquired the cultural kudos in the West ... science began to be recognized as the supreme cognitive authority, the intellectual system to which all others should defer’. Thus, Western Enlightenment thought was characterized by a strong epistemological commitment to science, with conceptions of ‘truth’, and the criterion for judging what is ‘true’ increasingly governed by the principles of science.

An extensive body of critical social science scholarship has, however, for some time now highlighted the epistemological limitations of scientific rationality (e.g. Bowker and Star, 1999; De Sousa Santos et al., 2007; Latour, 1999; Turnbull, 2000), thinking which appears to remain completely absent from research on mental health care provision in Africa. This body of work has indeed argued that ‘reality’ is a lot more complex, unpredictable and context-dependent than assumed by the logic of science, a reality which cannot so easily be captured by predictive rules and universal laws. Such work has also destabilized the myth that scientific methods are able to generate objective and incontrovertible knowledge. It has demonstrated how scientific knowledge is neither neutral nor given, but imbued with power and interests, and scientific knowledge practices, including RCTs, are deeply political. Such work has shown how scientific observations and measurements are not made in isolation, but are developed within particular theoretical frameworks and are thus invariably filtered through specific ideological agendas.

All of this is not to suggest that technically sophisticated scientific research is not important. Indeed, the tremendous advantages coming out of industry, medicine and technology could not have occurred without scientific principles and procedures. The problem is however, through its underpinning assumptions of objectivity and definitiveness, scientific evidence becomes a kind of orthodoxy, establishing itself as the authoritative, even sole criterion of truth claims (Bowker and Star, 1999; De Sousa Santos et al., 2007). As a consequence, other potentially meaningful ways of knowing tend to be silenced or disavowed within the formally accredited canon of knowledge, something which is increasingly being demonstrated by scholars working within the tradition of Science and Technology Studies (Mol, 2006, 2008; Mol et al., 2010; Montgomery, 2006; Moser, 2008; Pols, 2004; Scott, 1998; Stengers, 2003, 2008; Turnbull, 2000).

Such scholars are showing how in privileging only formal, deductive, epistemic knowledge, certain important parts of nurturing, vitality and life-giving are in turn being lost or judged unfit for knowledge within the current 'evidence-based' knowledge economy. These 'parts', such scholars are demonstrating, are frequently more spiritual and emotional, more messy and unsettled, and not easily measurable within the familiar kinds of enumerations and abstractions of science. And these more messy parts of care and well-being, it is argued, might only be accessible through other forms of knowledge – tactile knowledge, spiritual knowledge, embodied knowledge, practice-based knowledge and movement-based knowledge, among others. And yet under the current epistemic edifice of science, these alternative forms of knowledge and ways of knowing are ultimately being delegitimized, 'regarded as anecdotal, backward, static traditions, as old wives' tales and superstitions' (Scott, 1998: 331).

Indeed, a small body of recent empirical research, based on in-depth ethnographic methodologies in countries such as India (Brijnath, 2011, 2012; Jain and Jadhav, 2008, 2009), Peru (Orr, 2013) and Ghana (Read, 2012), is revealing that there are potentially important ways of constituting knowledge about mental well-being and care which may lie outside of scientific, epistemological codes. This research demonstrates how there may be certain significant components of care practices which cannot easily be measured or modelled, as they are essentially tacit and

embodied in particular moments and contexts. For example, based on her 12-month ethnographic study in Delhi, Brijnath (2011, 2012) explored the importance of the concept of *seva* (literally meaning ‘service’), which is perceived as a highly valued form of care for people who are unwell that takes place between family members. Likened to a form of divine worship, Brijnath demonstrates how this modality of nurturing is based on practices and ways of knowing which are outside of cognitive operations. Incorporating aspects of duty and love, pleasure and intimacy, touch and movement, the practice of *seva* is informed primarily by knowledge gained in people’s bodies, their senses, their moods, their unconscious, their wisdom and experience. According to Brijnath, for many people in Delhi, these more tacit and embodied components of caring encapsulated in the notion of *seva* constitute some of the crucial parts of what it means to care for those who are unwell and thus need to be embedded within mental health services if they are to be meaningful and appropriate for many patients and their families.

In a similar light, in his 12-month ethnographic study among peasant communities in the rural Peruvian highlands, Orr (2013) explored how food sharing and consumption form core dimensions of Quechua sociality, personhood and caring. He highlights how these local ontologies of commensality generate very specific forms of ethical political actions, which may play out not only in the work of *Yachaqs* (‘traditional’ healers) but also in broader networks of care, in community solidarity and conflict resolution, parenting and jurisprudence. According to Orr (2013):

These local conceptualizations of sociality, not envisaged in the standard mhGAP guidelines and similar proposals, should inform a more client-centered approach to mental health care in non-Western settings ... Without a sense of how relatedness, intersubjectivity, and sanity manifest for patients and carers, it is hard to engage with their narratives or to grasp the logic behind the therapeutic itineraries that they follow (p. 707).

Similarly, this small body of ethnographic research also reveals how understandings of ‘recovery’ and ‘wellness’ are often characterized by multiple, complex and potentially conflicting rationalities. As such, a focus on symptoms or disability defined in generic terms may not capture crucial aspects that are important to patients and their families. According to such research, these ‘things’ are often more subtle

and idiosyncratic, related to specific individuals, in specific social milieu. They are often messy and fluid and thus cannot be fixed, or predicted, or apprehended through standardized measures and predictive indicators. These ‘things’ may include, for example, the importance of meaning and interpretation and having a space for suffering (Jain and Jadhav, 2009); the significance of having positions in which esteemed forms of subjectivities and attachments can be exerted and acted (Orr, 2013; Read, 2012) and the value of spiritual strength and coherence (Brijnath, 2011). This body of research reveals how these more qualitative and less tangible ‘things’ are not ‘decorative’ additions that might make care practices more pleasant or humane. Rather, they constituted some of the fundamental and irreducible parts of wellness and healing for many people.

The point is that what is being articulated by this kind of research – conceptions of certain embodied and tacit aspects of care practices and the complexities and subtleties inherent in notions of well-being – is not easily rendered in the language of standardization and may lie outside of scientific metaphysical realities. The knowledge produced by this kind of research is difficult to explicate and will have trouble getting represented within evaluation studies. This knowledge therefore ultimately has no way of entering the formally accredited canon of knowledge on its own terms. Only the enumerable and generalizable are being judged as important within research on scaling-up care in Africa. Only that which can be captured through readily deducible indicators and quantifiable outcomes are being recognized as worthy of consideration – morbidity and mortality statistics, detection and relapse rates, efficiency parameters and economic variables.

Indeed, as shown above, the mhGAP Intervention Guide, understood as providing ‘the key ingredients for scaling up mental health services in LMICs’, was based on the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodology, a methodology which includes only quantitative evidence with the exclusion of any kind qualitative research. This kind of omission of more qualitative data has time and time again been shown to lead to misleading accounts that overlook certain crucial dimensions (Flyvberg, 2001; Law, 2007; Scott, 1998). The crux of the matter is that there may be potentially important aspects of the social world that cannot so easily be captured by the scientific processes of abstraction, reduction and standardization and prediction. And yet these more qualitative ‘things’

end up being excluded or silenced within the current evidence-based edifice. Ultimately, the hegemonic scientific paradigm in which research on mental health care provision in Africa is firmly inserted is thus setting the boundaries of legitimate knowledge and, by extension, legitimate forms of care. It is implying that very little of value can be known outside of the metacodes of science, indeed one of the great enchantments of the modernist and colonial epistemological order (Stengers, 2003, 2008; Turnbull, 2000).

What I am trying to convey here is not that science and the enumerable should be discarded, but rather that there is a need for greater epistemological inclusivity within research on mental health care provision in Africa. Surely it might be possible for research in this area to include other kinds of measurables and alternative sorts of evidentiaries? To legitimize ways of knowing which include the associative, the visceral and tacit? To appreciate forms of practice which speak of wisdom and experience, and not just data? To consider configurations of care which attend to the more subtle ‘things’ which people might find nurturing, but which cannot be made into standardized indicators and quantifiable outcomes?

Human rights

The language of human rights expresses such a strong moral agenda ... that any attempt to question or critique the premise of these rights is seen to stand on the side of injustice.

(Hadjor, 1998: 359)

I now turn to the second dominant paradigm informing research on mental health provision in Africa, that of human rights. The strong language of human rights is not unique to mental health discourse, but since the end of the Cold War, has become a ubiquitous framework for thinking more generally about social change (Alves, 2000; Arslan, 1999). The current era in which we live has in fact been referred to as the ‘age of rights’, whereby the human rights discourse has become ‘the new criterion of political legitimacy’ (Arslan, 1999: 196). Through its emancipatory rhetoric, promoting the ideals of liberation, equality and justice, human rights discourse is generally accepted as a ‘good’ thing. Problematizing the paradigm of human rights is therefore not an uncomplicated endeavour.

If we move beneath face-value understandings however, it is clear that the paradigm of human rights, in its theoretical origins and contemporary embodiment within international conventions, is underpinned by several highly polemical epistemological assumptions. Like ‘scientific evidence’, these assumptions are deeply rooted within the philosophies emanating from Western modernist and colonial thought (De Sousa Santos et al., 2007; Pannikar, 1984). The notion of human rights emerged during the era of European Enlightenment and was intimately intertwined with the rise of the modern-nation state and associated liberal philosophies (Brooks, 2010). In accordance with these philosophies, a human rights paradigm is underpinned by an inherent assumption of the universality of human nature. In other words, it is assumed that there is a common human nature, one which is endowed with a universally derived dignity. Relatedly, it is assumed that this dignity is objectively knowable by an equally universal organ of knowledge, that of rationality. Furthermore, there is the assumption that individuals are inherently separate from one another and from society and even the greater cosmos. In this view, a human being is fundamentally the individual, one which is essentially an autonomous being. Human rights are thus ultimately about defending the autonomy of the human individual. This set of assumptions is succinctly captured by postcolonial scholars De Sousa Santos et al. (2007):

The concept of human rights is based on a well-known set of presuppositions, all of which are distinctly Western and liberal in origin, namely: there is a universal human nature that can be known by rational means; human nature is essentially different from and higher than the rest of reality; the individual has an absolute and irreducible dignity ... the autonomy of the individual requires that society be organized in a non-hierarchical way, as a sum of free individuals. (p. 13)

This set of assumptions is indeed clearly evident in the UNCRPD, which, as demonstrated above, is being explicitly drawn upon as the gold standard within mental health care research on scaling up the provision of care in Africa. For example, the Preamble of the UNCRPD begins with a statement which ‘recognizes the inherent dignity and worth and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world’ (UN, 2006: 1). Moreover, it stated that the Convention recognizes ‘the universality ...

all human rights and fundamental freedoms' (UN, 2006: 1). Furthermore, Article 3 describes that one of the main guiding principles of the Convention is the 'Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons' (UN, 2006: 5).

The notion of human rights is thus underpinned by very particular assumptions about personhood and dignity, and how they can be known. Ultimately, these concepts take on a spurious aura of normativity, assumed to be knowable through a supposed objective and universal 'rationality'. And yet a large body of critical social analyses has demonstrated that what constitutes human dignity and morality, and by extension a 'human', are far from self-evident, outside of discourse, ideology, history or context. Such work has shed light on the diversity and complexity of moral sentiments in different polities (e.g. Engelke, 1999; Englund, 2000; Mamdani, 2000; Sardar, 1998; Wilson, 1997). For example, research in various settings in Africa has revealed that for many people, selfhood and dignity are understood as conditions which are acquired, rather than 'given'. As such, many people in these contexts place great value on the gradual social maturation of the person as constantly evolving. Relatedly, in such circumstances, personhood is frequently recognized as deeply intertwined with the spiritual, the corporeal and the social community, rather than about an autonomous individual (Engelke, 1999; Englund, 2000). As such, this research revealed that attempts to bring about social justice through the utilization of human rights rhetoric have frequently been unsuccessful as they have failed to respond appropriately to locally relevant meanings and value systems.

A similar kind of analysis has been made in the realm of mental health more specifically. For example, in-depth ethnographic research in Ghana (Read et al., 2009) and the Congo (Devisch et al., 2001) has revealed how caregivers commonly over-ride the autonomy of the individual in order to ensure receipt of care or protection of others. And this makes sense in both contexts where the notion of the mutual interdependence of people is widely valued, and the community's well-being is frequently prioritized over individual rights. The researchers demonstrate how appeals to human rights in both of these settings are failing to achieve their anticipated effects, as they are not resonating with the concerns and hierarchy of values that commonly prevail.

Through these examples, we see that there are fundamental problems with the assumption of universality that underpins the notion of human rights. Human rights discourse does not belong to the realm of morality per se, but rather reflects a particular political morality that may not be shared by everyone, everywhere. However, through its underpinning assumptions, the notion of human rights is able to gain a universal force that is unconditional. As Wilson (1997: 4) argues, 'Having established the nature of a universal human ontology, objectivity can be claimed for value judgements about political, economic, social and legal arrangements'. This is clearly reflected within research on mental health care provision in Africa, where the notion of human rights and associated UN conventions tend to be drawn upon as if they embody self-evident truths, requiring very little further elucidation. The slippery issues of dignity and justice are therefore decontextualized and engaged with in a 'one-size-fits-all' manner by such research.

To be sure, my argument is not one of relativism, a kind of 'anything goes'. Forms of care that respect and dignify people with mental disability are worthy ideals. But what is 'respectful' and what enhances 'dignity' are not as self-evident as the notion of human rights would have us believe. At the same time, I am not suggesting that in 'Africa' there are shared moral sentiments that are essentially different from sensibilities residing in 'the West' (wherever that may begin or end). Indeed, critiques of human rights discourse in Africa are often framed in this way, where it is argued that the liberalism and individualism inherent in human rights rhetoric make it inappropriate for people in Africa (e.g. Hadjor, 1998; Mamdani, 2000; Sardar, 1998). In our increasingly globalized world, where there is growing mobility and exchange of ideas, societies, including those in Africa, most commonly have multiple and overlapping legal tongues and moral orders (Geertz, 2000). As such, ideas of individuality, autonomy and self-determination, to name a few, may certainly be relevant for some people, in some postcolonial African settings, even if such notions might originate outside of the continent. But they also might not be appropriate. There might be other, more suitable, ways of making commensurate demands for dignity and justice, formulated in different languages of freedoms and entitlements. However, the notion of human rights does not allow any space for these alternatives. As Englund (2000) so pertinently concludes from his analysis of human rights discourse in Malawi:

Human rights talk ... threatens to overshadow other ways of conceiving human dignity ... by attributing legitimacy to specific moral notions, thereby defining the contours of what is not only acceptable but also conceivable. (p. 579)

Conclusion

Before envisioning the global civilization of the future, one must first own up to the responsibility of creating a space at the margins of the present global civilization for a new, plural, political ecology of knowledge

(Nandy, 1989: 266)

In this article, I have problematized some of the dominant discursive constructions of scaling up the provision of mental health care in Africa within contemporary Global Mental Health research. I have demonstrated how two interrelated paradigms, those of scientific evidence and human rights, are strongly mediating research in this area. I have argued that despite their appearance, these paradigms are not neutral or given, but are underpinned by very particular, and somewhat questionable, assumptions about the 'nature' of reality, and how it can be known. I have revealed how both are deeply dependent on ideas of a universal reality, one which can be objectively and definitively captured by rational means. I have touched upon how these assumptions of 'objectivity', 'universalism' and 'rationalism' are indeed deeply embedded within the epistemologies that form the intellectual heritage of Western modernist and colonial thought, a knowledge tradition which produced particular ways of ordering the world.

What I have tried to demonstrate is that through their inherently modernist epistemological assumptions, the paradigms of scientific evidence and human rights have in turn become the gatekeepers of knowledge within mental health care research. Only the enumerable, and which is in accordance with the language of human rights, is being considered as legitimate forms of knowledge and, by extension, valid forms of care. As demonstrated by much postcolonial thinking, this negation of 'other' ways of constituting knowledge is indeed what lies at the heart of the Western, modernist and colonial epistemological order. This order ultimately reproduces the illusion that the only worthy ways of thinking and being in the world are those which originate from a modernist and colonial form of consciousness (De

Sousa Santos et al., 2007 Sardar, 1998; Stengers, 2003, 2008; Turnbull, 2000). In other words, unless one speaks through this dominant epistemological order, one will not be heard. This form of exclusion of other kinds of voices, which arise from different epistemological spaces, is what is meant by the often used phrase ‘epistemic violence’ (Spivak, 1995) or ‘epistemicide’ (Harding, 1998).

It is important to stress again, I am not implying that the dominant model of care being proposed, that of deinstitutionalization and integration, is flawed and should be discarded. Nor am I implying that the values of scientific evidence and human rights are necessarily ‘wrong’ or meaningless. Rather, what I am expressing discomfort with is the current dominance of these particular paradigms and their associated assumptions within research on mental health care provision in Africa. This hegemony is potentially disallowing other, possibly meaningful ways of knowing and thinking from entering the citadel of knowledge.

As such, what other potentially positive kinds of care are being lost within the current epistemic edifice of ‘evidence-based knowledge’ and ‘human rights discourse’? What alternative forms of care, which cannot be conceptualized in terms of costs and tangible clinical outcomes, but which might be equally important, are being neglected? What other sorts of potentially beneficial treatments, which may foster dignity and justice in ways which do not necessarily ‘fit’ with dominant human rights discourse, are being overshadowed? How might these alternative ways of assembling the world change current conversations on mental health care and the ‘gap’ in mental health care in Africa?

In this article, I have touched on, very briefly, certain examples of such potential alternatives. In providing these examples, my point is that ‘other’ ways of knowing and being exist, and yet the dominant epistemological order underpinning mental health research in Africa is ultimately foreclosing greater research into these kinds of alternatives. Ultimately, through these examples I have attempted to shed light on the dangerous dissonances that may potentially exist between discursive construction that perpetuate certain visibilities and sayabilities, and the existence of considerably heterogeneous local practices and understandings.

The challenge I therefore see facing research on mental health care provision in Africa is to start opening up the space for more diverse ways of thinking, or what postcolonial scholar Ashis Nandy (1989, p. 266) terms ‘a new, plural, political ecology of knowledge’. Creating such a space requires considering how generative dialogues, across different knowledge traditions and moral landscapes, might be promoted, rather than closed down. It necessitates reflecting upon how the rubric of scholarly acceptability might be more inclusive, valuing different measurables, alternative evidentiaries and other ways of imagining on their own terms.

Developing a more inclusive archive of knowledge on mental health care provision in Africa is not an uncomplicated task. Within a context of competing health priorities and limited resources, mental health is commonly not given precedence by politicians and senior health planners on the continent. As such, economies of scale in government, in decision-making by policy-makers and in assessments by donor agencies increasingly demand clear and simple strategies that are based on ‘hard’ scientific evidence. This is indeed appreciated by certain Global Mental Health researchers, who have emphasized that convincing governments and attracting donors to invest in mental health necessitate that there is a ‘consensus-based research agenda’ (Tol et al., 2012: 26), that there are ‘clear and consistent reasons and objectives’ (Thornicroft et al., 2010: 71) and that people ‘cast aside their differences to stand shoulder to shoulder to advocate for a shared cause’ (Patel, 2012: 9).

These irreducible lacks and pressing demands pose several limitations. And yet at the same time, fully subscribing to the current pressures of the global knowledge economy is likely to have dire consequences. As illuminated by sociologist of knowledge David Turnbull (2000: 227), if we do not actively foster a multiplicity of voices, ‘we will condemn ourselves to an inevitable death brought on by the inflexibility and sterility of a monoculture ... In the long run, social and cultural complexity cannot be winnowed away; it is all there is’. At the end of the day, unitary voices, single goals and definitive principles are bound to flounder, as they will inevitably do battle with complex realities and diverse contexts. What might therefore need rethinking are the sorts of causes that should be shared and the kinds of research agendas that should be promoted, and how these might celebrate, rather than thwart, heterogeneous solutions and cacophonous perspectives.

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6. RESEARCH PAPER TWO

Research on help-seeking for mental illness in Africa: Dominant approaches and possible alternatives

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Abstract

There is growing concern within the Global Mental Health arena that interventions currently being executed to scale-up mental health care services in Africa will be ineffective unless simultaneous steps are taken to address people's help-seeking behaviour. Drawing upon two particular conceptual tools commonly used within the field of Science and Technology Studies (STS), those of a 'classification system' and 'the black box', in this paper I look critically at discursive constructions of help-seeking in Africa within mental health research over the last decade. I demonstrate how research in this area can be divided into two dominant traditions, which I term the '*knowledge-belief-practice survey*' and '*indigenous-knowledge-system*' approaches. Although the content and value-codes between them may differ, I show how these two traditions are in fact structurally very similar. They are both mediated by the same kind of system of classification, one which demarcates the world into homogenous entities and binary oppositions. This is one of the most stubborn and powerful forms of classification buried in the 'black box' of the modernist/colonial inherited knowledge archive. It is a system of ordering which is fraught with many questionable and Eurocentric epistemological assumptions. I consider whether there might be other ways of understanding help-seeking for mental illness in Africa without re-inventing dominant forms of Eurocentric power and privilege. I demonstrate how two particular studies might offer a fruitful terrain for engagement. In conclusion I discuss some of the potential challenges this alternative kind of research faces in gaining more power and influence within contemporary Global Mental Health discourse.

Keywords: Africa; Help-seeking; Mental health research; Epistemological assumptions

Introduction

“What, then, is the scope for decolonising methodologies that are so clearly linked to formations of power and knowledge, so deeply shaped by their links to post-colonial and still-imperial forms of governance?...In the long run, there is only one way of finding out: by actually trying to contest homogenising quantitative narratives by developing powerful and convincing counter-hegemonic accounts”.

(Du Toit, 2005, p.14)

Over the last decade, Global Mental Health (GMH) discourse has been especially vocal about the dire mental health situation in Africa (Cooper et.al, 2011). One issue that has received particular attention is what is understood as the low levels of mental health care service uptake (Eaton et.al, 2011; Saraceno et al., 2007). There is indeed growing concern within the global health arena that despite psychiatric services becoming more available and affordable in Africa, they are still significantly underutilized (Kohn et.al, 2004; Demyttenaere, 2004). GMH discourse is thus placing increased attention on the need to better understand and target people’s help-seeking behaviour, so as to increase the uptake of services in Africa (Patel et.al, 2010; Petersen et.al, 2011).

This paper looks critically at discursive constructions of help-seeking in Africa within mental health research over the last decade. Rather than focusing primarily on the findings of such research, this paper is more interested in epistemological questions regarding the conventions of meaning-making that lie *behind* the knowledge that is produced, disentangling the power dynamics at play. In order to approach this task, I draw upon two particular conceptual tools commonly used within the field of Science and Technology Studies (STS), a broad theoretical corpus concerned with how health, bodies and disease are politically and discursively produced in medical science and practice (Law, 2008; Latour, 1999). In particular, I utilise Geoffrey Bowker and Susan Star’s (1999) idea of ‘classification systems’ and Bruno Latour’s concept of ‘the black box’ (1987, 1999).

Classification, according to Bowker and Star (1999) is an essential and unavoidable part of our ability to navigate and decode the challenges of our lives. However, this does not mean that systems of classification are either given or innocent. As defined by these scholars, a classification system is “a set of boxes (metaphorical or literal)

into which things can be put to then do some kind of work” (ibid, p. 10). What this suggests is that classifications create boxes, and it is the design of these boxes which mediates what can be put into them. Surfacing the design plans which propel classification is, however, difficult as they are as invisible as they are powerful. As Bowker and Star (1999, p. 286) stress, “Many scholars see categories and classification as coming from an absent sense of ‘mind’, little anchored in the exigencies of work or politics”. Thus, what are concealed within classifications are the shared properties, which appear so natural and intrinsic, but which are in fact constructed ways of seeing and acting in the world. These are deeply buried in what Bruno Latour calls (1987; 1999) ‘the black box’.

According to Latour (1987), the black box holds all the common sense assumptions that a culture shares which turns questions, priorities and interests into facts. As Latour (1987, p. 206) puts it, the box is “well sealed” and people generally do not “live in a world of fiction, representation, symbol, approximation and convention: they are simply *right*”. In other words, the coded principles of classification become so taken-for-granted, that almost by definition their underlying scaffolding disappears. According to Latour (1999, p.304) in later work, what this concealment enables is a focus on “inputs and outputs” and not on the complex processes that produce these effects. Those complex processes to which Latour refers, are all of the interests, values and politics that shape how we see and think in the world. These are what dictate the design and limit the options of classifications. And this process is normalised and archived in such a way as to be inherited and accepted as common-sense reality. This includes common knowledge about Africa.

Drawing on these ideas, this paper seeks to open up the ‘black box’ of the knowledge produced on help-seeking for mental illness in Africa by contemporary mental health research. It examines how the classifications within this research contribute to producing the knowledge that they are supposedly designed simply to store. The design plan of classification is multifaceted, usually characterised by an enmeshment of complex crosscurrents of interests and consequences. As Bowker and Star (1999, p.21) discovered regarding the classification of illnesses, there is “a panoply of tangled and crisscrossing classification schemes held together by an increasingly harassed and sprawling international public health bureaucracy”. This paper therefore aims to unravel the capillaries of power and interrelated knowledge

assumptions embedded in classifications of help-seeking, making their hidden ties visible.

Research in this area can be divided into two dominant traditions, which I term the '*knowledge-belief-practice survey*' and '*indigenous-knowledge-system*' approaches. Although the content and value-codes between them may differ, I show how these two traditions are in fact structurally very similar. They are both mediated by the same kind of dominant system of classification, one which demarcates the world into homogenous entities and binary oppositions. This system is in fact one of the most powerful and stubborn forms of classification buried in the 'black box' of the modernist/colonial inherited archive (Latour, 1991; Said, 1978).

This paper thus asks whether there might be other ways of understanding help-seeking for mental illness in Africa in ways which are not necessarily informed by a modernist/colonial form of consciousness. In other words, it considers how we might classify help-seeking behaviour without re-inventing dominant forms of Eurocentric power and privilege. If classification creates codes for meaning making that are as necessary as they are potentially harmful, the question is how we might "design classification systems that do not foreclose on rearrangements suggested by new forms of social and natural knowledge" (Haraway, 1991, p. 321). I highlight how two particular studies, which fall outside of the dominant research approaches, might offer a potentially fruitful terrain for engagement. Many of the critiques made in this paper are not particularly unusual or novel, but in fact reflect a long line of thinking within critical health sciences research and theory dating back to the 1980s. I thus conclude this paper by considering why, for the most part, this body of work continues to remain marginalized within contemporary research on help-seeking in Africa.

Accumulating an archive of mental health research

Various processes were undertaken to identify both qualitative and quantitative studies, published over the last decade, which have explored help-seeking for mental illness in Africa. The objective was not necessarily to be exhaustive, but to be able to provide a picture of some the main research approaches in this area. On-line searches were undertaken in Medline and PsychInfo databases using the key phrases: "mental

disorders”, “mental health”, “Africa” (including the names of all individual countries on the continent), “help seeking behaviour”, “health care seeking behaviour”, “help seek*”, “seek* help”, “seek* treatment”, “health care access”, “health care utilization”, “service uptake”, “treatment uptake”, “treatment barriers”. Where applicable, keywords were combined with Medical Subject Headings for the Medline databases and Subject Headings for the PsycINFO database. The reference lists of all applicable papers were scanned to identify further studies, and the authors of relevant papers were contacted. In addition, people known to be working in the field of Global Mental Health were contacted and asked if they could provide any relevant references. Some of the studies were also found by serendipity. Through my searches, I identified 48 relevant papers emerging from 14 African countries.

Analysis

Immersion in this archive suggested that research on help-seeking for mental illness in Africa could be characterised by two main approaches, which I term the ‘*knowledge-belief-practice survey*’ and ‘*indigenous-knowledge-system*’ traditions. The relevant studies, listed under each category can be seen in the Appendix²⁴. My analysis is divided into three parts, with the first two parts dealing separately with the main research approaches, followed by a final section in which I briefly explore how two particular studies fall outside of the main research traditions. Classifying these studies in this way is both performative and political. Classifications order things, and thus the particular non-coherences that do not fit into my schema, inevitably will be marginalized. The analysis might therefore be done quite differently, if ordered in an alternative way. What follows is therefore my situated interpretation (Haraway, 1991).

Research Category 1: Knowledge-belief-practice survey approach

The most prominent approach to studying help-seeking for mental illness in Africa is a perspective which I term the ‘*knowledge-belief-practice survey*’ tradition. Through the administration of large-scale, quantitative-type surveys, studies within this approach seek to understand the pathways people will take to seek help, and the

²⁴ See appendix five of this thesis.

potential barriers that prevent or delay people from accessing services. The central focus is on exploring people's beliefs about the causes and symptoms of, and appropriate forms of care for, mental illness. As such, the notion of 'belief', and particularly *cultural* beliefs, emerges as a fundamental category mediating interpretations within this research tradition; a primary box into which understandings of help-seeking are inserted (Bowker and Star, 1999).

Indeed, the large majority of studies within this approach assert that people in Africa tend to hold "traditional beliefs" in "magic" and the "supernatural", and as such, understand mental illnesses as "spiritual illnesses". For example, in their study amongst people attending primary health clinics in Dar-es-Salaam, Ngoma et.al. (2003, p.353) assert "In Africa, mental disorders...are perceived as a source of misfortune; ancestors and witches are believed to have a crucial role in bringing them about". By the same token, the following statement comes from Samouilhan and Seabi's (2010, p.75) study of students' beliefs about the causes of mental illness in South Africa:

In African culture, religious and spiritual beliefs inform all other beliefs, behaviours and practices...The African worldview subscribes to the idea that mental illness is caused by witchcraft, by a failure to connect spiritually with the ancestors...

These quotations aptly capture dominant sentiments across the majority of studies, with an abundance of statements that "the majority of the Ugandan population still harbours cultural beliefs about mental illness" (Ndyanabangi et.al., 2004, p.54); "Traditional notions...are widespread" (Deribew & Tamirat, 2005, p.157) and "The belief system of bewitchment/sorcery is still entrenched in the way of thinking and lifestyle of the African people" (Mkize & Uys, 2004, p.67). This apparent widespread belief in the supernatural is widely emphasized as the key reason for the pervasive patronage of 'traditional' forms of care in Africa. As unequivocally proclaimed by Bekele et.al (2009, p.481) in their research into the pathways to psychiatric care in Ethiopia:

Seeking care from traditional healers for mental illness is a reflection of the prevailing belief among the Ethiopian population that mental illnesses are

caused by supernatural forces...As such patients usually resort to modern mental health-care services only after receiving traditional treatments.

These kinds of contentions are ubiquitous across this tradition of research, with widespread comments such as: “People in Africa consult traditional healers because of cultural beliefs” (Mirza et.al, 2006, p.143); “Due to cultural beliefs about the causes of mental illness the mentally ill will consult a traditional healer first” (Ndyanabangi et.al., 2004, p.55); and “The cultural background of an individual determines who and where to go for help” (Mkize & Uys, 2004, p.67).

A very particular understanding of human action, including care-seeking, is embedded in these assertions, one which assumes that people behave in essentially predictable and rational ways, shaped primarily by a set of beliefs held by the care-seeker. And these propositions are assumed further to be determined almost exclusively by supposed ‘traditional’ African ‘culture’. Moreover, what is striking about these quotations is how the notion of African ‘culture’ is conceptualised as a homogenous entity, comprised of tidy and unchanging social boundaries. All Ethiopians, all Nigerians, all Senegalese people, all Africans for that matter, are binded seamlessly together, assumed to share the same beliefs and practices. Not only is supposed African ‘cultural beliefs’ constructed as internally monolithic, it is also tends to be represented as in direct opposition to supposed Western, biomedical knowledge. For example, Burns et.al. (2010, p.539) in their study of help-seeking in South Africa assert:

While studies in high-income countries show that both psychotic patients and their relatives attribute their illnesses to biological or natural causes, it appears that their counterparts in LMICs invoke spiritual and traditional explanations.

Similarly, Ngoma et.al. (2003, p.353) mentioned above proclaim:

Traditional medicine and biomedicine differ in their concept of the nature and causes of mental illness. In Africa...such disorders may be viewed in terms of magical and religious causes, but rarely as diseases within the Western biomedical paradigm.

Analogous sentiments are expressed by Adewuya and Makanjuola (2009, p.124) in their research on mental health care among Nigerians: “A strong belief in supernatural causation may imply that offering Western medical care would be futile”. At the same time, Gureje and Lasebikan (2006, p.48) from their research in Nigeria conclude “Belief in the supernatural causation of mental illness...is likely to make persons with mental illness unwilling to seek formal service for mental disorders”. Similarly, Samouilhan and Seabi (2010, p. 75) referred to above proclaim “A strong belief in traditional ideology could lead to the rejection of formal mental health services”, whilst Coleman et.al. (2003, p.381) in their study of epilepsy in rural Gambia conclude “In most parts of sub-Saharan Africa, notions about epilepsy are rooted not in a medical model but in a spiritual model”.

A line of demarcation is therefore constructed between Africa and the West, between supposed traditional African healing systems and beliefs, and apparent Western biomedical frameworks of knowledge and care. This bifurcation evolves further as it produces a proliferation of negative assumptions about African people and their way of life. Apparent African beliefs and practices are represented as *inherently* primitive, irrational and damaging, as opposed to Western biomedical truths which are valorised as *essentially* sophisticated and modern. For example Osungbade & Siyanbade (2011), conclude in their paper of help-seeking in a rural Nigerian community:

The dominant tendency to use traditional treatment over *modern* medicine in many African countries is common and *worrisome* as it amounts to denial of prompt and *appropriate* treatment [my emphasis].

In a similar manner, Selassie (2008, p.1645) in his analysis of the management of epilepsy in sub-Saharan Africa proclaims:

The causal link of epilepsy to natural spirits has neither *scientific basis* nor allows *rational approach* for intervention. To the contrary, it wastes valuable time and the meagre resources of the patients by interfering with a possible link with biomedical care providers until too late [my emphasis].

These assertions are hardly value-free. Apparent traditional cultural beliefs and practices are given an inevitable appearance of primitiveness and inferiority, in stark contrast to supposedly enlightened, Western biomedical truths. Indeed, these value-judgements are most pertinently revealed in the kinds of recommendations put forward by many of the studies, where it is explicitly asserted that interventions need to focus on ‘correcting’ supposedly false cultural beliefs and behaviours so they are more in-line with a biomedical system of knowledge and practice. It is widely emphasized that there is a need for education and awareness-raising campaigns, “aimed at *modernizing* general population causative models and attitudes” (Ohaeri and Fido, 2001, p.498). It is asserted that such programmes must “*teach* people about the *real* symptoms, causes and treatment of mental health problems” (Deribew and Tamirat, 2005, p. 153); “*sensitize* residents to *Western knowledge*” (Sharkawy et.al, 2006, p.211), and “encourage utilization of *modern treatment*” (Osungbade and Siyanbade, 2011, p. 428). This is seen as essential in order to “change *irrational* perceptions” (Deribew and Tamirat, 2005, p.153), or else “those in need are likely to continue using the traditional pathways to care in preference to a new alien service” (Eaton and Agomoh, 2008, p.557). Not only is there a strong emphasis on educating the community, there are also widespread calls for the need to train and educate traditional healers. As Bekele et.al (2009, p.482) argue:

It is important to train them [traditional healers] about early detection and timely referral of psychiatric patients... This will reduce the risk of disability and economic burden to the individual and country, especially by avoiding *undue delay* of treatment and expenditure on *non-effective treatments* [my emphases].

Or in the most unambiguous words of Mkize and Uys (2004, p.68):

Health professionals should embark on *educating* traditional healers in the concepts of mental illness... and the recognition of signs for referral to health professionals, thus shortening the clients’ journey to *proper* health [my emphases].

Thus, pulling these various threads together, the knowledge produced by this research tradition is underpinned by a host of interrelated assumptions and meanings-

codes about the supposed nature of human action, about culture, and about medical science. These particular assumptions take on a 'natural' and self-evident quality with this research, ultimately 'black-boxed' within the supposed normalised categories of science, culture and belief. And yet these categories are far from natural or given, having been the subject of much critique by a now veritable academic industry of STS, postcolonial and anthropological scholars.

For example, the assumption within this research tradition that human action, including care-seeking, is inherently stable and rational, based upon the beliefs that people hold, has been rigorously disputed. Much critical work has demonstrated how far from operating in a mechanical, law-like, cause-and-effect manner, human action is profoundly complex and unpredictable, mediated by an array of contextual processes (Law, 2008; Mol, 2008). Indeed, in his analysis of some of the central epistemological presuppositions implicit in what he calls an 'empiricist theory of medical language', Byron Good (1994) highlights how the notion of 'belief' has come to function as a key analytical term within biomedical discourse. He shows how, deeply rooted in a rationalist philosophy of science, this concept of 'belief' reduces all of the contingencies and vicissitudes associated with illness and related behaviours to a set of propositions held by individual actors, in their minds. According to Good (1994), such reductionism has in turn so often led to misleading accounts of how and why people behave in the ways that they do, and inappropriate forms of medical practice.

At the same time, the inherent assumption embedded within this tradition of research that 'culture' is a monolithic and distinct entity, comprised of tidy and unchanging social boundaries has also been widely destabilised. For example, it is argued that identities, cultures and structures of knowledge, including those on the African continent, are neither homogenous nor static. Rather, these are complex and disjointed social constructs which are constantly in flux, having assimilated and mutated over centuries (Comaroff & Comaroff, 2012). As Lesley Green (2008, p.148) argues:

To suggest that 'culture' has existed without internal differences of opinion, innovation, or contact with new ideas throughout human history is

demonstrably false...The idea that ‘a knowledge’ can be wholly ‘indigenous’ to ‘a people’...is just not a complete picture.

Indeed, the work of Arun Agrawal (1995, 2002) is particularly illuminating in this regard. He demonstrates how the demarcation between Africa and the West, between traditional ‘African’ systems of knowledge and ‘Western’ knowledge frameworks is unsubstantiated. Providing diverse examples, he shows how over the last several centuries, ‘African’ and ‘Western’ forms of knowledge have experienced much contact, exchange and transformation, leading to extensive overlap between them. Agrawal (1995) unpacks in great detail three major themes that presumably separate ‘African’ systems of knowledge and ‘Western’ knowledge frameworks: that of substantive differences; methodological and epistemological differences; and differences related to context. Drawing on a diverse range of theoretical traditions he shows how none of these claims have substantial grounds: “attempts to draw a strict line between Western and African knowledges on the basis of method, epistemology, context-dependence, or content...are ultimately untenable’ (Agrawal, 2002, p. 293). Ultimately, he shows how in conceiving ‘culture’ as a homogenous and distinct entity, all the multiplicity and dynamism of identities and systems of knowledge and practice are made invisible and erased.

Furthermore, the assumption deeply embedded within this research tradition that supposed ‘traditional’ African cultural beliefs and practices are *inherently* primitive and irrational, whilst Western biomedical truths are *intrinsically* rational and superior has been the subject of much critique by various STS and postcolonial researchers (For example Connell, 2007; Comaroff & Comaroff, 2012; Latour, 1991). According to such scholars, our identification of ‘rational’ and ‘superior’ forms of knowledge and practices are never given or self-evident, but rest upon all kinds of values and assumptions around what ‘the modern’ comprises. For example, in his book *We Have Never Been Modern*, Latour (1991, p.76) argues that things are never innately ‘modern’ or ‘pre-modern’, but only by means of a “harsh disciplining” and the “work of sorting out, cleaning up and dividing up”, are certain entities compelled to become modern, and others designated as archaic or irrational. For Latour then, we have simply been caught up in a process of classification and re-classification, and as such, if we change the “classification principle”, we can in turn get a “different temporality on the basis of the same events” (ibid, p.75).

Research on help-seeking within this tradition is thus underpinned by a host of questionable and Eurocentric assumptions. These assumptions coalesce around a very particular way of classifying the social world, one which tends to demarcate the world into homogenous entities and binary oppositions: ‘cultural beliefs’ versus ‘biomedical truths’; ‘Africa’ versus ‘the West’, ‘traditional’ versus ‘modern’, ‘primitive’ versus ‘civilized’. This system of ordering is indeed one of the most powerful and stubborn forms of classification buried in the ‘black box’ of the modernist/colonial inherited archive, including colonial medicine (Connell, 2007; Green, 2012; Said, 1978). As most pertinently demonstrated by Edward Said (1978) in his *Orientalism*, through the metalanguage of colonialism and modernity, imaginary lines were drawn and homogenous identities were constructed. In legitimizing tropes of otherness and polarizations of difference, these binaries served to unambiguously distinguish Europe from other societies, and validate its supposed “positional superiority” (Said, 1978, p. 7).

Colonial medicine was indeed intimately entangled with this kind of thinking, characterized at least in part by the struggle between supposed ‘rational’ Western science and ‘primitive’ ‘traditional’ therapeutics (Comaroff 1993; Vaughan 1991). In its imaginary, ‘Western’ medical science, embodied the highest form of rationality and modernity, in contrast to the supposed backward and superstitious nature of ‘indigenous’ cultural beliefs and practices. Put bluntly medical modernization of African populations entailed attempting to drive out supposed ‘primitive’ traditional therapeutics, and promoting forms of care which were based solely on biomedical theories and practices.

The second dominant mental health research tradition on help-seeking, to which I now turn, attempts to contest many of these Eurocentric assumptions that weigh heavily on this first tradition of research. And yet although the context and value-judgements may have changed within this research approach, the same way of ordering and classifying the social world remains firmly intact. This in turn, I suggest, ultimately limits the possibility of genuinely transcending the epistemological order of European Colonial Modernity and its suspect system of classification.

Research category 2: Indigenous-knowledge-system approach

I term the second dominant body of research which seeks to understand help-seeking for mental illness in Africa the '*indigenous-knowledge-system*' approach. This approach draws heavily on the 'new cross-cultural psychiatry' tradition, and in particular Arthur Kleinman's (1980, 1988) 'explanatory model' framework. In the late 1970s and 1980s, Kleinman and colleagues criticised the tendency of epidemiological research world-wide to assume that Western psychiatric models and taxonomies are universally applicable. Heavily influenced by medical anthropology and sociology, these scholars condemned psychiatric research for assuming the inevitable superiority of Western biomedical frameworks and classification systems. Advocating a conceptual distinction between disease and illness, such scholars asserted that 'disease' is the malfunctioning of the body, whereas 'illness' comprises the lived experience of suffering (Kleinman, 1980; 1988). This subjective understanding of disease, according to such scholars, is mediated by people's 'explanatory models', which are "shaped by cultural factors governing perception, labelling, explanation, and valuation" and which play a fundamental role in determining how people understand and respond to disease (Kleinman et.al, 2006, p.141). For these scholars then, different cultures will have unique explanatory models that are distinct from, but equally legitimate to, Western psychiatric nosology.

Drawing on this 'explanatory model' framework, and most commonly using qualitative methodologies, the second dominant research tradition focuses on exploring local people's explanatory models, and how these shape their help-seeking behaviours. In line with the 'explanatory model' framework, it is commonly asserted within this body of research that African people have their own explanatory models, and own forms of healing, which are inherently different from Western views. For example, Crawford and Lipsedge (2004, p.143) conclude from their research amongst Zulu-speaking South Africans:

Models of Western psychiatry tend to locate the source of psychological disturbance within the individual. In stark contrast, the Zulu tradition locates both the source of individual psychological distress and responsibility for its treatment firmly within the community.

Relatedly, Teferra and Shibre (2012, p.1) assert, based on their research on the ‘explanatory models’ of mental illness in Ethiopia:

There is a dichotomous belief regarding what causes severe mental disturbance: people living in western countries tend to focus on biological and psychosocial factors; whereas in non-western countries the focus is mainly on supernatural and religious factors....

In a similar fashion, Okello and Musisi (2006, p. 70) conclude from their research amongst Bagandan Ugandans, “Although the symptoms of depression were seen as constituting an illness, its conceptualization, name, causation and treatment were not deemed to fit into conventional western biomedical psychiatry”. By the same token, Mosotho et.al. (2011, p. 447) and Mbanga et.al. (2002, p. 69) emphasize respectively that an important finding from their research in South Africa “is the marked variation in manifestation of the symptoms of the anxiety among Sesotho speakers in comparison with Westerners” and that “Attitudes towards and beliefs about schizophrenia... differ substantially from those described in previous work in the West”.

What tends to emerge within this research is that these local explanatory models are not only distinct from, but are just as valid to those arising in the West, or as Okello and Musisi (2006, p.61) put it, are of “equal value to western biomedical psychiatry”.

Such assertions of equality are most pertinently revealed in the recommendations put forward by many of the studies. Rather than stressing the need to educate people and modify their beliefs, as was characteristic of the previous research tradition, it is widely asserted that the onus lies on service providers, who need to better appreciate local explanatory models. As Johnson et.al (2009, p.276) from their research on depression in Uganda argue:

It is neither appropriate nor effective to simply transport Western-based methods of conceptualizing and treating mental illness to African countries...professionals in Uganda and elsewhere should be educated about cultural conceptions.

Similarly, Mosotho et.al (2011, p.447) in their study of anxiety among Sesotho speaking South Africans proclaim:

There should be no room for cultural arrogance. Africans are neither Americans nor Europeans...African people should be treated within the framework of their own culture and belief systems.

Thus, traditional beliefs are categorised as entities that should be recognized and celebrated, rather than disparaged and modified. Supposed 'traditional' healing practices are classified in a similar light. Many scholars within this research tradition praise the work of traditional healers, portraying them as competent care-providers. For example Mosotho et.al (2011, p.446) quoted above assert:

Spiritual and/or traditional healers have played a significant role in combating a range of diseases that have affected African people for centuries....they therefore deserve a place next to mental health professionals trained in the western tradition.

Similarly, Crawford and Lipsedge (2004, p.143) cited above argue:

Traditional healers are highly respected members of the community and provide great stability ... [They] have a deep understanding and knowledge of the Zulu peoples' historical, religious and cultural beliefs...

Thus, here we find some quite different content and meaning-codes to the previous research tradition. According to the large majority of studies within this tradition, there may be ways of understanding and responding to mental illness that are different to biomedical frameworks, but which are not necessarily inferior. Research within this approach thus shuffle and complicate the content of what falls under 'the modern' and 'the pre-modern', refusing to place 'African' cultural beliefs and healing systems in one column and 'Western' biomedical knowledge and practices in the other. And yet the knowledge produced within this approach is in fact *structurally* still very similar to the previous tradition. Although the values have changed, the logic has not.

Once again, help-seeking behaviour is understood to be determined first and foremost by people's cultural beliefs. Like the first research tradition, human action is thus assumed to be essentially predictable and rational, determined primarily by cultural beliefs. And once again, this notion of 'cultural belief' tends to be categorised in monolithic terms. Essentialist claims are widely made within the studies, with common phrases such as: "the African people" (Mosotho et.al, 2011, p.447), "the Zulu peoples' cultural beliefs" (Crawford and Lipsedge, 2004, p.143), "African people should be treated within the framework of their culture and belief systems" (Mosotho et.al, 2011, p.447), or as Okello and Musisi (2006, p. 61) most explicitly state: "People from different cultural contexts and traditions define and experience reality in very different ways, including their views about mental disorders". Thus, as with the previous research tradition, 'Africa' tends to be classified as a homogenous entity, with the subjectivities and systems of knowledges prevailing on the continent binded seamlessly together.

Moreover, similar kinds of rigid polarizations and binary oppositions that we saw in the first research tradition are strongly retained. Once again, strong lines of demarcation are constructed between supposed Western biomedical models and apparent indigenous African healing and belief systems. There is ubiquitous talk within the studies about "models of Western psychiatry....in stark contrast to the Zulu tradition" (Crawford and Lipsedge, 2004, p.143), or that "Traditional beliefs should be given equal value to western biomedical psychiatry", and how "Western-based methods of conceptualizing and treating mental illness" should not be "transported to African countries" (Johnson et.al, 2009, p.276). Indeed the primary focus of research within this tradition is to distinguish apparent African traditional understandings and healing systems from those which supposedly reside in the West, in an attempt to legitimize and celebrate the former.

At the same time, the explanatory model approach upon which these studies are based is structured by an inherent distinction between supposed disease and that of illness. That is, at the core of this approach is the assumption that 'real' and objective disease is distinguishable from the 'subjective' experience and meaning of illness. This dualism of objective disease and subjective experience of illness has been the subject of much critique by critical STS and anthropological scholars (Craffert, 1997; Good, 1994; Mol, 2008). According to such scholars, this symmetry, now at the heart

of most sub-specialities of medicine, is deeply rooted in the shifts that occurred in medical science during the 18th century and the rise of the ‘medical gaze’. More specifically, with the discovery of autopsy and rise of modern pathology, it became possible for the physician to identify disease in a way totally independent of the patient’s experience of it. From this point, disease was increasingly seen as autonomous from patients’ experienced sense of it, and the patient’s capacity for self-knowledge and interpretation was isolated away from the body. As such, disease entities were conceptualised as resident in the physical body; whether grossly evident as the widely reproducing cells in cancer, or more subtly evident through their effects as in the disordered thoughts and feelings of schizophrenia or major depression. Put differently, disease was assumed to be biological, universal and ultimately transcending social and cultural context. Although the experience and understandings of illness may vary by social and ecological context, real disease or pathology does not.

And yet this dualism has so often been found to be incongruous with what critical STS and anthropological researchers are observing in the field (Craffert, 1997; Good, 1994; Mol, 2008). Such research reveals that people do not just represent and make meanings of disease through socio-cultural processes. Rather, the very nature of disease, and associated signs, symptoms and definitions are *constituted by* the complex social-cultural milieu in which people live. As such, disease and illness are essentially intermingled, at once biological, moral, spiritual, emotional, social, cultural and political. Ultimately, as revealed by such researchers, abstracting the world of physical objects and physiological processes from social and meaningful phenomena has frequently led to distorted forms of medical understanding and practice.

In sum, although the second research approach attempts to destabilise many of the Eurocentric assumptions of the first research tradition, in retaining the same form of classification, one which is based on essentialised categories and rigid binary oppositions, it ends up reproducing the very epistemological framework it seeks to contest. This in turn ultimately limits the possibility of an effective subversion of the modernist/colonial epistemological order and its many questionable assumptions. As Green (2012, p.4) most pertinently articulates, “In uncritically accepting the conceptual structure of modernity, the capacity to offer different thought is

curtailed”. To use her analogy, “transposing the colours on the chess board does not change the frame”.

An alternative approach?

The question is then, might we be able to find other ways of understanding help-seeking for mental distress in Africa which are based on alternative kinds of classification systems that are neither Eurocentric nor Afrocentric? Might we be able to change the frame, rather than just the content, of conversations on help-seeking? And how might this transform the way in which we understand how people do, and potentially could, seek support for mental illness in Africa?

Two particular studies, grounded in more critical and constructivist perspectives, and employing in-depth ethnographic methodologies, may offer a potentially fruitful terrain for engagement. For example, Ursula Read (2009, 2012) conducted fourteen months of ethnographic research amongst people with mental illness and their families living in rural communities in Kintampo, Ghana which included, inter alia, an exploration of help-seeking behaviour. She found that people with mental illness drew upon, and experimented with a kaleidoscope of healing modalities and therapeutic resources in fundamentally pragmatic and diverse ways. In particular, her research revealed that a preference for one form of care over another was driven less by beliefs about the nature of illness and its causation, and more about a practical attempt to restore well-being and attain positions in which valued forms of subjectivity could be exerted. And these subjectivities emerged as multiple and diverse, frequently based upon potentially conflicting rationalities and deeply entangled with socially meaningful processes.

For example, Read found that many people discontinued antidepressant or psychotropic medications not because they did not know about the potential benefits, but because these treatments frequently led to adverse effects that disrupted their ability to work, created dependencies and contributed to all kinds of family conflicts. Similarly, the widespread patronage of traditional healers was often less about ‘cultural beliefs’, and more to do with the manner in which the forms of care provided by such healers frequently incorporated some of the fundamental and irreducible parts of wellness and healing for many people. Ultimately, this research

suggested that a focus on ‘beliefs’, defined in generic terms, tends to obscure the many crucial aspects of wellbeing and recovery that are important to patients and their families and which shape the therapeutic choices they make.

In a similar manner, René Devisch et.al (2001) explored the dynamics surrounding help-seeking practices, including those related to mental illness, of residents living in Kinshasa, Congo. They found that help-seeking was inherently idiosyncratic and fragmentary, consistently shifting between a plurality of therapeutic settings. Service users and their families tended to visit and consistently move between both biomedical forms of care and indigenous healing practices. And both of these healing systems were seen to provide partial and transitory solutions, both being sources of constraint and opportunity, comfort and discomfort. Through the choices made, the health-seeker attempted to find solutions that ‘fitted’ with their identities and moral landscapes. And such subjectivities and value hierarchies were intimately shaped by local conceptualizations of community and personhood, understandings which were in turn deeply embedded in the spiritual, the corporeal and the social community. Ultimately, Devisch and colleagues argue that without a complex understanding of how relatedness and intersubjectivity shape conceptualisations of ‘wellness’ and ‘recovery’, it is hard to grasp the logic behind the therapeutic itineraries that people follow.

These two studies thus employed detailed and careful ethnographic methods in order to build up a comprehensive and particularized familiarity with the social life and practices of those studied. Rather than focusing solely on ‘cultural beliefs’, these scholars attempted to tap into the tremendously complex political, social and structural environments in which help-seeking arise. Moreover, rather than assuming a kind of homogeneity and distinctiveness of entities which can be captured through rigid categories, such research was premised on the assumption that identities and actions are fluid and interdependent. People were understood to move between multiple healing modalities, to hold diverse beliefs and values and to possess an assortment of needs and priorities, none of which could not be fully understood or spelled out in rational terms. Understandings and behaviours thus materialized as multiple and circumstantial matters that were difficult to pin down and generalise precisely because they were interdependent and socio-political questions about multifaceted individuals in complex social milieu. Similarly, all healing practices

surfaced as partial and limited; as diverse entities filled with both gaps and contradictions. No one mode of healing was assumed to be inevitably superior to another, but all healing systems were understood as somewhat incomplete and indeterminate.

As such, this research resisted bounded and totalizing accounts of how people do, and should, seek support for mental illness. No simple explanations and definitive solutions were provided. Rather, what emerged most strongly by this research was the need for in-depth and more provisional understandings of local circumstances and conceptualisations of wellbeing and recovery; for more partial forms of categorizing and ultimately more nuanced kinds of recommendations. Accounts such as these therefore have crucial implications for the prospect of building understandings of help-seeking for mental illness that are more robust, more localized, and more connected to local histories and relationships. In changing the ways in which cultural geneses and influences were categorised, this research begins to shift the grounds on which questions about the nature of help-seeking may be posed and explored. Ultimately, such research holds great potential for articulating help-seeking for mental illness in postcolonial Africa through more appropriate configurations and possibly along new epistemic lines.

Discussion and conclusion

In this paper I have opened up the ‘black box’ of knowledge on help-seeking for mental illness in Africa within contemporary mental health research, making visible and interrupting the dominant classifications and categories mediating the knowledge produced. I have argued that contemporary research in this area can be understood as dominated by two main approaches, approaches which are structurally very similar. I have demonstrated that while there are obvious differences between them, both approaches are structured by the same kind of system of classification, one which is deeply inserted within the knowledge tradition of modernity and colonialism. Both research traditions have a single, monolithic benchmark by which to judge and value the world; they share a view of identities, cultures and knowledge that denies change, complexity and multiplicity, as well as the movement of people and things in more than one direction; they both possess a rationalist understanding human behaviour as

mechanical and based upon law-like principles of cause and effect; and they are both premised on Africa's distinctiveness and essential difference.

The dominance of this particular system of ordering has worrying implications. For example, the first research tradition's widespread calls for education programmes which correct people's supposed 'irrational' beliefs and behaviours and teach traditional healers apparently 'proper' modes of caring, tends to reproduce old forms of oppressive power and medical elitism. This in turn risks subjugating, rather than empowering, both mental health service users and providers (Kirmayer, 2012; Levine, 2012). Indeed, these particular proposals are deeply embroiled with the growing calls within Global Mental Health discourse for greater 'mental health literacy' amongst service users and the general population (Ganasen et al., 2008; Petersen et al., 2011). The concept of mental health literacy ultimately translates into being literate in a biomedical system of knowledge (White & Sashidharan, 2014). These kinds of proposals also share much with the growing trend within low-and-middle income countries that is attempting to bring traditional healers 'in line' with biomedical science by testing the efficiency of their practices through the principles and methods of science. This has been described as a kind of 'Randomized Controlled Crime', as 'alternative' healing systems are tolerated only so long as they can be shown to have a scientific basis (Adams, 2002, p. 679; also Levine, 2012).

At the same time, the recommendations made by the first research tradition face the danger of failing to achieve their anticipated effects, as they are based upon knowledge which may insufficiently capture how and why people actually seek help for mental illness. Is it possible that the current underutilization of services in Africa is less about people's supposed erroneous beliefs, and more about a potential disconnect between how research is understanding people's needs and behaviours, and the actual ways of life and forms of meaning-making that prevail within the community? Is it conceivable that the high usage of 'traditional' healers, which this research tradition strongly suggests, is not because people are 'ignorant', but because the care provided by such healers might be valuable to those who access them?

The second research tradition attempts to understand, and validate alternative ways of knowing and being which may lie outside of biomedical metaphysical realities. However, the problem with the proposals put forward by this research is that they

tend to romanticise and valorise all that goes under the name of ‘traditional medicine’ or ‘traditional beliefs’, whilst delegitimising supposedly Western biomedical forms of mental health care. This could have potentially very dangerous consequences, as the case of HIV/AIDS in South Africa most pertinently suggests. Here, supposed ‘African medicine’ was advocated as the antithesis of ‘Western science’, undergirding the state’s policy to deny HIV-positive people antiretrovirals, which cost millions of South Africans their lives (Green, 2012). The idea that biomedical forms of care are irrelevant and inappropriate for people with mental health problems in Africa, as the second research tradition suggests, could indeed have similar dire repercussions. People may be refused psychotropic medications, treatments which have been shown to have very real and significant benefits for many people with mental illness in Africa, particularly those of a more severe nature (Patel and Thornicroft, 2009).

Therefore, what all of this implies is that there is a need for research on help-seeking in Africa to rethink how it might conceptualise the needs and priorities, the forms of meaning-making and the ways of responding to mental illness that prevail within communities. It necessitates considering how research might genuinely tap into, and potentially legitimise, epistemologically diverse socio-moral frames of illness and recovery on their own terms, and within their own metaphysical worlds. This is not an easy task, one which raises all sorts of slippery epistemological questions around how medical evidence is produced and legitimised (Levine, 2012). Ultimately, these kinds of questions need to be opened up for further consideration and debate within the Global Mental Health arena.

This paper has suggested that two particular studies, which lie outside of the dominant research approaches, might offer useful resources in this regard. Through careful and in-depth ethnographic methodologies, such research developed theory-rich knowledge on help-seeking for mental illness in Africa which was deeply entangled with local realities, lexicons and matrices. The researchers began with very different assumptions, from those presumed within the epistemological order of European Colonial Modernity, about the kinds of selves, objects and their relations, and how they can be known. Thinking critically and reflexively about the larger organizing principles guiding their research, both of these studies sought to rethink how society, social change, human behaviour, agency, culture, identities and so forth

might be thought about and captured. Ultimately, it is research such as this that could help create a space for a more democratic archive of knowledge on service uptake in Africa, one which is based on alternative and more appropriate knowledge codes and classifications. This might in turn enable us to work, function and identify ourselves and others in worlds very different from the ones created by current seats of power.

What I am articulating in this paper is not particularly unusual or novel, but in fact reflects a long line of thinking within critical health sciences research and theory. Indeed, there is a rich legacy of critical debate dating back to the 1980s within medical anthropology (for example Good, 1994; Helman, 1994; Singer and Baer, 1995) and what might be termed the ‘psy-disciplines’, including psychology and psychiatry (for example Danziger, 1997; Inglby, 1981; Swartz, 1998) which have problematized the assumptions of universalism and rationalism underpinning biomedical systems of knowledge and practice. Moreover, this body of work has destabilised the essentialist undertones of the ‘indigenous knowledge systems’ approach and questioned the ability of this perspective to dismantle the biomedical hegemony. And these scholars have time and again stressed the need for more nuanced and critical forms of (mental) health research which are based on alternative ways of knowing to those arising from the modernist/colonial epistemological order.

And yet in spite of these calls, and promise of these more critical health traditions, they are to a large extent still marginalised in the public health arena, still relegated to a fairly well defined circuit of institutions and journals. As revealed in this paper, contemporary research on help-seeking for mental illness in Africa appears to be no exception. It is pertinent to ask, why this might be so. Paradoxically, many of the problematic features highlighted in this paper are precisely those which are attractive to governments and donor institutions. The present-day logic of the global knowledge economy increasingly requires information that might be useful for the processes of government and planning, and is thus able to make social and political spaces legible in relatively homogenous and universalising ways (Du Toit, 2005). Economies of scale in government, in decision making by policy-makers, in assessments by donor agencies, more and more depend upon uncontroversial, policy-relevant forms of knowledge which are based on replicable methodologies and categorical schemas. These pressures have in fact recently been alluded to by key proponents of Global Mental Health, who have argued that complexity and nuance is

unlikely to convince governments and attract donors (Patel, 2014; Saraceno et al., 2007). Indeed, as asserted at the 2006 annual conference of the Association of African Psychiatrists and Allied Health Professions:

Many donors and policy makers are not convinced that mental health care is worth the investment. It is our task...to provide the kind of 'hard evidence'...to help to persuade donors and policy makers that investing in mental health care is not a 'luxury', but a bare necessity (Ventevogel, 2006, p.273).

It is therefore not an uncomplicated task to create a space for more fluid and provisional accounts on help-seeking, accounts which cannot be abstracted from the complexity of local context and cannot easily be transported from one context to another. And yet I believe the costs of failing to open-up this space is likely to be high, as most pertinently illustrated by James Scott's (1998) enquiry into why so many efforts to better the human condition have gone tragically awry. In his analysis, Scott provides examples of all sorts of social, economic and health-related projects which have ended up wasting considerable amounts of money on inappropriate interventions, as they were based on decontextualized and standardized forms of information and schemas. As such, this paper is a plea for mental health researchers to resist fully subscribing to the current demands of the knowledge economy by fostering and celebrating other ways of knowing and imagining how people do, and potentially could, seek help for mental illness in Africa. This in turn might go some way towards helping to reduce the current 'gap' in mental health care so many countries on the continent face.

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7. RESEARCH PAPER THREE

Beneath the rhetoric: Policy to reduce the mental health ‘treatment gap’ in Africa

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Principal Supervisor	Dr. Nicki Thorogood
Thesis Title	Prising open the black box: The production of knowledge on the mental health 'treatment gap' in Africa

If the Research Paper has previously been published please complete Section B, if not please move to Section C

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Abstract

In this paper I problematize knowledge on reducing the ‘gap’ in mental health care produced by 14 national mental health policies in Africa. To contextualize this analysis, I begin with a historic-political account of the emergence of the notion of Primary Health Care (PHC), and its entanglement within the decolonization forces of the 1960s. I unpack how and why this concept was subsequently atrophied, being stripped of its more revolutionary sentiments from the 1980s. Against this backdrop, I show how, although the 14 national mental health policies are saturated with the rhetoric of Primary Health Care and associated concepts of community participation and ownership, in practice they tend to marginalize local meaning-systems and endorse an essentially top-down framework heavily informed by colonial medicine. The policies thus end up reproducing many of the very Eurocentric assumptions that the original Primary Health Care notion sought to transcend. More specifically, the paradigms of evidence-based research/practice and individualised human rights become the gatekeepers of knowledge. These two paradigms, which are deeply embedded within contemporary Global Mental Health discourse, are legislating what are legitimate forms of knowing, and by extension, valid forms of care. I argue that a greater appreciation of the Primary Health Care concept, in its earliest formulation, offers a potentially fruitful terrain of engagement for developing more contextually-embedded and epistemologically appropriate mental health care policies in Africa. This in turn might help reduce the current ‘gap’ in mental health care so many countries on the continent face.

Keywords: Africa; Treatment gap; Global mental health; policies; Epistemological assumptions

Introduction

Psychiatry in underdeveloped countries could profit...from avoiding the mistakes already committed in very advanced countries of the world. When we, however, try to abstract a lesson from European and American experience we must make sure that it will apply in the contemporary African situation...This is no easy matter, but we are getting more and more convinced that an independent diagnosis of our position may prove more profitable in the end than a borrowed remedy.

(Lambo, 1960:1703)

Over the last decade, the mental health situation in the global South has gained renewed attention as an important public health matter within the international arena (Global Mental Health Group, 2007; Patel, 2014). One issue of particular concern is what is understood as a considerable number of people with mental health problems in low-and-middle income countries not receiving care, now referred to as the mental health ‘treatment gap’ (Petersen et al., 2011; WHO, 2001). This issue has in turn given rise to a ‘broad new social movement’, led by the international psychiatric community but incorporating a broad coalition of actors and agencies (Horton, 2007: 806). This movement is implementing all sorts of research projects and interventions, backed by significant amounts of global funding, geared towards reducing this ‘gap’ in mental health care (Cooper, 2014).

Under the banner of this movement, strong appeals have been made to African countries to develop national mental health policies to guide their health care systems in addressing the ‘gap’ in mental health care (Faydi et.al, 2011; Omar et.al., 2010; WHO, 2001). These calls have been widely responded to, with the continent witnessing a major acceleration in national mental health policy development. According to the World Health Organization (WHO, 2011) nineteen African countries had a mental health policy in 2010, the vast majority of which had been approved or revised since 2005. In light of this growth in policies, a burgeoning body of research has emerged which is focused on evaluating the content of such policies and/or the processes followed in their development (Faydi et.al, 2011; Omar et.al, 2010; Ssebunnya et.al, 2012). Notwithstanding the importance of these issues, what have received far less attention, if any at all, are the epistemologies and associated politics, underpinning these policies.

As such, this paper looks critically at thinking around reducing the ‘gap’ in mental health care within 14 national mental health policies in Africa. Rather than focusing primarily on the content of these policies, my analysis is more interested in epistemological questions regarding the conventions of meaning-making that lie *behind* the knowledge that is produced by the policies, disentangling the power dynamics at play. In order to contextualise this analysis, I begin this paper with an historic-political account of the origins of the notion of Primary Health Care (PHC), and associated ideas of community participation and ownership. I unpack how the emergence of this concept was deeply intertwined with the forces of decolonization during the 1960s, and drew heavily on the grass-roots public health initiatives being pioneered in various low-and-middle income countries. At the heart of these initiatives was an attempt to destabilise the epistemologies underpinning colonial medicine, by developing contextually-embedded health interventions which draw on local resources and forms of meaning-making. Since the 1980s, although Primary Health Care has increasingly formed part of official public health jargon, it has tended to be stripped of its more complex and revolutionary policy implications. I explore how and why it was so quickly atrophied, ultimately representing only a brief, and primarily rhetorical disruption to, the paradigm of colonial medicine.

This analysis provides a historic-political platform from which to understand the nature of contemporary policy thinking on the ‘gap’ in mental health care in Africa, and in particular its embeddedness within more general global health trends. Turning to the 14 national mental health policies, I demonstrate how they are saturated with the rhetoric of Primary Health Care. And yet in reality, beneath the bold rhetorical statements, the policies do not involve any real public participation and ownership. Rather, ideas of community participation and ownership tend to play out as essentially matters of education and training in the supposedly proper nature of mental illness and apparently appropriate forms of care. And constructions of what is ‘proper’ and ‘appropriate’ across the 14 policies are guided by two main paradigms: those of scientific evidence and human rights. These paradigms of thought are indeed two of the main conceptual frameworks shaping contemporary Global Mental Health discourse (Global Mental Health Group, 2007; Mari and Thornicroft, 2010; Patel, 2014). I demonstrate how such paradigms are both underpinned by several contentious and Eurocentric assumptions, an argument which has been made by a number of critical cultural psychiatrists (Bemme & D’souza, 2014; Ingleby, 2014;

White & Sashidharan, 2014) and social science scholars (De Sousa Santos et al., 2007; Sardar, 1998).

To be sure, this is not an argument against the potential importance of scientific evidence and human rights. Rather, this paper is critiquing the *hegemonic* way in which these ideas are mediating policy thinking around legitimate forms of care, and the consequent marginalization of others ways of thinking, based on alternative epistemologies and knowledge politics. It is expressing discomfort with the policies espousal of a top-down model of care, guided by centrally-defined, Eurocentric criteria, somewhat masked by grassroots rhetoric. Ultimately, it is problematizing the way in which the policies end up reproducing many of the very Eurocentric assumptions that the notion of Primary Health Care, in its earliest formulation, sought to transcend. I conclude this paper by proposing that a return to the original notion of Primary Health Care might offer a potentially productive terrain of engagement for thinking about the development of more contextually-embedded and epistemologically appropriate mental health care policies in Africa.

Collection and analysis of the national policies

My analysis focuses on the knowledge produced on the ‘gap’ in mental health care of 14 national mental health policies: Ethiopia (2012); Gambia (2007); Ghana (1996) Lesotho (2005); Liberia (2009); Namibia (2005); Nigeria (2011); Rwanda (2012) Sierra Leone (2012); South Africa (2013); Tanzania (2006); Uganda (2011); Zambia (2005); Zimbabwe (2004). These policies are those which I was able to access between December 2011 and January 2013. To my surprise, national mental health policies in Africa are not readily available in the public domain, and thus locating them was not a simple matter. This was confirmed by the then Director of the WHO’s African Regional Office, who indicated that obtaining mental health policies in Africa requires negotiating directly with the Ministries of Health (MoH) (Personal communication, 4 October, 2011). Accessing the policies thus involved over a year-long process of communication with the MoHs in these different countries, who frequently themselves were unaware how to retrieve a copy of their own policy. In certain instances, when the policy was located, it did not exist in electronic form, and thus needed to be photocopied and posted to me as a hard copy. These difficulties around attaining the policies raise all sorts of questions around whose voices and

interests might be embodied in these policies, and the degree of ownership local governments genuinely have. I will return to these questions in the conclusion of this paper.

My analysis of these policies draws on theoretical insights from two broad areas of study, namely those of Science and Technology Studies (STS) and Postcolonial Studies. STS is a multi-disciplinary theoretical corpus concerned with how health, bodies and disease are politically and discursively produced in medical science policy and practice (Law, 2008; Latour, 1999). Postcolonial Studies is likewise a broad intellectual enterprise that is similarly interested in the basis of knowledge structures and the representational work that knowledge does. However, this field tends to direct its critique towards the relationship between colonisers and colonised, and the epistemological and cultural effect this relationship has on the production of knowledge (Ashcroft, Griffiths and Tiffin, 1995; De Sousa Santos et al., 2007; Moore-Gilbert, 1997; Said, 1978).

For my analysis, I draw upon specifically the Kuhnian concept of a paradigm (Kuhn, 1962) and Bruno Latour's notion of 'the black box' (1987, 1999), and situate these notions within a Postcolonial space of thinking. According to Thomas Kuhn (1962), a paradigm serves as a conceptual prism through which people make sense of the world. It constitutes a world view or what he also calls a 'disciplinary matrix', a kind of constellation of communal commitments and presuppositions. Conjointly, these elements provide 'abstracted rules' (ibid: 47) or accepted norms around what counts as significant questions, what modes of analysis are appropriate and what kinds of solutions are acceptable. What this suggests is that paradigms are not inevitable mappings of the world, but are constructed within, and emerge out of, particular socio-economic and political milieu. What makes paradigms such elusive entities for analysis, however, is that they are as invisible as they are powerful. As Kuhn emphasises (ibid: 37), 'One of the things a scientific community acquires with a paradigm is a criterion for choosing problems that, while the paradigm is taken for granted, can be assumed to have solutions'. Thus, what are concealed within paradigms are the shared properties, which appear so natural, but which are in fact constructed ways of seeing and acting in the world. These are deeply buried in what Bruno Latour calls 'the black box'.

According to Latour (1987) the black box holds all the common sense assumptions that a culture shares which turns questions, priorities and interests into facts. As Latour (1987: 206) puts it, the box is ‘well sealed’ and people generally do not ‘live in a world of fiction, representation, symbol, approximation and convention: they are simply *right*’. Thus, our paradigms of knowledge become so taken-for-granted, so intrinsically accepted as ‘given’, that almost by definition their underlying scaffolding disappears. According to Latour (1999: 304) in later work, what this concealment enables is a focus on ‘inputs and outputs’ and not on the complex processes that produce these effects. Those processes are all of the interests, values and politics that shape how we see and think in the world. Through such ‘black-boxing’, these processes are normalised and archived in such a way as to be inherited and accepted as common-sense reality.

Thus drawing on these ideas, and situating them within a Postcolonial perspective, my analysis sought to open up the ‘black box’ of knowledge on reducing the ‘gap’ in mental health care produced by the national mental health policies of 14 African countries. It attempted to make visible the dominant paradigm(s) of thought mediating the knowledge produced by these policies, exploring how they may remain bound to Eurocentric content and orientation. It sought to explore how these dominant structures of knowledge may be marginalising other ways of thinking about and addressing the ‘gap’ in mental health care, which may lie outside of a particularly Eurocentric form of consciousness.

Primary Health Care: Its emergence and how it was subsequently atrophied

Before turning to these policies, I first briefly touch upon the more general trends in global public health discourse since the 1960s, and in particular the emergence of the notion of Primary Health Care. This will provide a historic-political platform from which my analysis of the 14 contemporary mental health policies can be understood.

Origins of Primary Health Care: Decolonization and nationalist movements of the 1960s

The emergence of the notion of Primary Health Care, and associated ideas of community participation and ownership, was deeply intertwined with the forces of decolonization and spread of nationalist, anti-imperialist and leftist movements during the 1960s. Within this political context, the knowledge politics underpinning the epistemological order of European modernity and colonialism were increasingly being questioned (Cueto, 2004; Walt & Vaughan, 1981; Werner and Sanders, 1997). This order had produced particular ways of thinking, merging around a shared set of abstractions, inter alia rationalism, science, liberalism, universalism, human rights, and progress.

So for example, it was a knowledge tradition in which scientific modes of thinking became crystalized as the ultimate form of rationality, the guarantor of universal truths and progress (Cooper, 2014; Sardar, 1998; Turnbull, 2009); it was one in which questions of justice and morality were increasingly subsumed within the notion of human rights, with its universal and individualistic epistemological assumptions (Cooper, 2014; De Sousa Santos et al., 2007; Pannikar, 1984). And what was central to this epistemological order, was the way in which it tended to negate its 'others', assuming that alternative ways of thinking and acting, which may lie outside of its own consciousness, are ultimately illegitimate (De Sousa Santos et al., 2007; Sardar, 1998). The paradigm of colonial medicine was intimately entangled with this kind of thinking, characterized at least in part by a struggle between supposed 'rational' Western biomedicine and 'primitive' 'traditional' therapeutics (Comaroff, 1993; Vaughan, 1991). In its imaginary, 'Western' medicine, with its scientific rationalism and universal ethical codes, embodied the highest form of rationality and modernity, in contrast to the supposed backward and superstitious nature of 'indigenous' medical beliefs and practices.

Within the context of the liberation ferment of the 1960s and early 1970s, it was these particular paradigms that came under increased attack by international and African academics alike. Scholars of the time began to denounce the notion that in order for African countries to act effectively upon contemporary conditions, they needed to 'catch up' with the geopolitical North, following the same trajectory of

development (Walt & Vaughan, 1981). Key international health agencies and policy-thinkers began to interrogate colonial public health's preoccupation with the transmission of biomedical practices, and its denigration of 'other' healing epistemologies (Werner and Sanders, 1997). More and more scholars stressed the indignity of health care being 'owned' by particular groups, and the form and objectives of these systems being imposed upon populations on quasi-rational grounds (Cueto, 2004). There was thus increased talk about the 'wide and deep-seated error in the way health services are provided in developing countries', with a growing interest in new kinds of health care models, based on alternative kinds of epistemologies (Newell, 1988: 904).

It was within this context that various countries within Asia and Africa started pioneering what can be understood as 'alternative' kinds of health care initiatives, such as the now well-known Bare Foot Doctors programme in China (Baum, 2007; Cueto, 2004; Werner & Sanders, 1997). Known as Community-Based Health Programs, these programmes were not just health initiatives, but were part of the larger anti-imperialist struggles by marginalized people for greater voice and independence. Led by groups of community health workers, these grassroots initiatives sought to address key health issues by drawing on local resources and socio-moral frames of illness and recovery. The focus was on using these understandings in ways which encouraged community ownership and participation in the development and delivery of health care services (Werner & Sanders, 1997). In the realm of mental health care specifically, a number of innovative initiatives began to emerge, including the 'Aro village psychiatry' programme developed by Nigerian psychiatrist and activist Thomas Lambo. Employing what he called a kind of 'methodological syncretism', Lambo's village sought to integrate different care modalities in innovative ways, or what he describes as an attempt to fuse the 'secrets of the spirit world' with the 'best of science' (Bass, 1994: 77). Similar kinds of mental health care initiatives started emerging elsewhere in Africa during this time, including for example in Senegal, Ghana and Sudan (Alem et.al, 2008).

Alma Ata Declaration: The crystallization of Primary Health Care

The successes of these programmes were increasingly contrasted with the major public health initiatives being instigated by US agencies and the WHO since the

1950s, initiatives which were seen to be failing to achieve their anticipated effects in the developing world (Cueto, 2004; Newell, 1988; Walt & Vaughan, 1981). The late 1960s and early 1970s was thus characterised by a rising tide of critique of, and experimentation with alternatives to, the Eurocentric paradigms of health and development which had dominated since the colonial era.

Such sentiments culminated in the now landmark international conference that took place at Alma-Ata, Kazakhstan in 1978 (WHO & UN Children's Fund, 1978). At this event, a Declaration was passed which articulated the notion of Primary Health Care, a broad philosophy for thinking about the development and delivery of health care services. This philosophy drew heavily on the ideas underpinning the Community-Based Health Programs, with their emphasis on accessibility, medical pluralism and community ownership (Baum, 2007). As defined at Alma Ata, PHC involves the provision of health care as close as possible to where people live, to be delivered by a range of epistemologically diverse practitioners. Highly critical of medical and professional elitism, the Declaration highlighted how health professionals should be responsible for describing possible interventions and their implications, but should not choose (Newell, 1988; Werner & Sanders, 1997). Rather, such interventions should evolve from local socio-economic and political conditions, and respond to the expressed needs of the community (Schaay & Sanders, 2008). The complexities of what the Declaration was attempting to capture are exemplified by Newell (1988: 905), one of the architects of Primary Health Care:

A PHC system can still be classed as successful even if the illnesses and deaths targeted continue to occur *if* that society truly has a choice but decides to take up other priorities knowing the implications... This is completely different from the view that the targeted health priorities are an abomination because they are so easily dealt with, and it is intolerable that they should continue when effective technologies and sufficient resources exist to deal with them... The advocate of PHC will reply that even if these actions and interventions are applied and achieved, the health system may still be classed as a failure... If what results is still an oppression, does not deal with that society's priorities, and is inconsistent with the way of life and the dignity of that population, then it is not successful.

It is thus clear that the notion of PHC had strong socio-political underpinnings, intimately linked to issues of power and voice. Questions about the form and goals of health care were primarily about the authority and ownership in knowledge-production and decision-making (Baum, 2007; Werner & Sanders, 1997). The Declaration thus represented a remarkable moment when the dominant paradigm of colonial medicine was being interrogated and new ideas, based on alternative kinds of epistemological politics and moral landscapes, were being formulated. It was also a particularly unusual moment in that its conceptual roots lay with the ideas emerging from the grassroots health care programmes of the geopolitical South, rather than based on concepts originating from the global North. It thus represented a challenge to the global politics of knowledge production, in which social theory tends to be built on a 'one-way flow of information from the metropolises to the geopolitical peripheries' (Connell, 2007:12) or as Comaroff and Comaroff (2012:113) put it, where the 'global South' is seen as 'that half of the world about which the 'global North' spins theories'.

The rise of neoliberalism and the corruption of Primary Health Care

As the 1980s unfolded, all sorts of global public health initiatives were launched under the Primary Health Care banner, with the concepts of 'community care', 'participation' and 'empowerment' now forming part of the official jargon (Werner and Sanders, 1997). In practice however, these notions tended to be stripped of their more complex and potentially revolutionary policy implications (Cueto, 2004). Considerations of power and voice that were at the heart of the original Primary Health Care notion were increasingly placed on the periphery, with the privileging of technical service packages which could achieve measurable outcomes in the short-term (Schaay & Sanders, 2008). While community-involvement and health worker diversity was encouraged, the focus was increasingly on training and education in order to make the delivery of services possible (Baum, 2007; Werner & Sanders, 1997). Contemporary Global Mental Health initiatives appear to be no exception. Although Global Mental Health discourse and practice consistently refers to the need for greater community involvement, in reality, their role tends to be that of assisting in the implementation of an externally imposed medico-scientific and human rights agenda (Campbell and Burgess, 2012; Mills and Fernando, 2014).

It is pertinent to ask why the concept of PHC was so quickly corrupted, particularly in light of the fervent tide of radical thinking of the 1960s in which it arose. According to Werner and Sanders (1997:19) the revolutionary nature of the Alma Ata was unlikely to sit comfortably with global power structures, including the public health establishment, 'who for so long had maintained a powerful monopoly on the knowledge and power of healing'. Furthermore, almost immediately after Alma Ata, the global economic boom of the 1960s started receding, with the 1980s bringing about a combination of global recession, suffocating foreign debt and worsening poverty. This situation saw the emergence of a new political context dominated by more conservative, neoliberal ideas, heavily informed by European modernist thinkers (Castells, 2001; Pillay, 2003). Led by the examples of Margaret Thatcher and Ronald Reagan, the focus became on rationalizing public systems and developing clearly definable targets which would minimize costs and maximize outputs in the short-term (Castells, 2001; Sanders et.al., 2008). Such thinking very quickly spread to the developing world by the US-dominated International Monetary Fund (IMF) and World Bank as conditions for loans, loans which by now many developing countries were dependent upon (Castells, 2001; Pillay, 2003). And as the 1990s unfolded, and continuing into the present, these international financial agencies have played an increasingly powerful role in directing health care systems in developing nations (Baum, 2007; Cueto, 2004). Within this climate, the anti-imperialist and leftist sentiments of the 1960s have increasingly waned. And Alma Ata has ultimately proved incompatible with this ascendance of neoliberal ideas.

Analysis: The national mental health policies

In light of these trends in global public health discourse, I now turn to the national mental health policies emerging from 14 African countries. Looking at these policies as a whole, they all follow a very similar format, beginning with a socio-demographic description of the country, followed by an account of the national health care system. Thereafter, an epidemiological profile of mental illness in the country is commonly provided, where after a detailed summary of the national mental health care system is given. This summary, somewhat mechanistic and technocratic, includes inter alia, information on current national mental health legislation; details around financial and human resources dedicated to mental health;

descriptions of national mental health administration arrangements, service organizations and management structures; and information on mental health care training programmes and research activities in the country.

Having provided this background, all of the policies then go on to describe their vision, outlining the specific values, goals and action strategies endorsed. Here, all 14 policies state that a Primary Health Care approach will be adopted. Thereafter, the focus is on elucidating how such a model of care will be developed on a national scale. In such accounts, the rhetoric of community participation and empowerment emerges most explicitly. However, when one looks more closely at the descriptions of these notions, they emerge as essentially matters of education and training in ‘appropriate’ kinds of knowledge and ‘proper’ sorts of care. And conceptualisations of what are ‘appropriate’ and ‘proper’ materialise as based on two main paradigms: those of evidence-based knowledge/practices and human rights. How do these ideas play out within the policies?

Explicit endorsement of Primary Health Care, community ownership and local empowerment

All 14 policies state explicitly that the overarching policy framework is the Primary Health Care approach. For example, South Africa’s (9) policy states: ‘In line with the values of the Alma Ata Declaration...this document sets out the provision of a mental health system...based on Primary Health Care principles’. Similarly, Uganda’s policy (2) highlights ‘The Alma Ata Declaration and subsequent WHO recommendations have provided the guiding philosophy for the development of this policy’. Echoes are present across the 14 policies, where it is emphasized that ‘the guiding principle of this policy’ (Tanzania: 4) or ‘the underpinning philosophy for the development of this policy’ (Liberia: 2) is ‘the Primary Health Care strategy’ (Tanzania: 4; Zimbabwe: 5), ‘a primary health model of care’ (Lesotho: 27; Liberia: 32), a ‘Primary Health Care system’(Ethiopia: 2; Namibia: 9; Sierra Leone: 6) and one which ‘promotes community mental health at the grassroots-level’ (Rwanda: 4). Across the policies, it is emphasized that this approach is ‘the most viable way of closing the huge treatment gap’ (Lesotho: 27; Sierra Leone: 6), ‘the best way to address the large mental health treatment gap’(Liberia: 32; Namibia: 12) and ‘will

address the mental health care access gap that currently exists in the country’ (Nigeria: 2).

Many of the policies provide a formal definition of a PHC approach, where the ideas of community involvement and ownership feature most prominently. It is ascertained that such a framework of care is ‘an approach to the delivery of services which emphasizes decentralization and community participation’ (Zambia: 14) or prioritises ‘community involvement and participation’ (Liberia: 7; Namibia: 2; Uganda: 13). It is emphasized that PHC ‘refers to care which is based on the needs of the population...and requires the active participation of the community’ (Ethiopia: 17) and necessitates the ‘decentralization of mental health care, allowing for more participatory decision making...including the engagement of consumers and family members’ (Gambia: 8).

Much attention is placed on further unpacking these particular ideas, with all 14 policies containing a relatively large section, variously entitled ‘Community Involvement and Participation’. Here a wide range of different groups residing within the community are outlined, and descriptions are provided on how these various groups should be empowered to participate in the development and delivery of mental health care services. For example, comments such as these are ubiquitous across the policies: ‘Encourage active collaboration between all sectors involved in mental health, including strong community participation in mental health’ (Namibia: 10), ‘People with mental disorders and their families must be empowered and actively involved in the design, implementation and evaluation of mental health services’ (Sierra Leone: 10); ‘Mental health care users should be involved in the planning, delivery and evaluation of mental health services’ (South Africa: 21); and ‘Community involvement and participation are paramount to the success of mental health care delivery’ (Zimbabwe: 7).

Beneath the Primary Health Care rhetoric: A focus on education and training

When looking more closely at descriptions of empowerment and participation, however, there appears to be very little real influence and genuine authority on the part of the community. For example, Gambia’s (20) policy states [my emphasis]: ‘Many people have very little *knowledge* about mental disorders and are *unaware*

the availability of simple and effective preventive, treatment and rehabilitative measures'. The policy then provides the following bulleted set of 'action strategies' [my emphases]:

Families of people with mental disorders should be considered as partners in mental health care and therefore actively participate in it, being *educated* and *trained*;

Individuals with mental disorders, families and communities should be participants in mental health education programs;

Media will be engaged to *promote awareness* and the active participation of the community

In a similar way, within in Uganda's (16) policy, under the policy goal 'To promote and strengthen the involvement and participation of all stakeholders in mental, neurological and substance abuse control services', the following bulleted points are listed [my emphases]:

Develop initiatives aimed at *raising public awareness* about mental and neurological health, and substance abuse problems;

Carry out *community sensitization* about mental, neurological and substance abuse

Develop Information, Education and Communication materials...to *create awareness* of neurological and substance abuse

Analogous sentiments are contained in Liberia's (31) policy, where the under the heading 'Community involvement and participation' the following are stated:

The mentally ill and their families will be engaged and consulted when designing programs

There will be *education* for families and mentally ill patients about the nature, care and suitable treatment options for mental diseases

Teachers will be *educated*, so they can provide social skills training and rudimentary counselling in their schools;

There will be public *awareness programs* to *sensitize* the community

In a similar manner, having spoken about the necessity of facilitating ‘active community participation’, Zambia’s (9) policy goes on to describe in detail how ‘The Government shall therefore encourage use of *mass media and advertising strategies* to place mental health on the community health agenda’, while Zimbabwe’s (7) policy asserts that ‘It is hoped that as the public becomes *more informed*, this will result in an *empowerment process* whereby members of the community will appreciate their role in the promotion of mental health and the prevention of mental illness’. Relatedly, Rwanda’s (15) policy talks about the need to ‘involve the community more’ and ‘ensure that the community becomes responsible for mental health care’ and that ‘*information dissemination and community sensitization* will be promoted in this regard’. Numerous similar examples could be provided in this regard. The point is that within the section on ‘community participation and ownership’, the focus for all 14 policies is on unpacking the development and implementation of ‘education programmes’, ‘awareness-raising strategies’ and ‘mass media campaigns’. As such, ‘ownership’ and ‘empowerment’ emerge as essentially that of informing people about the supposed ‘true’ nature of mental illness and ‘appropriate’ forms of mental health care.

Within discussion on community participation and ownership, ‘traditional’ healers, as a particular group within the community, receive a significant amount of attention. According to all 14 policies, ‘traditional’ healers are widely consulted by people with mental disorders and their families, with ubiquitous statements that ‘traditional healers are commonly the first points of contact for many people with mental disorders’ (Gambia: 35; Uganda: 15), ‘are currently the first point of contact for most people who develop a mental health problem’ (Lesotho: 11; Nigeria: 14) and ‘are usually consulted by people with mental health problems before they seek help from conventional health practitioners’ (Zambia: 5).

Having highlighted the widespread use of traditional healers, it is thereafter commonly asserted that collaboration with such healers is essential. Bold statements such as these are common across the policies: ‘Traditional healers...will be involved in prevention, detection, rehabilitation and social inclusion of persons with mental illness’ (Ethiopia: 19); ‘Traditional healers should be involved in the care of people with mental disorders, in collaboration with formal mental health care system’

(Gambia: 7; Lesotho: 17) or as Sierra Leone's (11) policies unambiguously asserts, 'Collaboration with traditional healers will be a priority'.

However, once again, these notions of collaboration and involvement emerge as essentially matters of education and training. For example, according to Nigeria's (7) policy [my emphases]:

Dialogue and exchange of ideas may be helpful (within the context of the overall Governmental approach to *regulate* traditional health practitioners and encourage professional standards and accountability) with a view to exploring the possibility of collaborative ways of working which may eventually include the use of *diagnostic algorithms* by traditional healers to assist them in making *appropriate referrals*.

Such sentiments aptly capture dominant conceptualisations of what 'involvement' and 'collaboration' with traditional healers might entail. For example Liberia's (71) policy emphasizes how 'Along with Community health workers...traditional healers will be encouraged to participate in seminars and workshops about *the recognition of psychiatric disorders*', while Ethiopia's (24) policy highlights how 'traditional healers, who account for a significant extent of mental health care, will be *sensitized* and *trained* to improve their skills and services'. Relatedly, when talking about the 'need to involve the community more' in the provision of mental health care, Rwanda policy (14) asserts that it is necessary to 'define dialogue mechanisms with traditional-practitioners to establish contact with the aim of ensuring *complementarity* and to *mitigate charlatanism*'. In a similar manner, Gambia's (35/36) policy describes an initiative introduced by the MoH that sought to 'collaborate' with traditional healers. The policy explains, 'Essentially traditional healers, through the program are introduced to *modern* medications and treatment methods'. The policy concludes by emphasizing that the programme has been 'extremely successful', with 'improved *awareness* and *knowledge* about mental disorders...and their *appropriate* treatment amongst traditional healers'.

It is therefore clear that beneath the bold rhetoric, ideas of community 'involvement', 'ownership' and 'empowerment' tend to lack any real and meaningful substance, with very little genuine attempt to properly understand and respond to the

experiences and understandings of local people. Rather, these notions emerge primarily as matters of education and training across the 14 policies. As such, the policies seem unable to know patients and their families as anything but ignorant, and in need of psychoeducation in ‘proper’ knowledge. They appear unable to conceive of ‘traditional’ healers as anything other than in need of training in ‘appropriate’ forms of diagnosis and care. And as the policies unfold further, it becomes clear that what are conceived of as ‘appropriate’ forms of care, are those which are based solely and unequivocally on two main paradigms: those of evidence-based knowledge/practice and international human rights standards.

Evidence-based knowledge/practice

The notion of evidence-based knowledge/practice permeates the policies, centrally embedded within a variety of topics addressed by the policies. For example, the following kinds of statements are ubiquitous across the policies: ‘It is vital that service delivery is evidenced-based’ (Zambia: 12), ‘practice must be based on scientific evidence ...and adapted to scientific evolution in the field of mental health’ (Rwanda: 17), ‘The MoH is committed to the provision of evidence-based care’ (Nigeria: 2), ‘Mental health services should offer a range of interventions in keeping with evidence-based care’ (Namibia: 9), ‘the highest quality services will be provided in accordance with the best evidence-based medicine’ (Liberia: 29) and that ‘services shall reflect the highest standard possible according to current scientific knowledge’ (Gambia: 6; Uganda: 13). Indeed, the following verbatim statement occurs in Lesotho’s (22), Sierra Leone’s (19) and Gambia’s (12) policy: ‘High quality care means that the latest evidence-based interventions are provided for mental health at all service levels’.

Ensuring that ‘the latest evidence-based interventions’ are provided requires, according to the policies, that services are developed primarily through ‘a decision-making process for which there is consistent scientific evidence showing that a particular approach will improve outcomes’ (Liberia: 11; Namibia: 2), or as Ethiopia’s (19), Liberia’s (31) and Zimbabwe’s (6) policies state verbatim: ‘Scientific evidence will inform decisions for services and interventions’. Similarly, Gambia’s (7) policy emphasises how ‘Scientifically validated evidence will be the primary source of information used to inform decision-making for services’.

For the policies, not only should services be *developed* through evidence-based procedures, they should also be *delivered* through ‘evidence-based’ protocols.

Indeed, many of the policies place a considerable amount of attention on the development and subsequent training of health care workers in ‘evidence based guidelines’ (Ethiopia: 12; Nigeria: 11; South Africa: 20; Uganda: 5) or ‘evidenced-based protocols’ (Gambia: 10) or ‘evidenced-based tools’ (Rwanda: 13) or ‘evidenced-based treatment guidelines, protocols and standard operating’ (Sierra Leone: 9). For example, Nigeria’s (5) policy explains:

Good practice guidelines are an invaluable adjunct to improving care and establishment of good practice at all times...Evidence based guidelines for both primary care and specialist sectors shall be prepared.

In a similar manner, having spoken about the concept of ‘local autonomy’, whereby ‘the planning, delivery and management of mental health services should be decentralised to local, community levels’, Lesotho’s policy (22/23) explains:

Clinical protocols will be developed and extended to all sectors to enable staff to deliver appropriate evidence-based interventions...These protocols will apply to all levels of care...Once the clinical protocols have been established all health service staff will be trained and oriented in the use of these protocols for routine service delivery.

In addition to services needing to be developed and delivered through ‘evidence-based’ practices, ensuring the provision of ‘evidence-based interventions’ is seen to also require consistent monitoring and evaluating through evidence-based procedures. As Sierra Leone’s (19) policy states:

High quality care means that the latest evidenced-based interventions are provided for mental health services at all service levels. It also refers to a quality improvement monitoring mechanism...Care protocols and basic quality standards for services will therefore be developed at all levels of care.

This statement reflects the common view across the 14 policies, where it is highlighted that evidence-based monitoring and evaluation procedures are the ‘lifeblood of an effective mental health service’ (Lesotho: 19), and are ‘essential for the ongoing delivery of evidence-based services’ (Ethiopia: 4). In fact, all of the policies contain a relatively large section, variously entitled ‘Monitoring and Evaluation (M&E)’. Here meticulous details are provided on what such monitoring and evaluation should entail, essentially that of defining and collecting standardized mental health indicators and using these ‘for a continuous process of service measurement and improvement’ (Liberia: 66). For example, Lesotho’s (22) policy states:

It is essential that the quality of mental health services is improved and maintained...Towards this end, national standards for mental health will be developed...facilities will be regularly reviewed, assessed and accredited, using these quality standards...The mental health competencies of all health care staff need to be assessed, using the standards.

In a similar fashion, Gambia’s (13) policy explains:

Ongoing validation of services and interventions should be implemented and used to refine services and interventions...and inform evidence-based decisions....

It is thus clear that the notion of ‘evidenced-based’ knowledge/practice emerges across the policies as central to what it means for services to be ‘appropriate’ and of a ‘high quality’. According to the policies, services should be *developed* through evidence-based decision-making processes, should be *delivered* by health care workers trained in evidence-based clinical protocols and should be consistently *monitored* through evidence-based procedures of standardization and measurement. Ultimately, ‘appropriate’ care materialises as essentially ‘evidence-based’ care.

Although this notion of evidence-based knowledge/practice takes on a kind of self-evident quality within the policies, it is in fact underpinned by several, somewhat contentious epistemologies. Elsewhere, I (Cooper, 2014) and others (Bemme & D’souza, 2014; De Sousa Santos et al., 2007; Ingleby, 2014; Sardar, 1998; White &

Sashidharan, 2014) have problematized the paradigm of evidence-based knowledge/practice in considerable detail. In summary, this paradigm is underpinned by a set of now well-known positivist assumptions, with an emphasis on empiricism, rationalism and value-free enquiry. That is, it assumes that the world can be objectively and incontrovertibly known through the principles and methods of science, and in particular, a well-designed randomized clinical trial. Put differently, it is assumed that knowledge which is valid and meaningful includes *only* those aspects of ‘reality’ which are directly observable and measurable as tangible indicators and outcomes.

These kinds of assumptions are deeply rooted within the epistemological order of Western modernity, and associated paradigm of colonial medicine. As I have been emphasizing, the thinking space of Western modernity was characterized by a strong commitment to science, with conceptions of ‘truth’ and ‘validity’ increasingly governed by the principles of science. Deeply entangled with this order, colonial public health tended to promote *only* those forms of care based on scientific theories and practices, with the denigration of other kinds of care modalities, based on alternative kinds of epistemologies (Comaroff, 1993; Vaughan, 1991).

Thus, through their ubiquitous endorsement of evidence-based care, the policies reproduce the assumption that the *only* appropriate kinds of services are those which are based on scientific evidence. In other words, service development decisions, delivery practices and care evaluation procedures are understood as valid *only* insofar as they are informed by a scientific rationalism. As a consequence, other potentially meaningful ways of knowing and being, which may lie outside of scientific metaphysical realities, are automatically delegitimized and disavowed within the national policies.

All of this is not to suggest that scientific knowledge and practices are unimportant or not potentially meaningful. Indeed, the tremendous advantages coming out of industry, medicine, and technology in many African countries could not have occurred without scientific procedures (Latour, 1999). In addition, this is not an argument against the importance of evaluation and accountability in service provision. Indeed, the ways in which mental health care services globally have often

led to abuse and neglect, as much as to care, is a very frightening reality (Demyttenaere, 2004).

What is being problematized here, however, is the way the current evidence-based edifice, in which the policies are inserted, assumes that only *certain* kinds of knowledge, and only *particular* sorts of evaluative practices are legitimate. Ultimately, the policies are implying that very little of value can be known outside of the metacodes of science, indeed one of the great enchantments of the modernist/colonial epistemological order (De Sousa Santos et al., 2007; Sardar, 1998). The question is then, what alternative sorts of knowledges and practices, which may not be based on scientific rationalism, but which may be important to service users and their families, are being silenced? How might these ‘other’ understandings and ways of being, change the way in which ‘appropriate’ kinds of services are conceptualised, developed and assessed?

Human rights

Constructions of appropriate services within the policies are based upon another, interrelated paradigm, that of human rights. Across all of the policies, it is explicitly stated that the development and delivery of services should be consistent with human rights standards. More specifically, 7 of 14 policies indicate that the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) should be used as the guiding framework in this regard. Indeed, statements such as these are scattered across the 14 policies: ‘services will uphold and protect the human rights of people with mental disorders’ (Lesotho: 16), people should be ‘cared for...with due regard to their rights as human beings’ (Nigeria: 5); ‘treatment will be consistent with international conventions on human rights’ (Ethiopia: 20, Liberia: 29); or ‘as laid out in international human rights conventions’ (Lesotho: 16).

After indicating that services should be in accordance with international human rights standards, the policies tend to provide a long list specifying which particular rights should be promoted and upheld by mental health care services. These lists appear almost as blueprints of the rights outlined by the UNCRPD, including exhaustively, but variously phrased: the right to be treated in the least restrictive environment, rights related to involuntary admission, rights related to seclusion and

restraint, and rights to confidentiality, informed-consent, non-discrimination, privacy, and autonomy. For example, the follow excerpt comes from Sierra Leone's (15) policy, which aptly reflects the common way in which human rights features in the policies:

Treatment should promote and respect the human rights of people with mental disorders...People with mental health problems and their families must be informed about their treatment and rehabilitation and must have the liberty to give consent to their care...Clinical guidelines including confidentiality issues and informed consent...will therefore be developed.

Another example comes from Gambia's (6) policy, again pertinently capturing dominant policy sentiments:

People with mental disorders should enjoy full human rights...Mental health treatment and care should promote and protect the autonomy and liberty of people with mental disorders...People with mental disorders have the right to be treated in the most effective, least restrictive and least intrusive manner...Care delivered to people with mental disorders should be strictly confidential.

And a further illustration from Liberia's (30) policy:

Treatment will be consistent with international conventions on human rights...This will include the right to essential and appropriate mental health care; treatment will promote autonomy and not be custodial; the seriously mentally ill will be treated in a safe and the least restrictive environment; the use of physical restraints will be discouraged; confidentiality will always be upheld and adhered to.

Numerous similar examples could be provided. The point is, for the policies, 'appropriate' forms of care are essentially those which are based on human rights codes, and in particular, the principles of 'autonomy', 'liberty', and 'privacy'. In discussions around human rights, many of the policies acknowledge that there are diverse understandings of, and healing modalities for, mental illness. However, it is

stressed that these should be tolerated only if they are in line with human rights standards, or as South Africa's (20/21) policy puts it, 'There are varying cultural expressions and interpretations of mental illness, which should be respected, insofar as they protect the human rights of the mentally ill'.

Through its emancipatory rhetoric, promoting the ideals of freedom, privacy and choice, human rights are generally accepted as good things. If we move beneath face-value understandings, however, like 'evidence-based knowledge/practice', the paradigm of human rights is also underpinned by several polemical knowledge assumptions. And these epistemologies are deeply inserted within a modernist/colonial thinking space, as I have demonstrated in detail elsewhere (Cooper, 2014). In summary, in its theoretical origins and embodiment within contemporary international conventions, the paradigm of human rights tends to assume a universality of human nature (De Sousa Santos et al., 2007; Pannikar, 1984). That is, one which is endowed with universal dignity and knowable by an equally universal organ of knowledge, that of rationality. Human rights discourse also has a strong individualistic undertone, with the assumption that human beings are essentially individual, autonomous entities (Sadar, 1998). This set of assumptions is succinctly captured by De Sousa Santos et al (2007: 13):

The concept of human rights is based on a well-known set of presuppositions, all of which are distinctly Western and liberal in origin, namely: there is a universal human nature that can be known by rational means; human nature is essentially different from and higher than the rest of reality; the individual has an absolute and irreducible dignity ... the autonomy of the individual requires that society be organized in a non-hierarchical way, as a sum of free individuals.

A human rights paradigm is thus underpinned by very particular assumptions about personhood and dignity, and how they can be known. However, these understandings may not be universally shared. As I have demonstrated in detail elsewhere (Cooper, 2014), a large body of critical social research in Africa, including in relation to mental health, has demonstrated that understandings of human dignity and morality, and by extension a 'human', are considerably varied and diverse. Such research has revealed, for example, that for many people in Africa, selfhood and dignity are

understood as conditions which are acquired, rather than ‘given’, and thus place great value on the gradual social maturation of people as constantly evolving. Relatedly, in such circumstances, personhood is frequently recognised as deeply intertwined with the spiritual, the corporeal, and the social community, rather than being about an autonomous individual. Ultimately, this research has revealed that attempts to bring about social justice through the utilization of human rights rhetoric have frequently been unsuccessful, as they are incompatible with locally relevant meanings and value hierarchies.

To be sure, my argument is not one of relativism, a kind of ‘anything goes’. Forms of care that respect and dignify people with mental disability are worthy ideals. But what is ‘respectful’ and what enhances ‘dignity’ are not as self-evident as the notion of human rights would have us believe. Ultimately, human rights discourse does not belong to the realm of morality per se, but rather reflects a particular *political* morality that may not be shared by everyone, everywhere. Through its underpinning assumptions however, the notion of human rights is able to gain a universal force that is unconditional. Consequently, ‘other’ ways of making commensurate demands for dignity and justice, which may be formulated in different languages of entitlement, are ultimately marginalized by the paradigm of human rights. As exemplified in the national mental health policies, *only* those kinds of services which are based on international human rights standards, and in particular the inherently individualistic and liberal codes of ‘autonomy’, ‘liberty’ and ‘privacy’ are deemed ‘appropriate’. The slippery issues of dignity and justice are therefore decontextualized, and ultimately engaged with in a ‘one-size-fits-all’ manner by the policies. As a consequence, alternative kinds of values and moral systems, which may not be in accordance with international human rights standards, but which may be important to service users and their families, are ultimately silenced by the policies. And these ‘other’ understandings of justice and dignity might fundamentally change the way in which ‘appropriate’ kinds of services are conceived of and evaluated.

Conclusion

In this paper I have argued that the 1960s represented an extraordinary moment in history when the hegemonic paradigms of the health care professions were being interrogated, and alternatives were being sought. It was out of this context that the

concept of Primary Health Care (PHC) arose, a notion which was based on ‘other’ kinds of epistemologies and moral landscapes to those which had dominated since the colonial era. Sadly, however, the emergence of PHC can be understood as representing only a brief and primarily rhetorical disruption to, the paradigm of colonial medicine. Since the 1980s, it has been taken up and promoted in ways which scarcely resemble its original formulations. In this paper I have demonstrated how national policy thinking around reducing the ‘gap’ in mental health care in Africa is no exception to this trend.

I have shown how although formally espousing a grassroots, Primary Health Care approach to mental health care service development and delivery, in reality, the policies achieve the opposite: the marginalization of local values and meanings and the endorsement of an essentially top-down framework which is heavily informed by the knowledge politics of colonial medicine. In particular, the paradigms of evidence-based science and individualised human rights become the gatekeepers of knowledge within the policies. These legislate as to what are legitimate forms of knowing, and by extension, valid forms of care. Such thinking shares much with contemporary Global Mental Health discourse where, as Vikram Patel (2014:10), one of the key architects of the Movement for Global Mental Health unequivocally states, ‘While there must always be space for discourse and conflicting ideas, these must be based firmly on an equal commitment to science and to the right of people who are demonstrably unwell to receive care’ (see also Cooper, 2014; Global Mental Health Group, 2007; Mari and Thornicroft, 2010). Ultimately, intimately entangled with these Global Mental Health sentiments, the policies end up reproducing many of the very Eurocentric epistemologies that the PHC concept, in its original formulation, sought to transcend.

This has very real consequences in relation to the ‘gap’ in mental health care which the policies are seeking to address. The policies might find that when the services being promoted are implemented, they still remain underutilized. Indeed, a growing body of epidemiological research is showing that despite government-funded mental health services becoming more available in Africa, they are still considerably underutilised on the continent (Kohn et.al, 2004; Demyttenaere, 2004). As I have suggested elsewhere (Cooper, in press), might such low levels of service uptake point to a potential disconnect between dominant constructions of ‘appropriate’

services, and the common ways of life and forms of meaning-making that prevail within the community? Might the high usage of ‘traditional’ healers, which all of the policies strongly emphasise, be because the care provided by such healers is valuable to those who access them, rather than as a result of people’s supposed ignorance, as so many of the policies suggest? Ultimately, as suggested by Ecks and Basu (2009), might the whole ‘gap’ in mental health care be reconceptualised if ‘other’ social resources and ‘alternative’ forms of healing are thought about differently?

All of this suggests that rather than focusing on ‘educating’ and ‘sensitising’ people in biomedical science and international human rights discourse, mental health policies in Africa might benefit from encouraging a better appreciation of, and more appropriate response to, the values and priorities of those they are attempting to help. Similarly, rather than concentrating on ‘training’ traditional healers in the supposedly ‘correct’ approaches to mental health care, the policies might profit from fostering a greater understanding and recognition of these ‘other’ healing practitioners. Importantly, this does not translate into testing the practices of such healers with scientific methods associated with objectivity and scientific protocols, including clinical trials. This approach is becoming a growing trend within Africa in an attempt to establish collaboration between ‘biomedical’ practitioners and ‘traditional’ healers (Lang, 2014; Levine, 2012; Turnbull, 2009). Such initiatives have indeed been described as a kind of ‘Randomized Controlled Crime’, as ‘alternative’ healing systems are tolerated only so long as they can be shown to have a scientific basis (Adams, 2002: 679). As such, policies may need to rethink how diverse forms of meaning-making and the ways of treating mental illness might be potentially legitimised on their own terms, and within their own metaphysical worlds. This is not an easy task, one which raises all sorts of slippery epistemological questions around how medical evidence is produced and legitimised (Levine, 2012). These kinds of questions need to be opened up for further consideration and debate within the mental health policy arena in Africa.

These sorts of questions were indeed exactly what Nigerian psychiatrist and activist Adeoye Lambo was grappling with when he pioneered his innovative ‘Aro village psychiatry’ programme. Warning African psychiatrists about the dangers of implementing a ‘borrowed remedy’, Lambo (cited in Bass, 1994: 69) emphasised that ‘Just as there is no one single religion, so too is there no one single way to

practice medicine. There are many medicines'. And according to Lambo, the best 'practices of medicines' are those which are intimately entangled with local realities, lexicons and matrices and properly respond to such contexts, whatever the setting. This vision of Lambo's was precisely what the original PHC concept was trying to capture. As such, it might offer a potentially productive terrain of engagement for thinking about the development of more contextually-embedded and epistemologically appropriate mental health care policies in Africa.

This paper is aware of the dangers of representing 'Africa' as dependent borrowers and dupes of so called Western systems. However, the key argument still holds: that mental health care policy-thinking on the continent is deeply intertwined with strong epistemic power relations and economic forces operating on a global scale. Indeed, I had not intended, initially, to present my analysis of the 14 policies together as a single narrative. And yet delving into these policies, I was again and again surprised by the large degree of homogeneity between them, with so many statements frequently occurring verbatim across the policies. I was also constantly struck by how similar the policies were to Global Mental Health discourse, in many ways embodying a kind of blue-print of the policy recommendations that are being advocated within the international arena (See for example Mari & Thornicroft, 2010; Patel & Eaton, 2010; WHO, 2003).

This high degree of uniformity raises all sorts of questions around exactly whose voices are reflected, and whose interests are embodied in these policies. My difficulties in obtaining the policies, and related unawareness of the existence of their own national mental health policy by so many Ministries of Health, raise further questions around how these policies were developed and whose opinions they might actually reflect. I can only speculate on these kinds of questions here. The point is that local Governments on the continent may have somewhat limited power in directing the nature of their own national mental health policies, and might ultimately be constrained in their ability to promote alternative models of mental health care. However, to end on a more positive note with the words of Adeoye Lambo (1960:1703), who in the emancipatory spirit of the 1960s stressed, 'It is no easy matter, but we are getting more and more convinced that an independent diagnosis of our position may prove more profitable in the end than a borrowed remedy'.

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8. RESEARCH PAPER FOUR

“How I floated on gentle webs of being”: Psychiatrists stories about the mental health care ‘treatment gap’ in Africa

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Student	Sara Cooper
Principal Supervisor	Dr. Nicki Thorogood
Thesis Title	Prising open the black box: The production of knowledge on the mental health 'treatment gap' in Africa

If the Research Paper has previously been published please complete Section B, if not please move to Section C

SECTION B – Paper already published

Where was the work published?	N/A		
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Abstract

A strong movement has emerged recently which is highlighting the high levels of untreated mental illness in Africa and making proposals for reducing this ‘gap’ in mental health care. This movement has been criticised for insufficiently attending to the epistemologies embedded in its recommendations, and inadequately considering the views of practitioners ‘on the ground’. Employing a narrative-based approach, I accessed the stories about the mental health ‘treatment gap’ of 28 psychiatrists all working in public mental health care settings in South Africa, Uganda, Nigeria or Ethiopia. Rather than focusing on the content of these stories, I was more interested in their underpinning meaning-codes and epistemological politics. Dominant thinking about the ‘treatment gap’ was heavily informed by a biomedical paradigm, and associated epistemological order of European Colonial Modernity. There were, however, cracks in this master narrative, which crystallised in the stories that were told by three particular psychiatrists. Their narratives operated within an alternative paradigm, one which appears to be informed by the tradition of phenomenology, and in particular the ideas associated with French philosopher Merleau-Ponty. This more marginalised thinking may offer important insights into reducing the mental health ‘treatment gap’ in Africa in ways very different from those created by current seats of power.

Keywords: Mental health treatment gap; Africa; Psychiatrists; Narrative analysis; Epistemologies

Introduction

Spider

*For me, the knowing came when psychodelia slapped me loose
and pitched me screaming as I flailed widely in desperate search for reason.
But watching
I realised how I floated on gentle webs of being
and inhaling
smiled deeply as butterflies billowed by.*

(Poem created by one of the psychiatrists in this study)

Over the last decade, the mental health situation in Africa has gained renewed attention as an important public health concern within the global arena (Global Mental Health Group 2007). One issue of particular concern is what is understood as the high levels of untreated mental illness, now referred to as the mental health ‘treatment gap’ (WHO 2001, 2008). Concerns about this large ‘gap’ in mental health care has in turn given rise to a “broad new social movement” led by the international psychiatric community, but incorporating a broad coalition of actors and agencies, which is focused on ‘narrowing’ this gap (Horton 2007, p. 806). Under the banner of this movement, a plethora of global research projects, interventions and policies have been developed and implemented which are receiving significant amounts of funding from a range of international agencies and governments (Cooper 2014).

These initiatives have, however, been met with various dissenting voices, with growing controversy over the conceptualisation, goals and imagined outcomes of this movement (Mills and Fernando 2014; Summerfield 2012). In particular, it has been argued that insufficient critical attention has been placed on the underpinning epistemologies of Global Mental Health discourse (Bemme and D’souza 2014; Swartz 2012). Moreover, concerns have been raised about the somewhat ‘top-down’ approach of Global Mental Health initiatives, which are seen as inadequately incorporating the views of people who are directly involved with the provision and uptake of mental health care in Africa (Cooper 2014; Campbell and Burgess 2012; Timimi 2011).

In light of these concerns, I employed a narrative-based approach to access the stories of 28 psychiatrists about the mental health ‘treatment gap’. These psychiatrists were all working in public mental health care settings in South Africa, Uganda, Nigeria or Ethiopia. Rather than focusing primarily on the content of such stories, I was more interested in epistemological questions regarding the conventions of meaning-making that lay *behind* the stories that were told. That is, I sought to open-up the ‘black box’ (Latour 1999) of these stories, unearthing the underpinning knowledge assumptions and capillaries of power. The underlying premise of this research is that such assumptions, which are frequently deeply hidden, have profound consequences. They help to shape the kinds of questions that can be asked and thus the solutions that can be generated (Weed 1995). As such, unless we examine the epistemological assumptions mediating the psychiatrists’ narratives, the kinds of strategies they propose through their stories might prove to be ineffective and inappropriate (Krieger 2000). Possibly even more serious, without looking critically at the knowledge politics underpinning the practices the psychiatrists advocate, these practices face the danger of oppressing particular people and subjugating certain voices, rather than supporting them (Kirmayer 2012).

Through the stories they told, the majority of psychiatrists produced a particular way of thinking about the ‘gap’ in mental health care and its potential reduction, one which draws heavily upon a biomedical master narrative. This dominant narrative structure has been shown to be deeply entangled with the epistemological order of modernity and colonialism, and associated Eurocentric tendencies (Bracken et.al. 2012; Clark 2014; Deacon 2013; Good 1994). This was, however, not the whole story; there were cracks in the master narrative. Beneath the audacious and relatively unequivocal statements made, certain psychiatrists conveyed a degree of ambivalence and uncertainty with regards to their knowledge claims. These cracks crystallised in the stories that were told by three particular psychiatrists, stories which fundamentally contested the master narrative and its underpinning epistemologies. These three psychiatrists operated within an alternative knowledge framework, one which appeared to be informed by the tradition of phenomenology, and particularly the ideas associated with French philosopher Merleau-Ponty (1962, 2004). This alternative paradigm might enable mental health service providers to function in worlds very different from the ones created by current seats of power, and go some

way towards reducing the current ‘gap’ in mental health care so many countries on the continent face.

Methodology

Our lives are full of stories: we read and tell and listen to them; we watch them unfold in art, ritual, and social life; we perform them ourselves; they give form and meaning to our daily existence.

(Montgomery 2006, p.47)

The psychiatrists

In total, 28 psychiatrists, comprising 19 men and 9 women, were included in the study. These psychiatrists were purposively sampled from four African countries: 8 from South Africa, 6 from Uganda, 7 from Nigeria and 7 from Ethiopia. The commonality between the psychiatrists was that they were all working in Government-funded, public sector and urban-based mental health facilities. Furthermore, all of the psychiatrists were African nationals. Seven of the psychiatrists had undertaken their psychiatric training in Europe, 5 in the United States with the rest having obtained their training in Africa. The psychiatrists from South African were all based in Cape Town, those from Uganda were situated in Kampala, the Nigerian psychiatrists were all working in Lagos and those from Ethiopia were all located in Addis Ababa. Eighteen of the psychiatrists worked in standalone psychiatric hospitals, while the rest were based in psychiatric units located in general hospitals or clinic-based settings.

Gaining access to these psychiatrists was facilitated by the fact that I had previously worked on the Mental Health and Poverty project, a project which focused on evaluating and developing mental health policy, legislation and services in a variety of African countries²⁵. Through this project, I developed professional links with various psychiatrists in the South Africa, Uganda, Nigeria and Ethiopia, who I contacted and asked whether they would be willing to participate in this study. Further psychiatrists were recruited through snowballing techniques. The sample of this study is relatively small. However, the size of this sample must be viewed in

²⁵ <http://r4d.dfid.gov.uk/Project/50165/>

light of the paucity of psychiatrists available in Africa. Current available estimates indicate that there are only 22 practicing psychiatrists in Uganda (Kigosi et.al 2010); 40 in Ethiopia (Ethiopian MoH 2012) and fewer than 100 in Nigeria (Issa 2005). The availability of public sector psychiatrists in South Africa is relatively higher, with estimates that there are approximately 0.28 psychiatrists per 100 000 population (Lund et.al 2009). I do not wish to suggest, however, that the views expressed by the psychiatrists included in my research characterise the sentiments of all psychiatrists in these four countries, let alone the continent as a whole. The stories that were told were specific and local, about particular sites and situations. However this does not mean that their significance is necessarily restricted to the local. As Mol (2008) and Turnbull (2000) found when using stories as a form of knowledge production, it is somewhat paradoxically because of their specificity and attention to detail that stories have the power to travel, to offer wider insights that may be transported to other contexts.

A critical narrative-based enquiry

Although varied and diverse, a narrative-based enquiry is based firmly on the premise that stories are primary meaning-making structures. That is, they constitute fundamental ways of knowing and creating identities, of ordering our interactions with each other and the environment (Turnbull 2000; 2004). Although there is considerable debate around the nature and role of narrative, there is some general agreement that might be summarised in Lamarque's (1990, p.131) characterisation [my emphases]:

In the most general terms to narrate is to tell a story...narration involves the recounting of events...narrative imposes structure, it connects as well as records...Stories don't just exist, they are told, and not just told but told from *some perspective* or other.

A similar kind of description is provided by Pluciennik (1999, p.656):

The distinguishing features of narratives as opposed to other forms of writing would seem the sequentiality and emplotment...Out of the *selective* (re)description of objects, elements, events, conditions, and characters and

myriad possible relationships between them...it is the plot, the thread of the story which emphasizes *particular* paths, possibilities and plausibilities...

Narratives thus organise things in space and time, creating links and connections between places, people, events and actions. Importantly, what both of these descriptions suggest is that narratives are not innocent tools, providing neutral accounts of a supposed pre-existing reality. Rather, narratives are constructed, creatively authored, and replete with values and assumptions. When telling stories, people must select which details to recount, what to emphasise, and how to connect the different elements, all of which involve particular choices (Turnbull 2000; 2004). As such, narratives express particular ways of seeing the world and treating evidence. They frame the world in Kuhnian style (1962) paradigms, determining what sorts of questions are valid, what kinds of answers might be legitimate and what kinds of knowledge counts. A narrative based enquiry thus primarily concerns itself with unpacking the particular ways of seeing and knowing that are brought into being through our narratives, and which alternatives are potentially silenced (Reissman 2008).

Furthermore, what both Lamarque and Pluciennik's descriptions suggest is that despite their particularity, narratives are not only individual, but are also socially organised phenomena. Even the most personal accounts rely on and invoke a body of tellable story forms, an established canon of story lines and rhetorical tropes. "Culture speaks itself through an individual's story", as Riessman (1993, p.5) puts it, with all stories told within a tradition of other narratives. Narratives are thus constructed in particular socio-cultural contexts and draw upon available social resources to make meaning. Within this wider fabric of tellable stories, some paradigms come to dominate, and are thus reproduced within seemingly unique, personal narratives. However, at the same time that personal narratives tend to reinforce certain hegemonic knowledge orders, they may also provide openings for creativity and invention in reshaping the social world. In other words, at times subversive stories can be told, stories which defy and transform (Ewick and Silbey 1995). Ultimately, in illuminating dominant narrative codes, and unearthing more marginalized ones, narrative-based research can become a form of epistemological politics (Turnbull 2000; 2004).

Proceeding from this view of narratives as socially-embedded, meaning-making structures, I conducted individual interviews with each psychiatrist in an attempt to elicit stories or ‘whatever comes to mind’. I began each interview by indicating that I was interested in their understandings of why people who need mental health care may or may not be getting the care they need. Thereafter, I asked extremely broad, and open-ended questions which were structured as ‘narrativised’ topics or story-telling invitations (Hollway and Jefferson 2000). These questions included, for example, if they could describe how they came to be working at the hospital, what a typical day involves, what sorts of challenges they face, what kinds of patients they are currently seeing and have seen in the past, and incidents with patients they found challenging, positive and/or memorable. Where thoughts were expressed in relatively general or abstract terms, I tried to anchor these to specific incidents which had actually happened, encouraging the psychiatrists to describe examples from their daily experiences.

Throughout the interviews, I opened up spaces for extended turns and associative shifts in topic, encouraging one story to lead to others even if they appeared to be non-linear, partial and fragmentary. I ended up asking very few of the questions that I had devised prior to the exchanges, with the majority of psychiatrists telling long stories in response to a few brief questions. I was indeed struck by the psychiatrists’ tendency to open up and provide rich and detailed stories, with each interview lasting between 1½ hours to 4 hours. Most interviews were thus characterized by a continual elaboration of the themes and ideas that *they* presented in *their own* accounts. This was important as I felt that I was gaining access to the participants’ own meaning frames, as we followed their own associative trails and unfolding logic (Riessman 2008).

A critical narrative-based analysis

All of the interviews were transcribed verbatim and then analysed through a thematic analysis approach. Thematic analysis is a useful method for identifying and describing recurring patterns in texts that have a common storied form (Riessman 1993; 2008). I used this approach to illuminate themes related to my specific research question regarding how psychiatrists think about the ‘gap’ in mental health care. As my primary interest was in the underpinning epistemological assumptions

and politics of such thinking, I supplemented my analysis with a Parkerian discourse enquiry approach (Parker 1992). This approach understands language as an ideological tool, and aims to expose the ways in which language serves to (re)produce, maintain or transform different ‘realities’ and power relations. In particular I used Parker’s three auxiliary criteria- discourses support institutions; reproduce power relations; and have ideological effects- in order to locate the psychiatrists’ stories within broader social resources and dynamics of power.

Far from being seamless accounts, stories are filled with gaps, inconsistencies and contradictions, and making these visible requires constantly moving between the parts and the whole of the interview(s) (Hollway and Jefferson 2000). As such, I paid attention to the specific narratives within each individual interview. My focus was on the manner in which the stories were told, the way events were constituted, and how facts were assembled and links were made. I explored how through stories the psychiatrists generated, and came to terms with, contradictions, tensions, and predicaments, and how moral lines were drawn and conclusions were made. I also paid attention to the emotional aspects of each specific story, identifying, for example, moments of hesitation, pauses, metaphors, stress and intonation, and laughter. Indeed emotions constitute a fundamental part of stories, where the teller frequently wishes the listener to *feel* their truth, and become emotionally engaged (Kleres 2010). I explored how these narrative configurations and emotional tones were shaped by particular social resources; the storehouse of plots called upon and the underpinning values and politics of these collective plots. In order to identify patterns and commonalities, as well as points of disjuncture, I consistently located the insights emerging from the specific stories within the form of each individual interview as a whole. Evidence from the individual interviews was then contextualized within the themes and ideas that were emerging across the interviews (Riessman 1993; 2008).

Analysis Part I: A biomedical master narrative

‘When I use a word’, Humpty Dumpty said, in rather a scornful tone, ‘it means exactly what I choose it to mean- neither more nor less’.

*‘The question is,’ said Alice, ‘whether you can make words mean so many different things.’
‘The question is,’ said Humpty Dumpty, ‘which is to be master- that’s all’*

(Carroll, 1872, p.72)

In the stories that the psychiatrists told, a number of interrelated assumptions emerged about the nature of mental illness, about human behaviour, about biomedical science and about the goals of mental health care. These assumptions coalesced to produce a particular way of thinking about the ‘gap’ in mental health care, one which is deeply embedded in a biomedical paradigm. This paradigm of thought has been problematized in considerable detail by a now veritable academic industry of critical social science scholars (Bracken et.al. 2012; Clark 2014; Deacon 2013; Good 1994). In particular, they have demonstrated how this paradigm is intimately entangled with the epistemological order of modernity and colonialism, including colonial medicine. They have shown how this conceptual framework is based upon a host of questionable assumptions and Eurocentric tendencies, and have consequently often resulted in distorted forms of medical understanding and practice.

In brief, a biomedical paradigm is premised upon a rationalist version of reality, one which assumes that the world, both social and natural, functions on the basis of predictable and universal principles of cause-and-effect. So, for example, human action is understood as intrinsically stable and predictable, guided by an inherent logic to maximize perceived benefits. Similarly, disease is assumed to be a universally recurrent entity which produces distinct signs and symptoms. And this entity is conceived of as distinguishable from the subjective experience of illness. Put differently, although experiences and understandings of illness may vary, it is assumed that ‘real’ disease ultimately transcends socio-cultural context. The primary tasks of clinical medicine, according to this paradigm, should be oriented towards diagnosing and treating the signs and symptoms of suppose ‘real disease’. It is assumed further that clinicians are able to perform these tasks through the principles and methods of biomedical science. In other words, biomedicine is constituted as possessing the capacity to objectively know, and accurately treat, the supposedly natural order of pathology.

Biomedicine is thus normative within this paradigm of thought. Other ways of knowing and being are essentially distinguished from, and evaluated in terms of, their proximity to biomedical knowledge and practice. Whereas biomedicine is seen to provide supposed accurate *knowledge* of real disease, people are assumed to hold subjective *beliefs* about illness, opinions with potentially suspect grounds in apparent

objective reality. Ultimately, within this paradigm, rational beliefs and behaviours are those which are in line with the principles and methods of biomedical science.

Colonial medicine was intimately entangled with this kind of thinking, characterized at least in part by the struggle between supposed ‘rational’ biomedicine and apparent ‘primitive’ ‘traditional’ therapeutics (Comaroff 1993; Vaughan 1991). In its imaginary, ‘Western’ medical science embodied the highest form of rationality and modernity, in contrast to the supposed backward and superstitious nature of ‘indigenous’ cultural beliefs and practices. Put bluntly, medical modernization of African populations entailed attempting to drive out supposed ‘primitive’ traditional therapeutics, and promoting forms of care which were based solely on biomedical theories and practices.

A biomedical paradigm of thought is thus underpinned by a host of rationalist assumptions, Eurocentric tendencies and binary oppositions. This particular way of thinking about and ordering the world is strongly reflected and reproduced in the stories the large majority of the psychiatrists told about the ‘gap’ in mental health care. For the purpose of analysis, I structure these stories around two dominant themes, and unpack how this biomedical paradigm manifests and cuts across both themes. These themes are the lack of access to mental health care services and the lack of uptake of available mental health care services.

Lack of access to mental health services

Many psychiatrists began our interview by asserting strongly that the tremendous lack of material and human resources dedicated to mental health care is one of the main factors contributing to the large gap in mental health care. As described by one psychiatrist from South Africa:

It comes down to simply there are not enough hospitals and clinics to treat people, simply not enough beds, not enough qualified health care personnel, or medications. So we are paralyzed in properly tackling the enormous need that is out there.

Similarly one psychiatrist from Ethiopia emphasised:

The core problematic revolves around the large number of people who have easily definable mental health problems but do not have access to the services they need. We know what will help, we know how to get them better, but unfortunately we just don't have capacity to do this.

As reflected in these excerpts, the psychiatrists talked about the issue of limited resources in relatively certain terms, so often highlighting the 'easily definable' nature of mental illness and how they 'know what will get people better', but 'simply' lack the resources to do so. Many psychiatrists explained further, again in a somewhat unequivocal manner, how this incapacity has resulted in a situation whereby people are forced to seek support from other sources. As the psychiatrist from Ethiopia cited above elaborated with conviction:

So of course, they are then going to look for help elsewhere...help that is closer and more accessible...And this is why so many of our patients use traditional means, because they just don't have access to modern means...

Many other psychiatrists drew a similar conclusion, frequently emphasising that "people have no choice but to look elsewhere, to find other means, like holy water sites or prayer houses" that "people obviously then get help elsewhere from a range of more folk kinds of help" or "so our patients seek support through other means, such as faith healers and traditional healers". Indeed, aptly depicting the views of so many psychiatrists, one psychiatrist from Nigeria asserted, again in relatively unequivocal terms:

I have no doubt that if we can provide a service that is close to where people live, where they don't have to wait for hours...we will significantly reduce this enormous gap in treatment...People will get the treatment they need and they won't need to go elsewhere for help.

For many of the psychiatrists then, ensuring that people 'get the treatment they need' within a context of scarce resources necessitates "thinking creatively" or "thinking out of the box" in order to "find innovative ways" or "novel strategies for extending the reach of our services". Innovation, for the large majority of psychiatrists, tended

to emerge as two-fold. Firstly, it materialised as about equipping non-specialist health workers in primary health care and community settings to provide mental health care. Secondly, it was emphasised that there is a need to better collaborate with ‘traditional’ healers in the delivery of care. Although couching these two strategies within somewhat pioneering terms, elaborations of what such initiatives would entail were, however, deeply steeped in biomedical epistemologies.

In terms of the first strategy, numerous psychiatrists unambiguously stated that “Integrating mental health into primary health care is the way to go, the only way forward” and “we need task-shifting strategies in primary and community care”. The potential of this kind of approach emerged most prominently when many psychiatrists described what for them a typical day at work entails. Within such accounts, there was a tendency to emphasise the ‘clear-cut’ nature of mental illness and the ‘straight-forward’ nature of the functions they perform, with the common conclusion that patients can therefore easily be dealt by non-specialist health workers. Indeed, the following narrative emerged repeatedly across the interviews:

Most of what I do is really about making diagnoses, administering treatment, tracking the symptoms, following up to check that they don’t have excessive side-effects...And going back to what I was saying earlier, you don’t need specialist to do these kinds of things...non-specialists can be taught to do these things... (Ugandan Psychiatrist)

Another psychiatrist from South Africa explained:

The majority of people I see are actually quite straightforward...I get the details of the problem, come to some sort of working diagnosis, and then usually put them on medication, and often also provide some kind of therapeutic intervention...So, really, I am seeing people which could easily be dealt with by other people...With the right kinds of training and guidelines, non-psychiatrists could easily take on these tasks...

This psychiatrist from South Africa went on to describe the World Health Organization’s MHGap Intervention Guide, highlighting how this “what-to-do manual” is a good example of the kind of clinical guidelines non-specialist could use

to help them perform the necessary tasks:

So, the patient will say I am not sleeping well, I have lost my appetite, my weight is dropping. The nurse can then turn to the page of the manual where you have the symptomatology of sleeplessness or loss of concentration, and the manual explains what the symptom represents and lists what next questions to ask and actions to take. So all the nurse really has to do is following these steps...

As depicted in these excerpts, the psychiatrists talked about the management of patients with mental illness as a relatively uncomplicated endeavour, primarily a matter of making diagnoses, administering treatment and monitoring side-effects. For the psychiatrists then, it is possible and desirable to model the scenarios a health care worker may face, and accurately stipulate a set of clear-cut steps on how to act. What is implicit in this particular understanding is that ready diagnoses exist, effective interventions are known and mental health care goals are well-defined, that is, defining and treating the signs and symptoms of illness. In other words, it is assumed that if health care workers have the supposedly correct facts, they can easily deduce the best path of action to take, an understanding which is indeed fraught with the kind of rationalism so characteristic of biomedical epistemologies.

The second innovative strategy suggested by many of the psychiatrists for increasing the availability of mental health care services involved the necessity of collaborating with traditional healers. 'Collaboration', however, for the large majority of psychiatrists emerged as essentially matters of education, training and monitoring. After indicating that there is a need for partnerships with traditional healers, so many psychiatrists provided detailed accounts of the supposedly harmful and abusive nature of such practitioners. Comments were made about the "terrible kinds of human rights violations that go on in those kinds of places" or the "enormous abuses" that take place amongst traditional healers. Other psychiatrists spoke about the distrust such healers often have for health services: "Many healers are suspicious of us...they think we might take their livelihoods away, because they make money out of this. So they aren't willing to hand over potentially lucrative clients to us". For most of the psychiatrists then, 'working with' traditional healers tended to translate in essence into that of training and supervision and encouraging referrals:

Part of the solution requires working together with traditional healers...But it would be our responsibility to *supervise* them if we going to work together. So if a patient comes to you, and they on these medications, encourage them to continue the medication, *encourage them to come see us* [Nigerian Psychiatrists, my emphases].

And as articulated by another psychiatrist from Uganda:

We need to think about better collaborating with traditional healers...It is not easy though... Like, *changing*, you know, is not easy...Sometimes what they are doing is really quite abusive...There are so many cases of *extremely harmful practices*, like restraining people, chaining, cutting...So we need to engage with them to try to *minimize these practices* and emphasize the *need for them to refer* [my emphases].

As such, through the stories that the psychiatrists told, they were unable to know traditional healing systems as anything other than ineffectual, abusive and corrupt and in need of education and supervision. Ultimately, listening to the psychiatrists' narratives, I could not help but think of colonial medicine's trope of 'Africa's traditional therapeutics', therapeutics which were incontrovertibly relegated to the realm of primitivism, degeneration and irrationality (Comaroff, 1993; Lucas and Barrett, 1995; Vaughan, 1991).

The lack of uptake of available mental health services

For many of the psychiatrists, the lack of access to mental health services was not the only reason for the large 'gap' in mental health care. The underutilisation of available services was seen as an additional contributing factor:

At the same time that there's a real problem with access, there's the other problem that even though there is a lack of services, those services that are available are still not being used. Like people might live within walking distance to a clinic, yet they don't come... [Nigerian psychiatrist].

The interviews were replete with accounts such as these, with many psychiatrists describing, with much exasperation, how frequently people do not take up available services, come late, drop out of care or stop following their treatment regimes. In accounting for this situation, most psychiatrists attributed it to the inadequate levels of knowledge, or what was commonly referred to as insufficient “mental health literacy” amongst service users, their families and the general population. Indeed, the psychiatrist from Nigeria cited above went on to explain why he thought people ‘just don’t come’:

I think a lot of it has to do with a lack of mental health literacy...Often people don’t know that this is a real illness...They don’t know about services, well the right kind of services...And they don’t evaluate their symptoms appropriately...sometimes I wish psychiatry was like other medical disciplines, where you could put up a scan and say ‘look at the deficit. This is not what your brain used to look like and you need to let us fix this deficit’.

As suggested by this psychiatrist, ‘appropriate’ forms of thinking and the ‘right’ kinds of services are those which understand mental illness as a universally recurrent and ‘real’ entity, one that is no different from other medical conditions. Similarly, another psychiatrist from South Africa described a study which involved providing out-patients with free medication, as well as transport money and a small stipend to attend fortnightly clinic check-ups. He was bewildered as to why many of the study participants failed to come to the services and frequently stopped their medication. Again, this was attributed to their lack of supposedly ‘appropriate’ kinds of knowledge:

And yet in spite of all of this, so many dropped out of the study...in many ways it’s bizarre, even funny. We are paying them to come, and giving free medication, but they don’t come and they stop their meds (laughs)...But I think a lot of the time it comes down to not knowing how important it is to take treatment...But there are also other issues, all the spiritual stuff, like the belief that this is a calling and by taking the medication or seeing us you’re resisting the calling... [South African psychiatrist].

This reference to “the spiritual stuff” was a particularly persistent issue that emerged

within the psychiatrists' stories about the widespread lack of 'mental health literacy' and consequent failure to take up services. The interviews were saturated with comments about people believing that "their affliction lies within the supernatural realm and so the cure is sought from healers" or that "Because they believe the problem is caused by spirits they go where they believe the spirit can be removed". Indeed, people's spiritual *beliefs* became a key analytical category for many of the psychiatrists, one which tended to be juxtaposed with supposed biomedical *knowledge*:

It is very common for people not to come to psychiatric services, or present late, and then drop out. And of course it's rooted in beliefs around the causes of disease. Many don't believe it's a medical disease. They think it's a bad omen... So because of that, they think coming to us would be a waste of time... [South African psychiatrist].

For many of the psychiatrists then, in addition to expanding the availability and accessibility of services, reducing the current 'gap' in mental health care also necessitates educating people about the 'proper' nature of mental illness and 'appropriate' forms of care. And what is proper and appropriate emerged as essentially forms of knowledge and practice which are based on the principles and methods of biomedical science. Indeed, ubiquitous comments were made by the psychiatrists about the need to "create increased awareness across society", undertake "mass education initiatives" and "mental hygiene programmes". It was emphasized that "people need to know that mental health disorders are no different from *physical problems*" and that "mental illness is *not spiritual*, but a *real illness* that is preventable and curable". It was stressed how people require "information on the *proper* causes, symptoms and *appropriate* treatment options" and "knowledge about *appropriate* and *sensible* pathways to care". Many psychiatrists emphasized how such education also needs to form an integral part of the care provided to service users and their families [my emphases]:

You need to constantly talk to the patients and tell them that this is not a spiritual thing but a *real medical illness*... You need to tell them that there's a real chance that if they don't come to us, don't take their treatment, they won't get better [Ugandan psychiatrist].

This was echoed by another psychiatrist from South Africa [my emphases]:

You need to help them understand that this is a *real illness*. Even sit the whole family down, because often families collude with the patients. But it isn't easy. Some families *refuse to co-operate* with us, because they don't think their child is ill. They think that it's spiritual...In those cases, it's a lot harder. But we try work with that. Well, work around that (laughs)...

When I asked this psychiatrist if she could provide an example of where she “worked around that” she recounted the following:

Recently a patient believed her illness was a calling to become a healer. And no matter what we said, she and her family just didn't believe she was psychotic, even though it was evidently clear...So in these kinds of cases it is about being pragmatic...you know focusing on what will get this person better...

This notion of ‘being pragmatic’ by ‘focusing on what will get this person better’ was in fact alluded to by numerous psychiatrists. Many explained that changing people's beliefs is challenging, and so rather than “fighting with patients and their families”, health care providers need to place their attention primarily on “the things that really matter”. And these ‘things’ tended to emerge as primarily about identifying and addressing the signs and symptoms of illness:

I used to spend lots of time trying to get patients to understand the nature of their illness. But I came to appreciate that people have all sorts of understandings, which aren't going to change...So, explaining these things to people now feels a bit meaningless, well it doesn't seem to mean much to me anymore (laughs)...So I now focus rather on the important things that people need to know and remember...The simple stuff really, like about warning signs, signs of relapse, the importance of treatment adherence... [Ethiopian psychiatrist].

What is therefore evident is that for the psychiatrists, patients' own understandings

and experiences of illness are either invalid and in need of correction, or alternatively irrelevant and need to be ‘worked around’. In both cases, the implicit assumption is that there is a clear distinction between the real world of physiological objects and the personal experiences of this reality; between the objectivity of biomedical knowledge and the subjectivity of beliefs. And the primary goal of clinical care is to utilise the principles and methods of biomedicine in order to identify and address the underlying signs and symptoms of supposed real disease.

In summary, and tying the various threads together, through the stories that the psychiatrists told, mental illness emerged as an entity which is “easily definable” or “straightforward” or “clear-cut”, and first and foremost a “real disease”, one which can be abstracted from subjective meanings and experiences. The principles and methods of biomedicine were constituted as normative; the paragon of objectivity and rationality. They were seen as providing the means for attaining the goals of care, goals which emerged as essentially self-evident- that is, identifying and addressing the signs and symptoms of real pathology so that people might become disease-free. ‘Other’ ways of thinking and being, which may lie outside of a biomedical form of consciousness, were in turn indisputably relegated to the realm of irrelevance, fiction or primitivism.

As such, although proposals for reducing the ‘gap’ in mental health care were couched in the progressive terms of ‘innovation’, ‘collaboration’ and ‘pragmatism’, ultimately such recommendations did not embody any real kind of departure from a biomedical mode of thinking. They were still based upon the host of Eurocentric tendencies and binary oppositions that lie at the heart of this master narrative: the objective versus the subjective; knowledge versus belief; the rational versus the irrational; the modern versus primitive. And they were still premised upon the rationalist fantasies of the world so characteristic of biomedical epistemologies. That is, it was ultimately assumed that if services are made more available, and people are made aware of the ‘true’ nature of mental illness and the benefits of biomedical services, they will inevitably seek such services. And people will get better. And the ‘gap’ in mental health care will be reduced.

This is, however, not the whole story; there were cracks in this master narrative.

Analysis Part II: Cracks in the master narrative

There is a crack in everything. That's how the light gets in

(Leonard Cohen, Anthem)

Beneath the audacious and relatively unequivocal statements made, certain psychiatrists conveyed a degree of ambivalence with regards to the underpinning knowledge claims of the dominant biomedical paradigm. These, somewhat momentary incidents of uncertainty, tended to emerge towards the end of the interview or whilst chatting in the corridors when I was leaving. For example, after thanking one psychiatrist from Nigeria for the interview, he casually remarked:

I must just say though, I do have a great anxiety that even if we develop more health centres and more train more people to deliver mental health services, we still not going to solve the problem. Like will people come to those services? That remains a question.... I do worry that five years down the line we will look back and say why didn't we do things differently then. But don't quote me on that (laughs).

During my interview with this psychiatrist, he had made many bold statements about the nature of the problem and how it should be addressed. I was therefore struck by the level of doubt he expressed in this final remark. I was also intrigued by his trepidations around voicing this perspective, indicating that I should not quote him on these kinds of uncertainties he had. In a similar manner, towards the end of our interview, another psychiatrist from Ethiopia made the following comment:

It does concern me though that mental health care is becoming so clinical. I am not sure that that really satisfies the patients. I mean, what we are offering, and obviously we do offer help, but I think that we are inclined to overestimate what we can do....in reality, we are really struggling to do something that is sometimes maybe marginally effective. Maybe I shouldn't be saying this on tape (laughs). But I do feel that a lot of what we are dealing with really are so intractable for people. There no magic solutions out of it.

So maybe our expectations need to change, so we don't always feel so defeated when they come up against the real world of unsolvables.

Once again, the uncertainty conveyed here, and apprehension around expressing it, is clearly evident. An analogous kind of apprehension was expressed by another psychiatrist from South Africa. During my interview with this psychiatrist, she received a phone call and asked whether I would mind stepping outside. After about 20 minutes she invited me back in the room and exclaimed:

Shame, this poor mother. I mean, well (sighs)...I suppose so many of the families we see, and our patients, are really dealing with a lot. You know, having to hold a lot of distressing, even horrific things. And obviously, we have to hear and receive it all with respect and with you know, sensitivity. Often we feel, well I certainly feel, sometimes that I am being, perhaps, I might be accused of being dismissive, or I am, you know, not acknowledging enough the content that they would like to bring...And of course this causes a lot of anxiety for us. Well for me at least.

This psychiatrist went on to describe, in a fair degree of detail, the kinds of anxieties she feels when dealing with patients and their families, and suggested that these apprehensions have an effect on the kinds of care that is provided:

You know, that power you get as a doctor is sometimes irresistible in treating your own anxiety....So, assert the power and everything is going to be OK. And that's why maybe we become very paternalistic with patients and their families, trying to tell them that this is what it is and this is what they must do. And there are good reasons for it, I mean in crisis, you have got to keep your head, and the best way of keeping your head is making clear decisions. If you don't have an absolute decision in your mind, you feel uncomfortable. Frightened maybe.

It is thus clear that appearing intermittently in the cracks of the stories that were told, certain psychiatrists expressed a degree of ambivalence with regards to the more dominant knowledge claims about the nature of mental illness, the goals of mental health care and the capacity of biomedical science. These somewhat fleeting

moments of tension crystallised in the stories which were told by three particular psychiatrists, who appeared to operate within an alternative knowledge framework. In what follows is a detailed analysis of the kinds of stories these three psychiatrists told.²⁶

Jeff: *“Treatment becomes a restoration of harmonies, rather than the imposition of silence”*

Jeff is a psychiatrist who has been working in an acute male in-patient ward of a large public psychiatric hospital in Cape Town for over 20 years. During my interview with him, we spent a lot of time talking about the specific patients he is seeing. During such discussions, he spoke about one particular man, whom he has been seeing for the past six years, and used this patient to illustrate some of his thinking around the ‘gap’ in mental health care. In beginning his story about this man, Jeff describes:

This young gentleman was really suffering when I first saw him. He was being controlled by a couple who were manipulating everything of his- his thinking, his capacity to swallow, to breath. And what really fascinated me was he would say to me, kind of waving his finger, ‘Jeff, I know you think that this is schizophrenia. I know you think that I am mad and so vat die pille [translation: take the pills]. But you just don’t get it. It’s real. It’s true’.

In talking about this man, I was immediately struck by form of narration Jeff employed. Rather than using a third person perspective, Jeff was telling me this story in the first person, suggesting the utterly real nature of this man’s experience. In fact, Jeff explicitly stated that these experiences were indeed very real:

Most certainly, I do think this man is ill, and we can say that he is deluded in some way. But how inadequate that is to understand, and then help him with this utterly real experience. It is really happening for this gentleman. And just the depth of this is hard to imagine, even impossible to conceive of how

²⁶ The names used in this section are all pseudonyms.

dreadful it must be to live in a world where you have no privacy, no longer the author of ones' actions.

Jeff spent much time talking about both the authenticity and incomprehensibility of this man's experience, and how, more than just being philosophically interesting, it also raises questions about how one might think about helping this man. Rather than telling people what to do and focusing on "fixing things", Jeff explained that what is of primary importance is the necessity of acknowledging this person's very real experience. Acknowledgement for Jeff emerged as a somewhat complex phenomenon:

I think in some way acknowledgement includes a deep appreciation that mental illness is an intimately personal and private experience, and that the person suffering has endowed it with meaning. But it also involves acknowledging the limits of what we know. Like what this gentleman was experiencing was beyond my ability to imagine. And this is true for a lot of what we encounter in our work. We actually don't really understand a huge amount. The causes, the pathophysiology, and effective treatments ultimately still remain elusive. Total mysteries. So let's not pretend that we know what needs to be done.

Jeff spoke in detail about his concerns that inappropriate claims are being made at the moment about what is known, and what should be done. For him, the desperate desire to address the large 'gap' in mental health care is resulting in widespread "claims of certainty when there is no certainty, assumptions of the inevitability of forthcoming answers to current mysteries". According to Jeff, if one starts off from such a place of conviction, there is the great danger that one will provide potentially inappropriate forms of care and alienate patients, who are in turn unlikely to welcome such services. As he emphasized, "When one starts off from a place of utter certainty, from a place of knowing, it becomes very difficult to properly acknowledge the person's experience, and as such, we end up prematurely foreclosing and limiting the scope of treatment". Referring back to this man, Jeff explains how he spent much time just listening to him, and trying to understand his predicament. Jeff also frequently met with his family and explained how "This

provided invaluable, utterly crucial insights...you know there is always a lot we can learn from families...they don't need to be educated".

Through such careful listening and learning, Jeff came to appreciate that this man was "desperately trying to make sense of his world, and these meanings were central for him". According to Jeff, what might be understood as the clinical features or symptoms of this man's illness, may have in fact been an attempt on this man's part to understand and live with his experience, or as Jeff puts it, "a way of deriving some kind of meaning, in the attempt to live with an anomalous set of experiences that might otherwise be intolerable". Jeff went on to describe in detail how this man consistently expressed ambivalence about taking medication, and how he came to realise that:

It was as if his delusions offered some kind of meaning for him, forming some complex part of his processes of reintegration. And I came to appreciate that these meanings needed to be acknowledged and respected and possibly even enhanced, rather than merely neglected and eliminated...Using medication to suppress these symptoms would have somehow denied this man of his reality...Created a kind of void for him.

In qualifying his statement, Jeff insisted that he is not suggesting that medication should be dismissed, as it is able to provide very powerful relief for many people. Rather, what was at stake for Jeff is the need to rethink the ultimate aims of care:

People are living with these realities, and will probably continue to do so in one form or another because a lot of what we are dealing with are actually chronic...So my job is not to rip this reality apart, to eliminate it, but to acknowledge it, and understand what sense you are making of it...To use a musical analogy, treatment becomes a kind of restoration of harmonies, rather than the imposition of silence...And for me, this is about moving beyond the banalities of treatment to thinking about what might be meaningful for you; what might be pleasurable or worthwhile getting-up for in the morning.

The 'restoration of harmonies, rather than the imposition of silence' is a provocative and powerful metaphor, one very different to the language of cure. For Jeff, the

deeply personal and ultimately enduring nature of mental illness means that generic forms of treatment and quick fixes are not appropriate. Rather, it is about providing individualised and meaningful forms of care. Jeff ended by emphasising how thinking in terms of ‘harmony’ rather than ‘silence’ is not an easy task, one which ultimately requires a considerable amount of humility, wisdom and expertise on the part of psychiatrists:

As psychiatrists the desire to act, to want to wish the symptoms away is extremely powerful. It is surely understandable to wish people’s pain and the delusions away. But as I so often say to my students, you have to learn to let go, learn to just accept and make peace with what is. This involves humility...It involves facing the fact that we are not god. But I think in accepting suffering, you also encounter its limits. And in turn I think you are able to help people, and they are more willing to accept that help.

Kenneth: *“How to put the pieces of their lives together. That’s what seems to matter”*

Kenneth is a psychiatrist working in Lagos who three years ago was tasked with developing two voluntary, out-patient psychotherapy groups for people diagnosed with depression and psychosis. Kenneth explains how although he facilitates both of the groups and they take place at one of the state-funded psychiatric hospitals, they are “essentially patient-run, with the patients dictating the structure and nature of the groups”. When describing these groups, Kenneth spoke about his initial surprise about the high levels of patient uptake of these groups:

In the beginning, when I was introducing these groups to my colleagues, everyone had mixed feelings about it, as people thought the patients just wouldn’t come...But the patients come. The attendance rate of both groups is nearly 100% every week. And it’s remarkable because some of the patients travel quite a distance to get here for it.

Kenneth went on to describe another issue that surprised him, what he referred to as the “high levels of knowledge” amongst the attendees of the group. What intrigued

Kenneth, however, was that that “for them it’s not really about that, you know knowing those kinds of things”. As he explains:

People always seem a lot less interested in you know, the diagnosis, the treatment, even the side-effects, and a lot more on what it all means for them. How to put the pieces of their lives together. That’s what seems to matter. How to make sense of what is happening to them...

This issue of searching for meaning came up again and again in the stories Kenneth told about these groups. For example, Kenneth described how many of the attendees frequently speak about visiting a traditional healer and the valuable forms of meanings such practitioners provide:

It seems that when they go to the healer, he tries to help them understand what might be happening to them...he invests their affliction, their symptoms with significance. Like hearing voices becomes ancestors speaking...And in this way, maybe their experiences change from being something problematic, to a more confirming and meaningful experience. And maybe this brings them some kind of relief to the pain and conflict they are experiencing...

In a similar manner, Kenneth recounted an incident that occurred during one of the groups, one which he “will always remember”:

During the meeting, this guy suddenly went into labour and started lying on the floor, screaming and having the whole labour pains...And all the patients kind of gathered round, and they wiped his brow and everybody was running to get towels and trying to calm him down and everyone was laughing and clapping...And of course that just passed, and we all just got on with things.

When I asked Kenneth if he could say more about why this incident stuck out for him, he explained:

I suppose just the way people accepted and supported this man. You know, really comforted him...Like nobody was saying ‘you mad you mad’...Everyone just accepted this man...I suppose a lot of the time when

they come to us I don't think they feel all that supported or comforted...Many of our patients actually hate us. They think we are tyrants. They want to get away from us. And maybe they are right...

For Kenneth then, patients' may be less interested in, and motivated by, a desire to identify and treat the signs and symptoms of their illness, and more about having forms of care which are confirming and meaningful; which provide nurture and support. Ultimately, what Kenneth appeared to be suggesting is that the underutilization of mental health services may be less about people's supposed lack of knowledge, and more related to the inadequacy of services in addressing the actual needs and priorities of those they are attempting to help.

Sheila: *"Every healing system has potential goods and bads"*

Finally, there was Sheila, a psychiatrist who manages one of the in-patient departments for women at a large psychiatric hospital in Cape Town. During our interview, she spoke in detail about a particular case which she described as "an enormously moving and humbling experience...which has become a source of great wisdom for me". This case involved a woman who was admitted to hospital after she disclosed to a social worker that she wanted to kill her baby. When Sheila met this woman, she thought that this woman had a clear case of postnatal depression, and therefore prescribed psycho-education for her and weekly role modelling sessions in order to enhance the mother-infant bonding. After six months, the mother appeared much better, and was therefore discharged. One week after she was discharged, however, the mother poisoned her baby and was subsequently imprisoned.

With great sadness, Sheila recounted how over the years she visited this woman in prison, and "gained a better understanding of what she was trying to tell me, but sadly my insight came too late". When she took the time to properly listen to this woman during the prison visits, she learnt that she was a married woman from an extremely impoverished family. In needing additional income, this woman accepted a man's offer to pay her for a sexual favour, through which her baby was conceived. As this baby was not her husband's blood-child, it was subsequently rejected by her family. The baby was therefore not introduced to his ancestors, and would therefore be unable to go through the formal rituals of childhood and adolescence, and would

ultimately never be considered a true man in the community. Sheila described how when she initially saw this woman, she had not properly understood “the more profound layers of meaning of her struggle than merely a nonattachment to her baby”:

My view in retrospect was a rather superficial and simplistic one...as though it would suffice to teach her about the importance of attachment...Had we looked more carefully at the pieces of the puzzle, perhaps this devastation could have been prevented.

She went on to describe how a superficial understanding of patients is not enough if one is to fulfil the function of a therapist and patient manager: “we need to properly see our patients, or else we will inevitably fail them”. According to Sheila, genuinely ‘seeing’ patients necessitates health care providers taking a more humble and less assuming approach, or as she puts it “it means starting off on the same level, rather than from a superior, inflated position...it means accepting that maybe our patients have real insights that we need to take seriously”. Sheila described further how when this mother was admitted, she kept emphasising to the nurses that she needed to speak with a traditional healer, something which was generally dismissed. Sheila explains how this experience “opened my eyes to the important role traditional healers might be able to play...they could have helped us with understanding and maybe addressing this woman’s situation”:

I actually presented this case at the traditional healers’ conference last year. And just to say, I was the only psychiatrist there. Like there is all this talk of the need for collaboration but this was a conference, organized by traditional healers, and no psychiatrists came...Anyway, it was amazing...some of the healers came to me afterwards, they were very moved, and they said to me that, next time, you phone us. We will work together.

Sheila spoke in considerable detail about how in attending this conference she came to realise that, despite ubiquitous talk of the need to work with traditional healers, there has been very little attempt on the part of mental health professionals to genuinely understand the practices of such healers, on their own terms. She went on to describe how since this conference, she has sought to better appreciate and work

with various traditional healers. For example, she described a particular case, which involved a suicidal 12-year old girl who was having very disturbing dreams calling her to become a healer:

I phoned one of the healers I had met at the conference, and consulted with him, and asked how often they have a 12-year old with a calling. He said it is very rare. But said I should get the mother to phone him, which I did... They had a long conversation, after which he was convinced that the dreams were not a real calling. So, they did what they needed to do... They did a blocking ceremony and he counselled the girl... I'm not sure what the advice was, but the anxiety left.

In talking further about the need for psychiatrists to be more open to “genuinely working with healers”, Sheila emphasised:

Obviously there are charlatans amongst traditional healers, but there are also some precarious psychiatrists. Every healing system has potential goods and bads. But we just automatically assume ours is more civilized... We are so arrogant and as a result, we never really learn the potential of some healers...

A critical, phenomenological paradigm

During the interviews with Jeff, Kenneth and Sheila, I was taken on a journey to a place which felt far away from the world of biomedical science. I heard about intractable suffering, about unimaginable experiences, about ancestors and blocking ceremonies, about caring and about limits. In the stories these psychiatrists told, very different sorts of assumptions and thinking about the ‘gap’ in mental health care from what we saw previously emerged. These psychiatrists operated within an alternative knowledge framework, one which could be understood in terms of the tradition of phenomenology (Husserl 1972), and in particular the kind of thinking associated with French philosopher Merleau-Ponty (1962; 2004).

At the core of a phenomenological perspective is an attempt to understand and do justice to the enigmatic ways in which people live and give meaning to their worlds (Jackson 1996; Matthews 2002). It is based upon the premise that all forms of

knowledge and experience are potentially significant and consequential, and should thus be taken seriously in their own right (Husserl 1972; Merleau-Ponty 1962; 2004). It is also based upon the assumption that our ways of knowing and being in the world are inherently complex and unpredictable and thus defy the ahistorical and universalistic form of rationalism exemplified by biomedicine. We are “active, purposive beings who have thoughts about the world, respond to it emotionally and imaginatively and who act on it sometimes deliberately, sometimes unthinkably” (Matthews 2002, p.49). From this perspective, in order to understand and do justice to the complex and enigmatic ways in which people act and give meaning to their life-worlds, necessitate that we try to loosen our ties with the dominant scientific theoretical structures that shape how we look at the world (Merleau-Ponty 1962; 2004). This does not mean abandoning scientific knowledge and practices, but rather about challenging the “dogmatism of science that thinks itself capable of absolute and complete knowledge” (Merleau-Ponty 2004, p.45/43).

These kinds of assumptions resonate strongly with the stories Jeff, Kenneth and Sheila told. In their narratives, mental illness materialised as inherently enigmatic and enduring, and most importantly, a deeply personal and private phenomenon. Indeed, what was most striking about the stories they told was that they were not chiefly interested in evaluating the supposed ‘truthfulness’ of their patients’ experiences or meanings, leaving such questions respectfully aside. Rather, they practiced a kind of “practical relativism” (Jackson 1996, p. 10) characteristic of phenomenological philosophies, whereby the emotional, the moral, and the subjective were conceptualised as potentially real and important forms of knowing and being.

In taking people’s experiences and meanings seriously, on their own terms, these three psychiatrists came to appreciate that people’s understandings and behaviours are deeply complex and varied, affected by all sorts of social, cultural and emotional realities and rationalities. More specifically, what emerged most prominently in the stories I was told, was that contrary to what one might assume, the wish to eradicate symptoms and become ‘disease-free’ may not be what is most desirable, and may not be what ultimately motivates service users’ actions. Rather, what may be more important includes, for example, finding meaning, acquiring a space for suffering, developing ways of living with difficult experiences, affirmation, acceptance and

comfort, and forms of care which are sensitive to the socio-cultural attachments people hold and supports the collectivities to which they belong.

The importance of these ‘alternative’ kinds of priorities and value-hierarchies has also been suggested by a number of ethnographic studies conducted with people with mental illness, and their families, in various low-and-middle income countries (See Cooper 2014 for a detailed description of this research). This research revealed how a focus on signs and symptoms defined in generic terms may not capture those aspects of well-being and recovery that are most significant to patients and their families, and which fundamentally shape their care-seeking itineraries. These may include, for example, a concern for the moral dimensions of sickness and suffering, a restoration of social functioning, the attainment of positions in which valued forms of subjectivity can be exerted, and the value of spiritual strength and coherence. What was revealed by the stories Jeff, Kenneth and Sheila told was these more qualitative and less tangible ‘things’ are not ‘decorative’ additional things that might make care practices more pleasant or humane. Rather, these things may inform the logic behind the therapeutic choices people make, the extent to which the care provided will be beneficial and, as exemplified by the case recounted by Sheila, may ultimately be implicated with matters of life and death.

In appreciating the idiosyncratic and complex nature of human beings, Jeff, Kenneth and Sheila also consistently act against the rationalist fantasies of biomedicine. Indeed, I was struck by how they regularly spoke about the uncertain and limited nature of biomedical knowledge and practices. For them, this partiality was not because there is currently incomplete knowledge, something which will be rectified in time as biomedicine progresses. Rather, bodies and minds and needs and actions are complex and thus transcend the capacity to be fully understood and known in rationalist terms. At the same time, the often chronic nature of mental illness means that there is invariably a limit to what can be done. For these psychiatrists, when dealing with complex, mysterious and chronic conditions, total control is ultimately never possible. This kind of understanding is what lies at the heart of Merleau-Ponty’s phenomenological perspective, one which appreciates that the world in which we inhabit “lends itself to unending exploration; it is inexhaustible... always incomplete, temporal and indeterminate” (Merleau-Ponty 1962, p. 378).

In resisting bounded and totalizing accounts which create an illusion of certainty and order, these three psychiatrists were able to imagine that ‘other’ healing modalities and therapeutic resources may benefit. The polarization constructed by so many of the psychiatrists between supposed rational biomedical science and irrational ‘traditional’ practices was considerably blurred by them. In the stories these three psychiatrists told, I heard about the “limits” of biomedical knowledge and practices, and about “the important role traditional healers might be able to play”. I was told about the potential “charlatans amongst traditional healers” but also about the possible “tyrannical” and “precarious” nature of many psychiatrists. Ultimately, as Sheila so succinctly put it, “every healing system has potential goods and bads”.

It is thus clear that the host of binary oppositions we saw previously were profoundly contested in these stories. No distinctions were made between interior experiences and external objects, between the subjective and objective, between knowledge and beliefs, between doctor as knower and patient as known, and between the rational and irrational. In obliterating these polarizations, Jeff, Kenneth and Sheila produced a very different kind of understanding from what we saw previously about the ‘gap’ in mental health care, and how it can be potentially reduced.

Rather than educating patients and their families, what emerged as most important was the need for service providers to understand and legitimise people’s own ways of knowing and being on their own terms, and within their own metaphysical world. For these psychiatrists, a lot is involved with being able to properly and genuinely see what people are communicating. It requires careful and meticulous listening to, and learning from, what patients and their families may be saying and trying to convey. It requires attuned attentiveness to the specific contingencies, predicaments and demands that patients present and which make-up their unique social worlds. In other words, rather than patients’ experiences and meanings being ‘worked around’, or worse yet corrected, as was suggest by the large majority of psychiatrists, these need to be properly seen and heard. And these need to be incorporated into the very definition of disease and the way it is addressed. Crucially, it is not about excluding the importance of neurological and intra-organic signs and symptoms that can be targeted through medication. Rather, it is about is rethinking how people’s needs and motivations, and the ultimate goals of mental health care are conceptualised in the first place.

At the same time, these psychiatrists highlighted the need to incorporate epistemologically diverse healing modalities and therapeutic resources when thinking about mental health care provision. Such incorporation is, however, not about bringing other healing practitioners ‘in line’ with the knowledge and practices of biomedicine, as was suggested by the majority of psychiatrists. Rather, it is about genuinely appreciating that ‘other’ healing paradigms may be helpful to people with mental illness and their families. This is also not necessarily about the syncretism or integration of different healing traditions. Rather, it involves different practitioners, who may have epistemologically diverse ways of knowing and practising, being willing to enter into *genuine* collaborations of *mutual* respect and learning.

Crucially for Jeff, Kenneth and Sheila, properly appreciating the ways of knowing and being of patients, families and alternative healing practitioners necessitates that psychiatrists cultivate a particular way of being. That is, a way of being which sincerely appreciates limitations and which ultimately learns to let go, giving up the dream of complete order and control. This way of being reflects what Merleau-Ponty (1962, p. xxiii) was getting at when he spoke about phenomenology as a “manner or style of thinking”, which is imbued with an attitude of “wonder” and “curiosity” and which can assist us in “relearning to look at the world”. That is, in unfixing habitual frames of thinking and relating, the possibility emerges for the production of potentially new forms of knowledge and practices, based upon alternative kinds of politics and epistemologies. This might enable mental health care service providers to think and function in worlds very different from the ones created by current seats of power. And this in turn might go some way towards the provision of more appropriate forms of care, ultimately helping to reduce the current ‘gap’ in mental health care so many countries on the continent face.

Conclusion

The real chance to make a difference... lies in a modest willingness to live, to know and to practice in the complexities of tension.

(Law 1999, p.12).

This study explored narratives around the ‘gap’ in mental health care amongst a selection of psychiatrists working in public health care facilities in different urban settings in Africa. The aim was to surface and destabilise some of the epistemological assumptions and power dynamics underpinning these stories. Thinking amongst the majority of psychiatrists was deeply inserted within a biomedical mode of thinking, one which is based upon many questionable assumptions, binary oppositions and Eurocentric tendencies. There were, however, cracks seeping through this master narrative. Although certain psychiatrists conveyed a degree of tension with regards to the dominant knowledge claims, there were three particular psychiatrists who operated in a qualitatively different kind of paradigm. What they articulated was not like biomedical science. But nor was it necessarily opposed to it. Their understanding sought to transcend it.

For them, the current ‘gap’ in mental health care may be less about a lack of services per se, as the majority of psychiatrists suggested, and more about a potential lack of particular *kinds* of services and particular *forms* of care. Indeed, although the majority of psychiatrists couched their proposals for reducing the ‘gap’ in mental health care in somewhat revolutionary terms, ultimately their recommendations did not embody any real departure from a biomedical mode of thinking. Such recommendations strongly echo contemporary Global Mental Health discourse, which is calling for decentralisation and task-shifting initiatives within primary health and community care settings, and for greater ‘mental health literacy’ amongst service users and traditional healers (Global Mental Health Group 2007; Patel et al 2011; Petersen et al 2011). Such discourse is increasingly being criticised for promoting forms of care in Africa that are still deeply steeped in biomedical epistemologies (Cooper 2014, In press a, b; Campbell and Burgess 2012; Mills and Fernando 2014). Many of the psychiatrists in this study were indeed intimately involved with various Global Mental Health projects in their respective countries when I interviewed them. This may, in part, explain the strong synergy between the psychiatrists’ narratives and more general Global Mental Health discourse.

According to the three psychiatrists in this current research, increasing the availability of services necessitates first and foremost rethinking the nature of the kinds of services that are expanded, and the associated epistemologies upon which these are based. Put differently, there needs to be a better congruence between

understandings of ‘legitimate’ services and ‘appropriate’ behaviours, and the ways of life and forms of meaning-making that commonly prevail amongst the people which services are attempting to reach and help. For these three psychiatrists, both the utilization and benefit of mental health care services are intimately entangled with the extent to which such services genuinely understand, and attend to, service users’ needs and priorities on their own terms, and within their own metaphysical worlds. And this ultimately encompasses more, and is more difficult, than just reducing symptoms and eliminating disease, as the majority of psychiatrists suggested.

These kinds of sentiments have recently been expressed by certain critical psychiatrists and anthropologists. For example, in their *Psychiatry beyond the current paradigm*, Bracken and colleagues (2012, p. 431) argue that there is a need for “a fundamental re-examination of what mental healthcare is all about...a radical shift in our understanding of what is at the heart (and perhaps soul) of mental health practice”. For these psychiatrists, this change in thinking is not about abandoning the tools of empirical science or rejecting medical and psychotherapeutic techniques, but about developing more nuanced forms of medical understanding and practice. Such an approach, involves “starting to position the ethical and hermeneutic aspects of our work as primary...engaging with the non-technical dimensions of our work such as values, meanings, relationships, politics and the ethical basis of care and caring” (ibid, p. 432). In a similar manner, Arthur Kleinman (2012) recently made a plea for medical education, practice and research to better foster what he refers to as “caregiving” or the “art of medicine”. For Kleinman, caring and taking care implies acknowledging the personhood of sufferers, affirming their condition and supporting their concerns about living, self, and dignity. According to Kleinman (2012, p.1551):

If caregiving is absent from discourses on health care then nothing else seems to matter. Even questions of ‘quality’ in health care become distorted. And the result is that all of us are demeaned and the profession of medicine and the processes of health care are transmuted into something that is hollowed of its humanity and moral value.

Attempts to acknowledge and attend to the personhood of patients is, however, a lot more complex than how it is currently being conceived of within contemporary public (mental) health discourse. The notions of ‘patient-centredness’ or ‘the patient

perspective' have for some time now been a key feature of public health research and practice, in an attempt to better understand and incorporate the subjective views and concerns of patients (Armstrong 1984). There is, however, the danger that the 'patient perspective' becomes yet another objectified variable. That is, it becomes a stable and predictable 'thing' which people 'have' and which can be generically captured and responded to (Armstrong 1984). As a result, all of the complex and multiple ontologies of being, hierarchies of values and socio-cultural systems that shape the nature of suffering and associated responses, are reduced to a bundle of standardized variables and discrete interventions (Kirmayer 2012; Mol 2008; Velpry 2008). Ultimately, trying to squeeze all of this complexity into simple diagnostic algorithms and standardized management guidelines is not to make it rigorous, but to mystify it, potentially producing misunderstanding and misappropriation (Kirmayer 2012; Mol 2008; Velpry 2008). At the end of the day, we are once again brought back to a distinctively biomedical mode of thinking about and providing care.

Thus, although more of the 'patient perspective' is clearly needed when thinking about the expansion and delivery of mental health care services, as suggested by the three psychiatrists in this current research, this cannot be approached through crude reductionist models. Rather, what may be most important is that practitioners cultivate a particular way of being, one which engenders greater uncertainty and doubt. This resonates with psychologist Leslie Swartz's (2007) problematization of the notion of 'competence' being widely promoted within Global Mental Health discourse, and the sense of comfort and complacency it generates. Rather than advocating for greater 'cultural competence', Swartz highlights the "virtues of feeling culturally incompetent", and how fostering such a stance of discomfort amongst mental health care service providers could fundamentally alter the way in which care is provided. Somewhat paradoxically then, what Swartz and Jeff, Kenneth and Sheila in this study are suggesting, is that uncertainty might be a precondition for assisting practitioners to negotiate more responsive and appropriate kinds of care. The trepidation conveyed by various psychiatrists in this study when expressing some of their doubts suggests that uncertainty may still too often be viewed as a problem, a shameful experience that should be quietly acknowledged behind closed doors. These silent uncertainties may thus require a space in which they can be articulated and seen. At the end of my interview with Jeff, he recited a poem he had recently created and which I have cited in the epigraph of this paper.

Now, having explored in detail the stories the psychiatrists told, I feel it is apt to reiterate the significance of Jeff's poem, which ultimately captures so much of what is at stake here:

Spider

*For me, the knowing came when psychodelia slapped me loose
and pitched me screaming as I flailed widely in desperate search for reason.*

But watching

*I realised how I floated on gentle webs of being
and inhaling*

smiled deeply as butterflies billowed by.

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9. A CONVERSATION ACROSS KNOWLEDGE SOURCES: IN SEARCH OF 'AFRICA-FOCUSED' MODELS OF SCHOLARSHIP ON THE MENTAL HEALTH 'TREATMENT GAP' IN AFRICA

Introduction

"In the late seventies I was a student of medicine and gradually got angry at the way suffering is handled in the caring professions. I realised that, basically, I wanted to react by yelling. By screaming out a revolting, inarticulate, harsh yell... Yelling, for all its loudness, doesn't carry very far though. But what other repertoires of relating to suffering are there?"

(Mol, 2001, p. 3)

In her poignant paper *Instead of Yelling*, Annemarie Mol (2001) describes her early experiences of studying medicine, and her frustrations around the ways in which suffering was being handled. Her encounters with the caring professions made her want to respond by yelling: "By screaming out a revolting, inarticulate, harsh yell" (ibid, p. 3). I too have so often felt like yelling during this research. In Chapter one I indicated that the idea for this research arose out of my growing sense of frustration with the representational politics of the field of mental health in Africa. Sadly, in delving into the 'black box' of knowledge on the mental health 'treatment gap' on the continent, my feelings of exasperation have magnified, rather than reduced.

In this chapter, I pull together some of the key themes which emerged across the different sources of knowledge analysed. That is, the knowledge produced at all three locations tended to be underpinned by a very similar set of meaning-codes and knowledge politics, epistemologies which can be understood as situated within a problematic place. It is a problematic place because (albeit unintentionally) they tend to perpetuate the legacies of colonialism and of racism, buttress common forms of privilege, and are potentially incongruent with the ways of life and forms of meaning-making that commonly prevail amongst those actually affected by mental illness in Africa. Across the three sources of knowledge there were, however, various cracks and cleavages within the master narrative. That is, the shrill and somewhat singular voice of scholarly authority was at times softened by a chorus of more marginalised voices. In this chapter I explore the enabling potential of these voices for bringing about more decolonised models of scholarship on the 'gap' in mental

health care in Africa. Ultimately, these might represent better and potentially more productive alternatives, to somewhat inarticulate yelling.

Dominance of the episteme of European Colonial Modernity

“Modernity spread out from Europe like a gigantic inkblot, covering the world and bringing us all into the same cultural condition”

(Connell, 2007, p. 54)

One of the central arguments made in this thesis is that, although knowledge on the ‘treatment gap’ is commonly assumed to be factual, when probed epistemologically, is heavily compromised in terms of Eurocentric content and orientation. In other words, I have demonstrated how the episteme of European Colonial Modernity has subtly and sometimes not so subtly, dictated the theory and research methodologies in this area. The epistemological authority of this gaze was indeed strikingly prominent and similar across the different sources of knowledge analysed, including the research, the fourteen national policies and the stories told by the majority of psychiatrists. In particular, I have demonstrated how two specific paradigms are playing a fundamental role in shaping thinking on the ‘gap’ in mental health care, which I referred to as the interrelated paradigms of evidence-based science (including biomedicine) and human rights. These particular conceptual frameworks, and associated underpinning assumptions and classification systems, were, however, ultimately black-boxed within the ubiquitous moral and scientific language of providing ‘access to care’, of promoting interventions ‘proven to work’ and of ‘advancing the dignity and liberties’ of the mentally ill.

In this research I have been disrupting the apparent self-evidence of these dominant paradigms so that they might cease to be black boxed entities. In Chapter Four, I surfaced and put into historical perspective, the epistemological assumptions and overarching system of classification underpinning these two particular paradigms. In order to destabilise their historical inevitability, I unpacked how these ways of thinking arose out of, and in turn provided an ideological basis for, many of the socio-economic forms of organization and capillaries of power characterizing 17th and 18th century Europe. In particular, I showed how the growing power afforded to them were deeply entangled with attempts in Europe to undermine the legitimacy of ecclesiastical and feudal doctrines, advance modern forms of capitalism and

and ultimately justify modernist Europe's supposed 'positional superiority'. In other words, the hegemonic status increasingly afforded to these paradigms can be understood as emanating from Enlightenment battles over the authorisation of knowledge and attempts to develop boundaries of socio-economic and political legitimacy. Ultimately, as Europe's socio-economic and political changes of the 17th and 18th centuries were consolidated in subsequent centuries, so too was the power and influence of these paradigms of thought.

In the succeeding four chapters, which consisted of four separate, peer-reviewed publications, I unpacked how this episteme of European Colonial Modernity, and associated paradigms and system of classification, are strongly mediating knowledge on the 'gap' in mental health care in Africa. Drawing on a range of Science and Technology Studies (STS) and Postcolonial theory and research, I disturbed the magic of this epistemological order further. I showed how many of the underpinning epistemological assumptions of these paradigms, including those of rationalism, naturalism, universalism and objectivity, are based upon a host of questionable and contentious certainties. Moreover, I shed light on how the dominant form of classification system mediating these paradigms is based upon all sorts of false polarisations and essentialised categories: knowledge versus belief, fact versus fiction, objective versus subjective, disease versus illness, traditional versus modern, primitive versus civilized, rational versus the irrational, Africa versus the West. I explored how these assumptions and forms of ordering may be producing misleading accounts and promoting potentially inappropriate forms of practice. In particular, I argued that such ways of thinking may be incongruent with the forms of life and meaning-making that commonly prevail amongst individuals and families actually affected by mental illness in Africa.

For example, in Chapter Eight, I unpacked how the psychiatrists tended to hold an understanding of mental illness as universally definitive, of human action as inherently rational, and of the goals of mental health care as inevitably entailing the eradication of the signs and symptoms of mental illness. I suggested that these assumptions may be obscuring the often enigmatic and diverse nature of mental illness, and insufficiently capturing the frequently complex and varied rationalities shaping service users' needs, their aspirations and the therapeutic choices they make. Relatedly, in Chapters Five and Seven, I demonstrated respectively how both

research on scaling-up the provision of mental health care services and the national policies tend to view valid services and behaviours as those which are solely based on the principles of scientific evidence and individualised human rights. I explored how these ideas of legitimacy may be incompatible with, and potentially marginalising, the more localised expressions of suffering and value-hierarchies that commonly exist amongst people mental health care services are attempting to reach and help. Similarly, in Chapter Six I demonstrated that research on ‘help-seeking’ for mental illness tended to understand how and why people do and should behave in a way which denies change, complexity and multiplicity, as well as the movement of people and things in more than one direction. Ultimately, I argued that this may be masking, and ineffectively tapping into, the existence of considerably heterogeneous local practices and multifaceted forms of meaning-making.

As outlined in Chapter Two, I had not intended, initially, to produce two separate analyses of research on the mental health ‘treatment gap’. And yet very quickly it became clear that research in this area was divided into two quite distinct focuses— one on the provision of care and how services should be scaled-up, and the second on the uptake of services, or ‘help-seeking behaviour’, and how this can be enhanced. Although my analyses followed this split, now looking back, it is evident that this division in research focus aptly reflects some of the larger issues that are at stake with knowledge on the mental health ‘treatment gap’ in Africa. That is, research on the kinds of services that should be expanded remains almost entirely detached from research on how and why people might respond to mental illness, and vice versa. Ultimately, this schism sheds further light on the kinds of dissonances that appear to exist between thinking on what needs to be scaled-up, and the kinds of practices and understandings that may occur amongst, and be important to, those actually affected by mental illness.

What should have emerged throughout my analyses is that the kinds of thinking and practices coming out of the episteme of European Colonial Modernity have undeniably enhanced and elongated the lives of many people, including in Africa. These advances cannot be overstated; there is no lip service here. For example, the randomized controlled trial, now at the heart of evidence-based medicine, has revolutionised the kinds of psychotropic drugs now available for treating a host of mental illnesses, and many people in Africa have benefitted from these (Patel and

Thornicroft, 2009; PLOS Medicine Editors, 2013). Similarly, interventions based on the principles of human rights have offered very real and important emancipatory potential for many minority groups in a diverse range of contemporary African settings (Lemarchand, 1992; Shivji, 2000; Werbner, 1995; Wilson, 2000). These sorts of advances and benefits should be genuinely recognised, celebrated and nurtured.

At the same time, however, there is a lot about the episteme of European Colonial Modernity and associated forms of knowing and being that is problematic, and which I am therefore criticising and suggesting need to be transformed. In particular, I am refusing the overarching kind of classification embedded within this episteme, one which demarcates the world into homogenous entities and stark polarizations. This form of ordering is mediated by a host of false oppositions, which ultimately perpetuate the Eurocentric legacies of colonialism and of racism, and buttress particular kinds of power and privilege. It also insufficiently captures the plural and shifting nature of meaning-making and ways of being that frequently exist amongst people, including those affected by mental illness in Africa. Ultimately, this way of ordering the world has so often led to misleading accounts and inappropriate interventions. I am therefore rejecting this classification system and its false polarisations, and arguing for the need for more fluid epistemological schema and forms of ordering.

At the same time, I am critiquing many of the epistemological assumptions embedded within the paradigms of evidence-based science and human rights, in particular, those of naturalism, universalism, objectivity and rationalism. That is, I am problematizing their premise of a reality which is *naturally* ‘out there’ and which operates according to the rational principles of cause and effect. Relatedly, I am rejecting the assumption of an inherently *universal* ‘nature’, one that is *naturally* shared by everyone, everywhere, across time and space. The world and its inhabitants (their minds, bodies, needs, desires, behaviours and so forth) are complex, unpredictable and context-dependent, and therefore cannot so easily be captured by predictive rules and universal laws. Similarly, I am arguing against the notion that the principles and methods of science are able to *objectively* and *definitively* capture and manage what is ‘out there’, and relatedly, that human rights principles represent *impartial* and *universal* moral codes. While these principles,

codes and methods may be meaningful and potentially helpful for explaining and managing certain phenomena, they are inevitably value-laden, contestable and limited. I am therefore rejecting many of the suspect epistemologies mediating the knowledge order of European Colonial Modernity, and arguing for forms of meaning-making which are based upon more desirable knowledge assumptions.

Finally, and relatedly, I am also problematizing the dominance of this particular episteme, and the forms of power and privilege and exclusion and silencing such supremacy is perpetuating. That is, there are fundamental problems with the way in which this knowledge order has become an orthodoxy, establishing itself as the sole criterion of truth claims. Such authority perpetuates certain kinds of power and privilege. It also occludes ‘other’ forms of knowledge from entering the formally accredited academic canon, and ultimately suppresses those social groups whose practices are informed by such alternative knowledges. In other words, this episteme has become the gatekeeper of knowledge, policing the boundaries of legitimate ways of thinking and, by extension, valid forms of being. I am therefore rejecting the hegemony of this knowledge order, and arguing for forms of knowledge which are more hospitable to alternatives.

Working otherwise: ‘Africa-focused’ models of scholarship

“Can we have social theory that does not claim universality for a metropolitan point of view, does not read from only one direction, does not exclude the experience and social thought of most of humanity, and is not constructed terra nullius?”

(Connell, 2007, p. 47).

So, the question is, how might we produce knowledge on the mental health ‘treatment gap’ in Africa that is based upon more fluid forms of ordering, more desirable knowledge assumptions, and which is more open to alternative epistemological codes? Emerging over four hundred years ago, the European Colonial and Modernist gaze has become extraordinarily well-entrenched, making it very hard to think differently and to know alternatives well. The search for alternative modes of meaning-making, which are not necessarily defined by this gaze, is also a perilous endeavour.

One such pitfall that emerged in this thesis is when struggles with new vocabularies and forms of expression end up returning us to the old, static and essentialised view of Africa, instead of setting us on a new path to knowledge creation. This was demonstrated, for example, in Chapter Six through my analysis of a body of research which I termed the ‘indigenous-knowledge-system’ approach. Employing the concept of an ‘explanatory model’, this increasingly popular research tradition sought to challenge the Eurocentric assumptions dominating mental health research on help-seeking. According to this research, people in Africa have their own unique ways of understanding and treating mental illness which are distinct from Western biomedical paradigms. Researchers working within this tradition argued that these ‘other’ ways of knowing and being should be the basis of mental health care provision, rather than the transfer of internationally standardised psychiatric treatments. As I demonstrated, although attempting to work against the dominant Eurocentric gaze, sadly this kind of research ultimately ended-up infusing new content into the very essentialist and polarised epistemological framework it sought to contest.

Another potential danger around developing alternative forms of meaning-making which emerged is when such alternatives enter into the formal knowledge economy, but end up being absorbed into, and transformed by, the great imperialist archive. A pertinent example of this was the notion of Primary Health Care, as explored in my analysis of the national policies in Chapter Seven. Born out of the decolonization forces of the 1960s and the grass-roots public health initiatives being pioneered in low-and-middle income countries, this concept embodied an important portal for thinking about mental health care in new and potentially decolonized ways. However, as this idea became integrated into mainstream public health discourse, it was increasingly stripped of its more revolutionary sentiments and epistemologies. Ultimately, the outcome represented what Bruno Latour (1999) calls a “Servant Narrative”. As he articulates, “this ban on the master narrative is never very effective, because, in the back of our minds, no matter how firmly we are convinced of the radical multiplicity of existence, something surreptitiously gathers everything into one little bundle” (ibid, p. 212). In other words, despite its innovative potential, the concept of Primary Health Care was ultimately sucked back into the grand, Eurocentric knowledge tradition.

Another example of such absorption into, and potential corruption by, the hegemonic epistemological order emerged out of the ubiquitous talk of ‘collaboration’ between biomedical practitioners and what were referred to as ‘traditional’ healers. Calls for such partnerships featured prominently across the three sources of knowledge analysed. However, beneath the somewhat progressive rhetoric, such co-operation tended to emerge as essentially training and educating ‘traditional’ healers in biomedicine and human rights. Thus, from this perspective, which Green (2012) refers to as the “show us that your gods exist” kind of approach, if anything outside of science is to be considered legitimate, ultimately it must be ‘proven’ by the methods and principles of science. If it cannot be ‘verified’ in this manner, ultimately it must remain in the realm of unjustified and irrational belief. Relatedly, in Chapter Eight, I hinted at the fact that the concepts of ‘patient-centredness’, the ‘patient-perspective’ and ‘cultural competence’ have undergone similar kinds of distortions and reductionisms as they have gained increased recognition within the formal knowledge economy.

The point is then that there is an urgent need for boundary pushing within the modes of knowledge creation. However the conundrum is how to develop such alternatives without falling prey to the tentacles of Eurocentric power by recourse to a mythologised indigeneity or by being consumed by the imperial dominion. In Chapter Three, I suggested that Achille Mbembe’s (2002) idea of “African Modes of Self-Writing” and Raewyn Connell’s (2007) notion of “Southern Theory” might be helpful in this regard. According to these scholars, there is a need for the African continent to find its own styles and theories of expression. That is, to develop new, locally-grown and decolonized conceptual territories and vocabularies which are centred on our continent’s own issues and needs, or as Maldonado-Torres (2007, p. 1) puts it, which are predicated on “populations whose identities, knowledges, and very existence have been systematically questioned or denied”. However, such forms of meaning-making need to be predicated upon the recognition of African identities and experiences as diverse, global and dynamic and which come forward as multiple forms of practices and knowledges. I have termed this kind of scholarship ‘Africa-focused’.

Importantly then, the development of such ‘Africa-focused’ forms of scholarship is not about unearthing or retrieving supposedly ‘authentic’ or ‘traditional’ forms of

knowledge. Nor is it about necessarily rejecting structures of thought which might originate from the geopolitical North. Indeed, throughout my research, I have drawn upon the works of European thinkers and a host of theories that might be understood as originating from the so-called 'West'. It is thus imperative not to conflate the use of 'Northern' theory with Eurocentrism, as Mbembe (2002) and Connell (2007) so pertinently emphasise. As these scholars suggest, knowledge, wherever and by whomsoever it is produced, is potentially available for transgressive, emancipatory and counter-hegemonic use. Thus, regardless of where they originate, forms of knowledge can become 'Africa-focused'. However, in order to do so, they need to be enmeshed with the heterogeneity of African realities, matrices and lexicons, and be shaped by these. In other words, it is about using whatever concepts and research tools that are appropriate to the multiplicity of issues, needs, questions and dilemmas facing the continent, regardless of where these tools might originate. Ultimately, 'Africa-focused' knowledges are 'fit for purpose'. Throughout this thesis I have placed scare-marks around the term 'Africa-focused' in an attempt to allude to the very specific and complex nature of my use of this term. That is, knowledges which are neither Afrocentric, nor Eurocentric, but 'Africa-focused'.

For scholars such as Mbembe and Connell and others, what is therefore urgently needed is careful and critical thinking about what kinds of methodological processes and conceptual resources might help produce such models of scholarship. Obviously, there are likely to be multiple and varied tools of this kind, and it would be problematic to suggest that one or other is *the* correct one. This would be to proclaim some newly captured moral high ground, and ultimately risks setting up a new kind of knowledge orthodoxy that I have been arguing against. Rather, it is about opening up questions around what kinds of tools might hold promise for facilitating such potentially transformative, 'Africa-focused' models of meaning-making. Various possibilities emerged in this regard in my research. That is, seeping through the loud master narratives, there were somewhat softer and more marginalised voices that suggested particular avenues out of which new, decolonised forms of knowledge on the 'gap' in mental health care might be able to grow. It is these possible opportunities which I wish to unpack further in the remainder of this chapter.

Ethnographic articulations: Tapping into mess, complexity and heterogeneity

“My plea is for another kind of science which reclaims the art of dealing with what is messy not as a defect but as what we have to learn to live and think in... something more similar to the slow knowledge of a gardener than to the fast one of the so-called rational industrial agriculture...”

(Stengers, 2011, p. 12)

One important chorus that was heard amongst the more muted voices in this thesis was that people’s mental health care needs and therapeutic itineraries are messy and shaped by a range of heterogeneous and multifaceted elements. Most importantly, what emerged was that the familiar kinds of enumerations and abstractions of evidence-based science are ultimately unable to deal with or adequately encapsulate all of these diversities and complexities. Thus, what this suggested is that producing more appropriate, ‘Africa-focused’ models of scholarship on the ‘gap’ in mental health care requires resources which might help us better see and think through the diverse, the fluid, the complex and the messy. As John Law (1999, p. 11) so eloquently writes:

How to talk about something, how to name it, without reducing it to the fixity of singularity or simplicity? How to resist the singularities that are usually performed in the act of naming? How to defy the overwhelming pressures on academic production to render knowledge simple, transparent, singular, formulaic?

One potentially promising tool which emerged in my research was critical ethnography. The ethnographic method, when done well, offers an important resource for imagining situated understandings, heterogeneous practices, and throws-up correspondingly important questions related to micro and macro processes and their interrelations (Chua, High and Lau, 2008). Ethnography attends meticulously to details and specificities; to the apparent banality of ambivalent small things. Such an approach provides rich stories about the ways in which mental well-being are understood, practiced and conceptualized within specific contexts and situations. It foregrounds careful attention to the diverse and complex ways in which people make sense of daily life in the face of illness, and locates such sense-making and associated practices within larger economic, political and historical forces (Mol, 2006;

Strathern, 2008). Ultimately, as a particular method, ethnography generates a kind of complexity that rationalisation cannot flatten out or sanitise (Mol & Law, 2004).

In Chapters Five and Six, I shed light on how a small body of mental health research is employing ethnographic methods to explore the lived experiences of individuals and families struggling with mental illness in various low-and-middle income countries. This research has shed light on the complex and diverse kinds of priorities and value-hierarchies that are significant to patients and their families, and which might shape the therapeutic choices they make. Yet as I and others (Horton, 2013, White & Sashidharan, 2014a,b) have argued, this kind of in-depth, ethnographic research is still scarce within the field of mental health research, particularly in Africa, and has so far remained a relatively untapped and marginalized resource within Global Mental Health research.

What I suggested in Chapter Six, through my analysis of Read (2009, 2012) and Devisch et.al's (2001) recent ethnographic research in Africa, is that what is at stake here is more complex than just the need for more in-depth, qualitative modes of understanding, although clearly this is required. Rather, what also matters are the underlying systems of classification which are mediating the research processes and shaping the nature of the knowledge outcomes. In other words, there is a need for more careful thought around how concepts are framed and entities are categorised, irrespective of whether one employs qualitative or quantitative approaches or a combination of the two. What was significant about both Read and Devisch's and colleagues' ethnographic research was that no rigid categories were used which smoothed out paradoxes, leakages and frictionalities. Rather, people were represented as moving between diverse healing modalities and as holding many overlapping and seemingly contradictory needs and priorities. The logic was one of multiplicity, with people seen to be living in a syncretic world in which both divinities and psychotropic medicines could be simultaneously combined. Moreover, different healing modalities were conceptualised as essentially intersecting, fragmentary and limited; as diverse entities filled with inevitable gaps and contradictions. These researchers thus transformed the ways in which cultural geneses and influences were configured, employing what can be seen as more partial and provisional forms of categorization.

As such, this research captures what Donna Haraway (1991, 1992) is getting at with her concept of *articulation* as an alternative to rigid classifications. Haraway (1991, p.321) is grappling with how we might “design classification systems that do not foreclose on rearrangements suggested by new forms of social and natural knowledge”. For her, the idea of articulation might present a malleable and more dynamic form of coding in comparison to classification. According to Haraway (1992, p. 324) “To articulate is to signify. It is to put things together, scary things, risky things, contingent things”. To articulate is thus to make links and alliances that are contingent and temporal, rather than fixed. It involves reordering the neat categories through which we understand reality, joining and putting together, for example, science and faith, Africa and Europe, modern and traditional, global and local. Ultimately, though such articulation, we might be taken into a world quite different from the one imagined by the epistemological order of European Colonial Modernity. As Haraway (1992, p. 324) describes:

An articulated world has an undecidable number of modes and sites where connections can be made. The surfaces of this kind of world are not frictionless curved planes. Unlike things can be joined-and like things can be broken apart- and vice versa. Full of sensory hairs, evaginations, invaginations, and indentations, the surfaces which interest me are dissected by joints.

Thus, what Donna Haraway, Read and Devisch and colleagues are all suggesting is that research which employs more provisional forms of coding might help us to shift the grounds on which questions are posed and recommendations are provided. These more tentative expressions or “friction-generating articulations” (Haraway, 1992, p. 321) are underpinned by alternative sorts assumptions to those which are presumed in the episteme of European Colonial Modernity about the kinds of selves, objects and their relations, and how they can be known. Ultimately, in resisting bounded and totalizing accounts, these more conditional modes of expression hold great potential for articulating mental health and recovery in Africa through potentially more appropriate configurations and along new epistemic lines.

Critical phenomenology: Taking ‘other’ epistemological worlds seriously

“The point is not to declare war on the conventions that bind us, the habits that enable us to be characterized. Instead, it is merely to place on the same level – that is, in adventure – all of our judgements, or our ‘as is well knowns,’ and thus to separate them actively from what gives them the power to exclude and to disqualify”

(Stengers, 2014, p. 27)

Another directly related tune that was heard amongst more marginalised voices in my research was that mental wellbeing and recovery frequently incorporate dimensions of life that are of a tacit, spiritual, emotional, experiential, and embodied nature. As with the messy and heterogeneous, these aspects emerged as similarly lying outside of a scientific metaphysical world and thus also not segueing easily into scientific schema. As such, if we are to develop more ‘Africa-focused’ forms of scholarship on mental health, we require tools which might help us better capture, and genuinely appreciate, these alternative ways of knowing and being on their own terms. In other words, how might we transform the dominant intellectual reflexes which compulsively relegate these ‘others’ to the realm of subjective belief, irrationality or hocus-pocus?

What is at stake here encompasses more, and is more difficult than just tolerating ‘alternatives’, or what Isabelle Stengers (2008) calls, ‘the curse of tolerance’, now so common amongst cosmopolitan multiculturalists (see also Latour 2004 who makes a similar argument). For Stengers (2008, p. 51), toleration is to be “part of a milieu that refuses ‘them’ the power to have us thinking and feeling, a milieu that claims it has no need or use for what they propose”. In grappling with how we might develop a different kind of intellectual milieu, Stengers (2012) talks about the need to “reclaim animism”. This is a particular kind of knowledge ecology which refuses the modernist and colonial intellectual heritage that “characterized its ‘others’ as animists” (ibid, p. 1). To reclaim animism is, for Stengers, about discovering the capacity to honour experiences and forms of meaning-making which are “not ours...to have ‘them’ making us thinking and feeling and wondering” (ibid, p. 7). In other words, it is about considering how we might be touched by the divine and allow the gods, the spirits and the supernatural to enter into the archive of intellectual knowledge. As Stengers (ibid, p. 8), so eloquently puts, “We need to discover how to

be compromised by magic”. Ultimately, we require theoretical vocabularies for ‘reclaiming animism’, for properly seeing, engaging with and being compromised by ‘other’ ways of thinking and being on their own terms, and within their own metaphysical worlds.

What emerged in my research is that phenomenology, and in particular the more critical tradition associated with French philosopher Merleau-Ponty (1962, 2004), might offer useful resources in this regard. Phenomenology has indeed been proposed by various critical medical anthropologists as a useful theoretical vocabulary for developing potentially transformative forms of clinical practice and research (for example Devisch, 2002, 2006; Devisch & Brodeur, 1999; Good, 1994; Jackson, 1996, 1998; Mimica, 2006, 2009; Weiss & Stanek, 2006). As Jackson (1996, p. 6) articulates, critical phenomenology seeks to “abandon the conceptual baggage inherited from colonial and imperial discourse” and holds great potential “for freeing us to experience other worlds from the ground up, as it were”. In Chapter Eight I explored phenomenology as a particular paradigm of thought, something I would like to expand upon here and in particular, the enabling potential of this approach for bringing about new, ‘Africa-focused’ forms of scholarship on mental health care in Africa.

As highlighted in Chapter Eight, at its most basic level, phenomenology is the study of lived experience (Schwandt, 1994). It seeks to describe and understand the lived complexity of experience, giving equal importance and attention to all forms of human experience including the “active and passive modes, facts as well as fictions, the precarious as well as the certain, the idiosyncratic as well as the shared” (Jackson, 1996, p. 25). More specifically, phenomenology seeks to return to what Merleau-Ponty (1962, p. xi) calls the “things themselves”. The ‘things themselves’ are people’s lived experience, in their immediacy, before they are imbued with any particular theoretical explanation. These ‘things themselves’ in their entirety in turn make-up the phenomenological notion of the “*Lebenswelt*” or “life-world” (Romdenh-Romluc, 2011, p. 12). This ‘life-world’ is the everyday world that we live and experience and inhabit- that domain of “everyday immediate social existence and practical activity, with all its habituality, its crises, its vernacular and idiomatic character, its biographical particularities, its decisive events and indecisive strategies” (Jackson, 1996, p. 8).

Phenomenology is thus about accessing, articulating and understanding people's life-worlds, within their own epistemological rationalities. Phenomenology is therefore not chiefly interested in questions related to the rational or ontological position of people's ideas and beliefs (Jackson, 1996, 1998). This is not to say that phenomenological enquiry discards the notions of 'truth' and 'reality' (Carman, 2008; Matthews, 2002). Rather, it undertakes what Jackson (1996, p. 10) terms a kind of "practical relativism" as it were, adjourning such questions temporarily. It is based on the assumption that beliefs can be significant and consequential, even if we consider them to be epistemologically superfluous. It is about taking these experiences seriously, trying to understand them in their own right (Carman, 2008). Ultimately, as Jackson (1996, p. 2) most aptly articulates, what phenomenology stands against is the "fetishization of the products of intellectual reflection" which identifies particular domains of experience and certain worldviews as legitimate means to accessing the 'truth', while disparaging or ignoring others. As such, phenomenology is about, even just momentarily, legitimizing all modalities of human experience and trying to make sense of them in their own right, without first and foremost evaluating them from a particular intellectual perspective.

Now, in its more traditional sense, as articulated by Husserl (1972), the so-called founder of phenomenology, in order to adequately describe and understand the 'essence' of directly experienced phenomena, one must "bracket" or "put in parentheses" all of one's own conceptualization, common-sense biases and theories (Matthews, 2002, p. 26). Only then, Husserl argued, can one properly understand and appreciate the 'things themselves'. This form of phenomenological reductionism or what Husserl called the "phenomenological epoche" was rejected by Merleau-Ponty (Carman, 2008, p. 39). Although highly influenced by Husserl's thinking, French philosopher Merleau-Ponty saw this 'epoche' as idealistic and unattainable. He argued that it is not possible to obtain a kind of "absolute subjectivity" whereby one "separates out the world itself from the world as meaningful to me" (Matthews, 2006, p. 17). We cannot totally withdraw our self and our ideas from the world, Merleau-Ponty argued, as we have an inescapable involvement and interdependency with the world. Rather, for Merleau-Ponty (1962), returning to the 'things themselves' requires that we try to loosen our ties, temporarily at least, from the dominant theoretical structures that shape how we look at the world. This loosening may in turn assist us with seeing and trying to understand the world with an attitude

of “wonder” and curiosity (Merleau-Ponty, 1962, p. viii). As he describes in the preface of *Phenomenology of Perception*:

Reflection does not withdraw from the world towards the unity of consciousness as the world’s basis; it steps back to watch the forms of transcendence fly up sparks from a fire; it slackens the intentional threads which attach us to the world and thus brings them to our notice... it reveals that world as strange and paradoxical... in order to see the world and grasp it as paradoxical, we must break with our familiar acceptance of it... (ibid, p. xv).

Phenomenology then, as Merleau-Ponty (1962, p. viii) conceives it, is a “manner or style of thinking” which can assist us in “relearning to look at the world” by making it ambiguous and perplexing and thus unsettling our received ways of knowing. For Merleau-Ponty, one of the main ‘intentional threads which attach us to the world’ is that of scientific schematization and logic. Thus, he argues that “returning to the ‘things themselves’, is from the start a foreswearing of science” and its dominant conceptual systems and values (Merleau-Ponty, ibid, p. ix). Importantly, Merleau-Ponty is not arguing that scientific knowledge should be abandoned. Rather, what should be challenged is the “dogmatism of science that thinks itself capable of absolute and complete knowledge” and which thinks itself “entitled to deny or rule out as illusory all forms of inquiry that do not start out from measurements and comparisons and, by connecting particular causes with particular consequences, end up with laws such as those of classical physics” (Merleau-Ponty, 2004, p. 43).

In an attempt to ‘challenge the dogmatism of science’ Merleau-Ponty’s (1962) phenomenology proposes a particular way of thinking about experience and meaning-making. For him, human understanding does not consist of indirect and passive ‘thought-like’ representations, sharply delineated from ‘reality’ (Matthews, 2002). Rather, our sense of the world comes from the fact that we live and act and interact and feel and think and move *within* this world, or as Merleau-Ponty describes it, it emerges from our ‘being-in-the-world’. Moreover, this ‘being-in-the-world’, according to him, is seldom a case of individuals acting alone, but is predominantly *in* situation, between people and in relation to others. That is, our understanding of ourselves and the world is “through and through compounded of

relationships”, always in a dialectical space of interaction with others (Merleau-Ponty, 1962, xiv).

For Merleau-Ponty, ‘being-in-the-word’ also has a corporeal dimension. In other words, our bodily, non-cognitive dispositions and capacities incarnate our lived experiences and thus constitute our perceptual world. As Merleau-Ponty (1962, p. 162) puts it, “Our bodily experience... provides us with a way of access to the world and the object... We are in the world through our body... the body is a natural self, a grouping of lived-through meanings”. Thus experience and meaning is not solely sensory, nor intellectual, but also bodily. Finally, according to Merleau-Ponty, this ‘being-in-the-world’ inevitably transcends our capacity to know and understand it fully. As he puts it, the world which we inhabit “lends itself to unending exploration; it is inexhaustible” (ibid, p. 378). Ultimately, our involvement with, and understanding of, the world are thus continually emerging or ‘becoming’, and thus always somewhat incomplete, temporal and indeterminate.

This phenomenology developed by Merleau-Ponty may thus represent an alternative kind of conceptual framework to the dominant, Eurocentric ones. As suggested by Jackson (1996), this paradigm proposes a way of thinking about experience and meaning-making which transcends the labyrinth of dualisms and rationalistic assumptions purported by the episteme of European Colonial Modernity. That is, no polarizations are constructed between interior experiences and external objects; between the reasoning mind and the unreasoning body; between subjectivity and objectivity; between subject and the world; between self and others; between supposed facts and supposed subjective beliefs (Carman, 2008; Matthews, 2002). Rather, existence and understandings are “Both intentional and bodily, both sensory and motor, and so neither merely subjective nor objective, inner nor outer, spiritual nor mechanical” (Carman, 2008, p. 78). As such, his philosophy opens up the space for ways of knowing and dimensions of life that are constituted in, and articulated through, modalities that go against the totalizing grain- the bodily, the sensorial, the emotional, the sacred, the imaginary and the even fantastical (Devisch & Brodeur, 1999).

Moreover, this understanding of existence being a space of ‘inter’ resonates strongly with common conceptions of identity and agency in Africa which frequently

emphasise relatedness rather than individuality (See Nyamnjoh, 2002 for a nuanced analysis of the primacy afforded to ‘relatedness’ in many understandings of the world and subjectivity in Africa). Finally, at the heart of Merleau-Ponty’s phenomenology is the value of genuinely acknowledging our gaps, our blanks and our ultimate un-knowingness in understandings of ourselves and others. Ultimately, this recognition of the limits of our knowledge fundamentally interferes with the kinds of certainties that are so embedded in the epistemological order of European Colonial Modernity.

As I demonstrated in Chapter Eight, the stories that were told by three particular psychiatrists, Jeff, Sheila and Kenneth, appeared to operate within this critical phenomenological tradition associated with Merleau-Ponty. Deeply embedded within this paradigm of thought, their thinking transcended many of the limitations of the master biomedical narrative and associated epistemologies. In undertaking the kind of ‘practical relativism’ associated with phenomenology, these psychiatrists were able to tap into, and sincerely appreciate, the many personal, emotional, moral, spiritual and socio-cultural dimensions of knowing and being that may be important to people affected by mental illness in Africa. Moreover, these three psychiatrists consistently acted against the rationalist fantasies of biomedicine, genuinely recognizing and incorporating into their practices, the inevitable partialness of medical science. In fact, much of their understanding related to the humility they have developed around what they know and what they can ultimately do.

In appreciating the diverse and complex nature of human beings, and the limits of biomedicine, these three psychiatrists’ thinking around the ‘gap’ in mental health care was very different to the more dominant kinds of views. For them, there is an urgent need to rethink how people’s needs and motivations, and the ultimate goals of care are conceptualized in the first place. Moreover, according to them, thinking around the ‘gap’ in mental health care requires transforming the ways in which we understand, and potentially learn from, ‘other’ healing systems which may be based on different kinds of epistemologies to biomedicine. Possibly most importantly, for those three psychiatrists, there is a need for greater humility on the part practitioners. That is, for them, it is important for service providers to cultivate a particular way of being, one which engenders greater uncertainty and doubt. And this incomprehension, this acknowledgement of only partial understanding, needs to

become woven into service providers' practices. So, what Jeff, Sheila and Kenneth were articulating is that thickening our knowledge and associated practices around the 'gap' in mental health care should be about less and not more, perhaps paradoxically, it is about fostering a gap in *knowing*. In other words, it is about those in current seats of power having less certainty, less conviction and greater admission of ignorance. Ultimately, it is through this uncertainty that a space is potentially opened for new forms of thinking and alternative sorts of practices to grow and become part of the clinical exchange.

Moving from a knowledge monoculture to an ecology of knowledges

“The critical strategic capacity to allow the comparative evaluation and growth of diverse knowledge traditions with differing epistemologies and ontologies, with differing ways of understanding and framing the world, may be humanity’s last hope for a future”.

(Turnbull, 2009, p. 4)

What is therefore clear is that there are more ways of seeing the world and expressing it than the gatekeepers of dominant knowledge producing systems would have us believe. If these other ways of knowing and being- the messy, the complex, the contingent, the tacit, the spiritual, the associative, the experiential, the visceral, the relational and so forth- are to possess any kind of power and influence, then something profound has to change within the centres of power themselves, and not only on their margins. That is, if we are to shift the epistemological privilege granted to Eurocentric forms of meaning-making to more 'Africa-focused' models of scholarship, then the canon of academic knowledge needs to be more democratic and epistemologically inclusive. This is indeed what various scholars are getting at when they assert the need for a “plural ecology of knowledge” (Nandy, 1989) a “polycentric global epistemology” (Maffie, 2009) or a “cosmopolitan ecology of knowledge” (De Sousa Santos et al., 2007). For such scholars, this kind of ecology of knowledge would be one which welcomes a wider range of knowledge practices and sources, is more “hospitable” to different iterations of reason and the reasonable, and ultimately enlarges its understanding of scholarly acceptability (Green 2009, p. 4).

The creation of a more open and hospitable knowledge archive is, however, a slippery task and inevitably faces the now widely debated and controversial issue of

relativism. That is, do appeals to knowledge diversity and inclusivity open the floodgates? Do we now live in a relativist world? Does this deny the possibility of choice, judgement or assessment, a kind of ‘anything goes’? In this thesis, I have argued that relativism is not a good option. For example, in my various analyses I shed light on the case of HIV/AIDS in South Africa to suggest that, within the context of very real suffering and limited healthcare resources, the dangers of taking a relativist stance are manifold. Relativism may also be somewhat of an epistemologically suspect position. For example, Donna Haraway (1999, p. 178) sees relativism as the “the perfect mirror twin of totalization in the ideologies of objectivity”. According to her, relativism and universalism “are both ‘god-tricks’ promising vision from everywhere and nowhere equally and fully... both deny the stakes in location, embodiment, and partial perspective; both make it impossible to see well” (ibid). For Haraway, a relativist position ultimately precludes judgement and evaluation, and as such, cannot be advocated.

Along similar lines, David Turnbull (2000) suggests that relativism is too weak an ethic, too strong an assertion of identity and a too unstable way of framing knowledge. For Turnbull, acknowledging epistemological diversity and rejecting that there are fixed or universal criteria for rationality, does not foreclose the possibility of assessment and criticism. As he suggests, no ways of knowing should be exempt from critical examination, deconstruction and interpretation. Thus, instead of accepting a single and transcendent rationality or being reduced to a feeble form of relativism, it is about taking as a question of research how we can work credibly, critically and ethically with diverse knowledge assemblages. That is, it is about fostering an intellectual project which engages with how we might rethink and rekindle the capacity to test knowledge and ways of knowing which do not straightforwardly disqualify nor valorise whatever does not fit the epistemological canon of modernity. Haraway (1999) envisions a similar kind of evaluative programme, one which she defines as “a power-sensitive conversation... which fosters a process of ongoing critical interpretation among ‘fields’ of interpreters and decoders” (ibid, p. 182) and which “privileges contestation, deconstruction, passionate construction, webbed connections, and hope for transformation of systems of knowledge and ways of seeing” (ibid, p. 178).

This kind of knowledge project is, however, almost non-existent in the field of public mental health. This is because the sorts of questions it explores are unrecognised within the metacodes shared by the majority of researchers, policymakers and practitioners alike. However, if we are to develop more ‘Africa-focused’ models of scholarship on mental health care, greater thought is required around how this kind of intellectual project and associated questions might be nurtured. Within fields of more critical social science scholarship, various researchers have started grappling with how different knowledges might be evaluated and potentially coexist. They have begun to develop certain useful conceptual resources in this regard, for example Berkes and Berkes’ (2009) “fuzzy logic”, Sillitoe and Marzano’s (2009) “linked spheres of knowledge”, Green’s (2009) “reflective equilibrium”, Elgin’s (2004) “felicitous falsehoods” and Turnbull’s (2000) “knowledge motley”. I am not going to delve into the specifics of these concepts here, as they are considerably complex and diverse. What I will emphasise, however, is that all of these scholars are in agreement that such an intellectual project necessitates starting-off from a place which recognises both the performative and representational nature of knowledge. That is, although knowledge systems may differ in their epistemologies, methodologies, logics and structures, it requires appreciating that they are all produced within specific social contexts and shaped by particular power relations and historico-political frameworks. It is only on this basis that it might be possible to compare and evaluate different knowledge traditions.

Proceeding from this vantage point is certainly a tricky move for the modern thinker, as it requires changing so many of the metaphors and narratives that lie at the heart of stories about ‘reality’. It necessitates becoming familiar and comfortable with ‘reality’, and knowledge about it, as comprising both verifiable evidence and faith, or as Latour (2010) has it, as simultaneously fetish and fact, a “factish”. This is difficult, as according to Latour (*ibid*, p. 11), “we Moderns, with our sciences and our technologies, our rights, our markets, and our democracies... are so convinced of the essential difference between facts and fetishes”. Indeed, if the findings from my research are anything to go by, cultivating such an intellectual project is likely to be an uphill struggle. But, its potential to nurture different, more ‘Africa-focused’ ecologies of knowledge on mental health care in Africa, I am convinced makes it worth the trouble.

Conclusion

“What were ducks in the scientist’s world before the revolution are rabbits afterwards”

(Kuhn, 1962, p. 111)

Let us end by returning to Annemarie Mol and her yelling. Despite her immense frustration at the caring professions, she concedes that “Yelling, for all its loudness, doesn’t carry very far” and poses the question “But what other repertoires of relating to suffering are there?” (Mol, 2001, p. 3). In this chapter I have put forward various thoughts in this regard, by suggesting certain concepts and methodological tools- ‘African Modes of Self-Writing’, ‘Southern Theory’, ‘ethnographic articulations’, ‘reclaiming animism’, ‘critical phenomenology’, ‘humility’, ‘ecologies of knowledge’ and ‘factishes’. These challenging and enticing concepts unsettle both Afro- and Euro-centricity and provide opportunities for new imaginings and understandings. Ultimately, they offer invitations to alternative kinds of questions and conversations on the ‘gap’ in mental health care in Africa, ones which might reflect different vitalities and speak to different notions of wellbeing and nurturing.

Most certainly, current demands of the global knowledge economy pose several limitations for these alternative kinds of concepts and methodologies to enter into sites of potential power and influence. Economies of scale in government, in decision making by policy-makers, in assessments by donor agencies increasingly depend upon uncontroversial, policy-relevant forms of knowledge which are based on replicable methodologies and categorical schemas. Many of the problematic features of knowledge on the mental health ‘treatment gap’ are precisely those which make them attractive to governments and donor institutions. Indeed, to-date, novel research and practice-based approaches to mental health care, which are grounded in more local, experiential knowledge, have struggled to attract research funding (Bemme & D’souza, 2012; Beresford 2012; Kirmayer 2006). And to a large extent, more critical forms of scholarship continue to be marginalised in the public (mental) health arena, still relegated to a fairly well defined circuit of institutions and journals. As such, asking current seats of power to better live with, and think in, the provisional, the heterogeneous, the complex, the ambivalent and even the supernatural, may be a tall, if not naïve order.

However, if people's needs and wants and desires, and associated behaviours, are only talked about in terms that are not relevant to their specificities and diversities, they will be submitted to regulations and rules that are foreign to them. Ultimately, as suggested by Mol, Moser and Pols (2010, p. 7) "This threatens to take the heart out of care- and along with this not just its kindness but also its effectiveness, its tenacity and its strength". Thus, if we are to address the multi-layered processes that deprive so many people in Africa the opportunities for mental well-being, then significant changes need to take place with the dominant kinds of paradigms in this area. Fortunately, despite their power, paradigms are vulnerable and inevitably do change. That is, neither the ordering, nor the order is ever entirely closed. Thus, to end on a more positive note, it is possible that anomalies will grow and that which does not 'fit' will gain increased significance within the field of Global Mental Health. And this in turn might help to bring about a cultural, political and epistemological transformation, one in which to use Kuhn's (1962, p. 111) analogy, "what were ducks before...are rabbits afterwards". Ultimately this is the hope and the dream.

APPENDICES

Appendix one: Study information sheet



Study Information Sheet

Knowledge on the Mental Health Treatment Gap in Africa

Investigator: Ms Sara Cooper
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My PhD research is exploring how the treatment gap for mental illness is being understood and addressed within post-colonial African contexts. You are one of a group of key individuals being asked to take part in my research. Before you decide whether or not you wish to take part, please read the following and contact me if you would like to discuss anything further.

What is the purpose of the study?

The purpose of my study is to gain a better understanding of how the treatment gap for mental illness is being understood and addressed within post-colonial African contexts. I am doing this by examining contemporary knowledge on this topic at specific locations- research, policy and practice. The ultimate goal is to explore how theory, policy and attendant practice on the gap in mental health care in Africa might best be articulated and addressed.

Why is this important?

Over the last decade, there has been growing international concern about what is seen as a considerable number of people with mental health problems in Africa not receiving care. Current estimates reveal that as high as 90% of people with mental disorders in low-income countries in Africa are not receiving care. This situation, now referred to as the 'large treatment gap' has in turn become a central global

health issue within health agencies and policy worldwide, with a strong international drive to reduce this current treatment gap. An increasing number of mental health policies and interventions are thus being proposed and implemented in Africa, which are focusing on improving the access and uptake of mental health services as key strategies to reduce the mental health treatment gap.

Why have I been chosen?

I am interested in hearing the personal stories and everyday experiences of psychiatrists who are working on the ground of public mental health care provision, in order to explore these professionals' understandings around why people may or may not be getting and accessing the services they require. I wish to elicit these professionals' views on key strategies for improving access and uptake of mental health services.

Do I have to take part?

No. It is completely up to you. Should you agree to take part, you are also free to withdraw from the study at any time, without having to give a reason.

What will your participation involve?

Your participation will consist of one interview, conducted by myself, Sara Cooper, a PhD student at the London School of Hygiene and Tropical Medicine. The interview will take place at a time and location convenient to you, either in-person or on the phone. The length of the interview depends on your availability, but is anticipated to be no longer than 1½ hours. With your permission, the interviews will be audio-recorded.

What are the risks and benefits of taking part?

Participation is voluntary. Talking about one's personal experiences can be difficult. As such, you are free to refuse to speak about anything you do not wish to, and you can withdraw at any time from the interview, without giving any reason. After reading through this information sheet, you will be given the chance to ask questions before signing the consent form.

You will be able to share your personal views and experiences of working in the public mental health sector, and in doing so, help me understand more about the complexities of meeting the support and help-seeking needs of people with mental health problems on a daily basis.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you should contact me using the details provided at the top of this sheet.

If you remain unhappy and wish to complain formally, you can contact my supervisor at: Dr. Nicki Thorogood, LSHTM, Tavistock Place, London WC1H 9SH. Tel: + 44 20 7927 2430; Email: Nicki.Thorogood@lshtm.ac.uk

Will my taking part in this study be kept confidential?

All quotes and other information arising from your participation in this study will be anonymised, with any identifying information redacted from all transcripts and written observations. Data will be kept in a locked filing cabinet and if material is

held on a computer, this will be password protected. Only myself, and my supervisor, Dr. Nicki Thorogood [contact details above], will have access to the original data.

What will happen to the results of the study?

Interview data will initially contribute to my PhD thesis, and may later be written up for publication in academic and professional journals. With your permission, anonymous quotes may be used in my PhD thesis, and other subsequent reports and publications.

Who is funding the research?

The study has been funded by three PhD scholarships:

1. Patrick and Margaret Flanagan Scholarship (Rhodes University, Grahamstown, South Africa)
2. National Research Foundation (South Africa) Doctoral Abroad Scholarship (GN: 75987:2011)
3. Oppenheimer Memorial Trust (OMT Ref. 19512/01)

Who has reviewed the study?

The research has been formally reviewed and approved by the Research Ethics Committee of both The London School of Hygiene and Tropical Medicine Ethics Committee [Ethics reference no. 6310] and the University of Cape Town [Ethics reference no. 162/2013].

Thank you for reading this form. Please do not hesitate to contact me if you require any further information regarding the study.

Appendix two: Interview consent form



Interview Consent Form

Knowledge on the Mental Health Treatment Gap in Africa

Investigator: Ms Sara Cooper
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Faculty of Public Health and Policy,
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15-17 Tavistock Place, London, WC1H 9SH
United Kingdom

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(UK)

I confirm that I have read, and that I understand, the Participant Information Sheet, and I am aware of what will be required of me if I take part in this study. I have had the opportunity to consider the information, ask questions about the study, and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time from the interview, without giving any reason.

I consent to the interview being audio-recorded. I understand that I can turn off the recorder at any time during the interview and that I can refuse to answer any question posed by the researcher. I agree to allow the researcher to use the information gained by my participation in the research in reports and research publications, but understand that my privacy and confidentiality will be protected at all times and that my name will not be recorded.

I give permission for anonymous quotes to be used in Ms. Cooper's PhD thesis, and other subsequent reports and publications.

I herein agree to take part in this study.

.....
(NAME IN BLOCK LETTERS)

.....
(SIGNATURE)

.....

(DATE)

As the researcher for this study I confirm that I have explained to the participant named above, the nature and purpose of the study being undertaken.

.....

(NAME IN BLOCK LETTERS)

(SIGNATURE)

.....

(DATE)

Appendix three: Interview topic guide

- 1) Introduction- who I am, what my PhD is about, why I am interviewing you.
- 2) Could you start off by telling me how you came to be working at XXX?
- 3) Can you tell me what some of your roles and responsibilities are at XXX?
- 4) Can you describe to me what a typical day at work usually entails for you?

Lead:

- *Have you had any unusual days recently?*

- 5) Could you tell me about some of the personal and professional challenges you face working here?

Lead:

- *Similar or different kinds of issues in the past?*

- 6) Are you happy to talk about some of the patients you are currently seeing?

Leads:

- *the kinds of issues the patient is presenting with?*
- *how the patient understands their issues?*
- *what forms of care you are employing?*
- *whether you feel such forms of care are working?*
- *whether the patient has consulted with any other kinds of care?*

- 7) Have you had any patient(s) recently which you found particularly challenging?

Lead:

- *Any examples from the past?*

- 8) Have you had any experiences recently with a patient(s) that you found particularly positive?

Lead:

- *Any examples from the past?*

- 9) Have you had any experiences recently with a patient(s) that you have found particularly memorable?

Lead:

- *Any examples from the past?*

- 10) Is there anything else you would like to share with me?

- 11) Thanks and debrief.

Appendix four: Studies included in the review of research on service provision

- Becker, A.E. and Kleinman, A. (2012). Introduction: An agenda for closing resource gaps in global mental health: Innovation, capacity building, and partnerships. *Harvard Review of Psychiatry* 20(1), 3–5.
- Benegal, V., Chand, P.K., Obot, I.S. (2009). Packages of care for alcohol use disorders in low- and middle-income countries. *PLoS Med*, 6, e1000170.
- Bhugra, D., & Minas, I. H. (2007). Mental health and global movement of people. *Lancet*, 370(9593), 1109–11.
- Breen, A., Swartz, L., Flisher, A.J., et al. (2007). Experience of mental disorder in the context of basic service reforms: The impact on caregiving environments in South Africa. *International Journal of Environmental Health Research*, 17(5), 327–334.
- Brijnath, B. (2011). Alzheimer's and the Indian appetite. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 30(6), 610–628.
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Appendix five: Studies included in the review of research on service uptake ('help-seeking')

Knowledge-belief-practice survey approach

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