



The Irrational Realities of a Governed Subject

POST-DEVELOPMENTAL PERSPECTIVES ON MENTAL HEALTH

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This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

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Appendix I World Health Organization Mental Health Action Plan 2013-2020

List of Acronyms

APA	American Psychiatric Association
CBT	Cognitive Behavioural Therapy
DSM	Diagnostics and Statistics Manual of Mental Disorders
GAC	Global Affairs Canada
GCC	Grand Challenges Canada
ICD-10	International Classification of Diseases and Health Related Problems, 10 th Edition
ODA	Official Development Assistance
WBG	World Bank Group
WHA	World Health Assembly
WHO	World Health Organisation

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Abstract

The relatively niche field of mental health in development studies has seen significant increased funding and the establishment of mental health as a development priority. Mental health in development contexts is often framed in terms of approaches to development prioritizing economic growth and human rights.

This paper examines the simultaneous presence of the two discourses that at first seem intuitively different. The way that the aid recipient is conceptualized ontologically in mental health development projects, according to prevalent epistemologies is examined as a potential commonality between the two approaches. Commentary is provided according to critical historical perspectives of mental illness, scientific knowledge production, and social planning.

Relevance to Development Studies

This paper argues that mental health is a growing field of development, seeing increased funding and increased attention in global development agendas. Given that the fields of psychology and psychiatry are predicated upon ideas of normal and abnormal behaviour, it is important to scrutinize the sociocultural norms and epistemologies that are being displaced by the project of modernization.

Keywords

Mental health; post-development; knowledge-production; global public health; World Health Organization; Global Affairs Canada; Grand Challenges Canada

Chapter 1: Introduction

The Author as an Inquiring Explorer

My critical dialogue with mental health started when I was quite young, but it grew in complexity due to two major influences: my professors in my Bachelor of Science psychology program who warned about the normative discursive effects of mental health, and Native Studies scholars in Canada taking medical anthropological approaches who, along with Indigenous decolonial activists, questioned the ubiquity of the biomedical model of health that psychiatry takes.

I started my Research Paper process with the intent of exploring how mental health development interventions were discussing what culturally-appropriate frameworks of healing could be. I aimed to problematize the meaning of context-specificity and cultural competency, and how these stood in relation to more decolonial, more radical explorations of well-being.¹ As I started exploring the actors involved in global health paradigms and tried to disentangle the meaning of the phrase context-specificity, I found myself increasingly disquieted by how often I encountered words like investment, productivity, or contribution. I wondered why someone's well-being was always being quantified by global currencies, work outputs, and economic growth (WBG and WHO 2016; Chisolm 2016), all with accompanying implications of social order. All of this was placed right beside the language of human suffering, compassion, and appeals to humanitarian principles.

My confusion culminated in this line I found on the development agency Grand Challenges Canada's (GCC) website (GCC ca. 2016):

“Grand Challenges Canada is dedicated to supporting **Bold Ideas with Big Impact®**. Funded by the Government of Canada and other partners, Grand Challenges Canada funds innovators in low-and middle-income countries and Canada. The bold ideas Grand Challenges Canada supports integrate science and technology, social and business innovation – known as **Integrated Innovation®**” (emphasis and trademarks in original)

I failed to understand where trademarks protecting intellectual property fit with an organization that poses itself as taking a human-centered approach to

¹ See authors such as Sue et al. (2009) speaking of the cultural biases that mental health workers may have and the adverse effects this could have on treatment. Kleinman and Benson (2006), on the other hand, discuss the weaknesses of cultural competency on a more practical and applied level.

development. I wondered, perhaps too naively or idealistically, where competition fit into a narrative of well-being.

The question then became to me, what is the definition of human being that is being used?

The Human Rights Based Approach (HRBA) has the potential to outline obligations, including non-economic ones, between actors that hold unequal levels of power (Gauri and Gloppen 2012), but this does not necessarily disrupt the power hierarchy between them and at times serves to maintain it (Rajagopal 2006). Further, the use of person-centered approaches can be used to mask ulterior motives behind interventions that serve developed countries' interests (Uvin 2007). Therefore, I wish to unpack how the language of human rights is used alongside economic justifications for intervention.

I will argue that development agencies involved in mental health interventions, no matter which discourse is chosen to justify the project, use methods of social planning that enforce, reproduce, and legitimise power hierarchies between developed and development contexts. When mental health interventions divide behaviours into normal versus abnormal and pathological versus healthy, this language strengthens the argument for the normative behaviours and cognitive functions proscribed by project objectives and predicted outcomes. Therefore, the institutions involved in funding and delivering these interventions hold incredible sway in what constitutes a healthy person, and who has value or a function in a given society or community.

My aim is to explore the power relations that maintain normative standards of behaviour in mental health. I will question the ontological lens with which aid recipients of mental health development interventions are viewed.

I argue that mental health interventions and agendas are affected by how development practitioners and scholars from dominant global and national governance institutions have viewed the aid recipient. I will also show how scientific discourse and discovery is not completely objective, and that it reflects certain values, movements, and historical contexts. In this sense, I will argue that the scientific methodology that produced a purportedly objective scientific body of knowledge took precedence over all other forms of knowing.

In short, what I wish to explore is a construction of the aid recipient as an economic actor, and how this narrative is bolstered by various dominant epistemologies.

Given the intimate nature of the philosophy of being, I have decided to make this Research Paper an active reflection of where I, with my multiplicity of roles and blurred positionalities and selves, exist within this discourse. What follows is an attempt to condense my life experience into a Research Paper crafted and authored for the purposes of my Master of Arts degree. It is a deep

examination into the construct of how the realities presented to me had shaped my personal experiences and how I myself have interacted with these realities and reproduced them with or on others around me.

Chapter 2 Theoretical Framework and Terminology: A Guide Through a Post-Developmental Critique

Theoretical Framework

The field of mental health inherently questions the ability of one person to relate rationally to an objective reality. Given that “[r]eality, in sum, had been colonized by the developmental discourse...” (Escobar 1992: 2), post-structuralist and post-developmental lenses investigating development on a discursive level will help me to explore various motivations development agencies may have in mental health.

Thus, I follow the lenses and philosophies offered by four major thinkers: Donna Haraway’s socialist feminist critique of knowledge production in the biological and ecological sciences; Foucault’s concept of governmentality and his historical mapping of Western European, sometimes more specifically French, views of madness and its heir mental illness; Escobar’s post-structuralist and post-developmental lens on planning to explore the power dynamics behind mental health intervention; and Boaventura de Sousa Santos’s concepts of an ecology of knowledge and epistemicide.

Power-Knowledge

The power to define reality through ways of knowing are equated with ways of exercising power over others (Sawicki 1991: 22; McDougall 2016: 309; Hanefeld and Walt 2015: 119). Power, in its most effective manifestation, is productive (Sawicki 1991: 21-22). Disciplinary practices may be seen as tools that repress, but it relies on divisions of normal and abnormal that must first be produced.

Naming and labelling are not mere reflections of the namer’s reality; they construct and create realities at the same time. Language is a productive tool that creates meanings, creates relationships between different objects and concepts, and critically influences how we conceptualize ourselves (Haraway 1991: 78, 81) as simultaneous objects and subjects. It is a way through which we communicate our realities with others around us, and in doing so assign value and importance to these realities. To do so, language helps communicators create categorical lenses through which we conceptualize our realities. I wish to ask how, then, does a development interventionist create a person at a discursive level? Seeing as Escobar summarizes Mohanty’s conception of the “colonialist move”, [which] entails specific constructions of the colonial/Third World subject in/through discourse in ways that allow the exercise of power over it” (Escobar 1995: 4), the Third World subject is a discursive product. It is therefore imperative to ask how these power dynamics unfurl.

Modernity and Its Relationship with Rationality

The planning project of development and modernity, as Escobar argues, relies on knowledge structures that are presented as objectively rational (1992: 140). In that sense, scientific discourse, which is itself predicated upon an attempt at objectivity, is used to bolster a sense of “modern society”. In economic growth theories that dominated development discourse in the post -World War II era of developed contexts, science was used to legitimate human capital approaches to planning initiatives.

I find it difficult to speak of development without speaking of conceptualizations of the project of modernity, as development is mobilized around the idea of problematic backward peoples in need of an enlightening and modernizing saviour (Escobar 1992: 136). Much of this is bolstered by a discourse of scientific rationality.

The standard qualification of modernity can be fairly fluidly defined depending on the aims of the standard-setter and the lens of the analyst. I would tend to follow Escobar’s view of modernity as one tied with rationality. However, Foucault also offers an interesting nuance within the mental health context. He argues that social segregation and social control is at the core of madness and that the focus of clinical psychology is to punish and correct behaviour (1988: 184). I would contend, therefore, that modernisation as it relates to mental health does lean upon rationalist observations, but that this is more so defined by the societal norms and values placed given to rationalism, rather than rationalism itself. What is key, I believe, is the assumed objectivity in scientific discourses and the value placed upon this objectivity.

Governmentality

I use a post-developmental approach to investigate the power dynamics in global agendas, more specifically in the mental health sphere. This approach uses a critical lens which I use to unpack the way in which definitions of development, modernity, and well-being are constructed, and to explore how dominant narratives surrounding these concepts continue to hold their relevance.

I follow Escobar’s poststructuralist view that “modernity and capitalism are simultaneously systems of discourse and practice” (2007: 22). I believe that the way to thinking through the question of the simultaneous dual approaches to mental health is conceptualizing how the person is viewed in governmentalist terms: a governable subject, of which the creation of the economic actor is just one facet.

The governable subject is a discursive product, created through governance institutions’ regulations and programmes (McKee 2009: 68). Values and functions are frequently riddled with implications of contributions to an unspecified something or someone. A post-developmental lens inquiring of power dynamics would help to unpack discourses beyond a literal and often essentialist interpretation, and perhaps unpack the something or someone.

Therefore, I approach the concept of a “person” here in my research paper as a governable subject, of which the economic actor/subject is just one possible manifestation. I use the term “actor” with a large caveat attached to it. My choice in using “construction” when describing the formation of an economic actor is a deliberate one, used to highlight the power that discourses have in the dialectical relationship between the namer and the named. Drawing on a governmentality framework, I view “person”, “people” and “actor” in a manner of limited agency as a way to investigate how people are prodded towards behavioural norms using the sciences of public health and psychology.

Development practitioners’ use of science in social planning leads to the impression that “social change can be engineered and directed, produced at will”, and further, that social planning and its relationship with modernity reinforces not only (mostly hegemonic) ideologies but also governable subjects (Escobar 1992: 132-133). Arguably, this could only be a dominant, hegemonic phenomenon if science and technology were the only discourses and techniques being used to spur development and social progress.

Ecology of Knowledges

One significant major problem with a dominant epistemology obfuscating other epistemologies is that there are multiple ways of interacting and forming our understanding of the world. The danger, then, is that western societies “have granted science the role of a fetish, an object human beings make only to forget their role in creating it, no longer responsive to the dialectical interplay of human being with the surrounding world....” (Haraway 1991: 8-9). We have forgotten that the practice of medicine, derived from supposedly objective means, is also at its heart a culturally-constituted “folk” model (Engel 1977: 130).

As such, I find de Sousa Santos’s concept of ecologies of knowledges to be invaluable for starting this line of inquiry. I argue that opening up the ways with which development and policy practitioners and analysts know and relate to the world would allow for different methods of relation with subjective realities. An ecology of knowledge would look beyond so-called legitimate knowledge systems. He argues that this hierarchy of knowledges results in an ignorance, and sometimes erasure, of other knowledge systems, which reflects a deep violence termed as epistemicide (de Sousa Santos 2007: 74). Given that dominant bodies of scientific knowledge, as Haraway argued (1991: 163), resulted from particular political and cultural aims to create, naturalize, and regulate an economic human, I propose that inherently, we must fundamentally question how ontological perspectives emerged from epistemic lenses. I propose that the concept of an ecology of knowledges is invaluable in unpacking how standards of behaviour, mental, and well-being came to be scientifically defined by development agencies.

Terminology, Naming, and Categorisation

The Author as a Psychological Being

As I continue to define my positionality, I do so in an additional effort to speak to the difficulty of defining mental health and well-being. My personal experiences growing up with contesting sociocultural conceptions of so-called (in)sanity and well-being inform a large part of my interest. My family had immigrated from Taiwan to Canada less than two years before I was born in Canada, with a decade's worth of a generational gap between my two brothers and me. I entered the state-funded public school system at a time when there was a de-stigmatisation of mental health. I felt these effects mainly through school officials, including my teachers, encouraging students to talk about our thoughts and emotions. This concept was quite foreign to my family members, and so I found myself caught in between two approaches to one's inner dialogue and emotional state. It became clear in my personal life that not only is there a competing definition of health and well-being, but that there are additional competing perspectives of what appropriate solutions to negative affects are – or even if they are problems at all.

Defining Mental Health and Well-Being

When I speak of mental health, I critique the World Health Organization (WHO)'s definition of mental health as:

a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. With respect to children, an emphasis is placed on the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions, as well as to build social relationships, and the aptitude to learn and to acquire an education, ultimately enabling their full active participation in society. (2013: 6)

Given that the document in which this quote appears is ratified by 194 states, and that the WHO-issued International Statistical Classification of Diseases and Related Health Problems, 10th Edition (ICD-10) is used as a diagnostics guide in the majority of its member states (WHO 2016), I will take this as emblematic of the definition used by the development actors I am analyzing, which includes the WHO.

As I hinted above, a general criticism of defining well-being is that this concept is culturally defined (White and Blackmore 2016). Even within western contexts, academics across various fields and from various theoretical tradi-

tions debate over which definition of well-being to use (White 2016). Some interventions may elide over questions like these in favour of a contextualisation of a Western biomedical framework.

When defining mental health and well-being, I refer to the work of Indigenous activists and academics from Canada who have pointed out that existing Western models of mental health do not fit with their own existing cultural understandings of wellbeing (Xaba 2007). Using these existing frameworks implies ironically, a correct way to be unwell as well as simultaneously a correct way to be well. The two are mediated, again, by a very particular method of healing that may be limited to mental and physical spheres. As argued by decolonial scholars, medical practices must include a variety of ideas of subjective emotional and psychological well-being which fall upon including different spheres that constitute a person's identity, such as ancestral relationships or relationships with nature (Quinn 2007). The effect of this acknowledgement would be two-fold: it brings attention to types of psychological suffering that may have been ignored by colonisers; it fosters the re-emergence of other methods of healing.

These indigenous scholars opened up a new line of questioning for me. Their critique of the limitation of the spheres of healing to the mental and physical also made me wonder what other spheres of experience are philosophically or spiritually entwined with healing. I believe that acknowledging these alternative forms of healing must include various ontological perspectives. For example, Kuokkannen (2000: 417) argues that Eurocentric philosophies and epistemologies relying on dualistic assumptions have precluded a variety of ontological views of the person.

I also recognize that there will be potential conflation of mental health with other terminology and phenomena. I will attempt to be as explicit as possible when speaking of mental health, but I hope that my confusion also highlights the very point that I am trying to make: my positionality will inevitably define my interpretation of well-being and its discursive effects. I will speak primarily of the medical model of mental health as situated in physical, cognitive, behavioural, psychosocial, and emotional spheres. This list is by no means exhaustive. I welcome the contestation around these terms as it is through problematizing the meanings of well being that I can arrive to my critique of the current biomedical model. My thesis will challenge the framework set up by the medical model of mental health, supported by the dominant epistemology and methodology of science, which limits itself to particular understandings of the self, health, and well-being. I am advocating instead for an expansion of different spheres of well-being. I hope that by stating this important caveat, the reader will understand that I am not providing a definitive statement for what constitutes well-being. In order to keep this as general as possible, I personally conceive of well-being as a subjectively-defined overall state of psychological satisfaction.

Medicalising Well-Being

The two main approaches to mental health can be characterized as the biomedical model and the biopsychosocial models, although the prevalence of the biopsychosocial model can be debated seeing as the biology part is still emphasized (see Deacon 2013; Gabbard and Kay 2001). The biomedical model situates the location of mental illnesses and mental disorders in biochemistry, neuroscience, and anatomy (Deacon 2013; Engel 1977: 130). Engel's seminal paper calling for a new paradigm in mental health popularized the biopsychosocial model, (Engel 1977; Gabbard and Kay 2001: 1956), arguing that while the physical body constitutes an important aspect of mental health, pure and absolute biomedical approaches tend to be overly essentialist. Consequently, the psychological and social aspects of health and wellbeing have largely been ignored. The approach taken by the WHO tends to take more of a biopsychosocial approach, with its acknowledgment that there are environmental, structural, and otherwise situational factors that contribute to mental well-being (WHO 2013: 8).

Ultimately, even though the biopsychosocial model moves away from and absolute reliance on biology, it still holds some factors in common with the biomedical model. For one, it also relies on empirically-produced data (Engels 1977), such as the holy grail of scientific methodology: randomized control trials (RCT) (Deacon 2013: 853).

Secondly, it follows a diagnosis-approach in an attempt to create a common language that would ease research and treatment, and situate it more firmly within the sciences. This approach is aided by the formation of diagnosis manuals (Deacon 2013: 853) such as the Diagnostics and Statistics Manual of Mental Disorders (DSM) formulated and published by the American Psychological Association, (APA), and the aforementioned WHO-issued ICD-10.

The last, most important point is that both approaches separate behaviour into sane versus insane, or, to use more contemporarily politically correct language, health versus unhealthy.

Mental Health in Development

I will not be so blunt as to claim definitively that conceptualising and defining well-being is in itself a colonial project; this is something that I believe warrants investigation. Before colonial encounters, societies may have normative hierarchies of normality or abnormality, or well-being and ill-being. However, although they are closely related, the effects of conceptualising well-being must be separated from the effects of the medicalisation of well-being. What I will claim is that medicalising it subsumes well-being under the sphere of intervention, as the science of human behaviour is used to correct deviant behaviours and cognitive thoughts. My argument is that the biomedical and biopsychosocial models are Western products that are currently being used and contextualized by mostly Western development agencies, who in this case of this paper are the World Health Organization and the Government of Canada. How is the medical

model of mental health reframing what is normal behaviour? Do we run the risk of restructuring societies and formulating new oppressions when we bring in a foreign definition of well-being? How is the language of ill-being and mental illness being used as justification for foreign intervention?

Discursively, this language of illness and wellness is a powerful tool. Dichotomies are a tool of domination and control in that they reduce a complexity of experiences into false binaries: true versus false, legitimate versus illegitimate, modern versus undeveloped, sane versus insane, healthy versus unhealthy. Dichotomies have been used in the modernisation project to not only divide those into ill and healthy; they also galvanize justification for intervention. As mentioned above, scientific objective rationality has been used to carve away what social planner saw to be undesired social aspects of communities and societies.

Psychological and biological corrections are used by techniques created through medical discovery and the scientific process, with wide-ranging ramifications. “On the personal level, psychiatric therapy is a species of repair work; on the social level, scientific policy dictates we use our skill to update our biology through social control. Our system of production has transcended us; we need quality control” (Haraway 1991: 35). The imagery Haraway provides here is striking. Humans are portrayed as cogs in a capitalist machine that can be corrected. Social planning and medicine are tools through which policy bodies can correct us to maximize our capacity in the modernisation project and its focus on economic development.

Dichotomies reduce a rich complexity of experiences onto reductive false binaries that impede an understanding of the diversity of ontological perspectives that could possibly be attained through the use of a “powerful infidel heteroglossia” that has the potential to subvert power hierarchies (Haraway 1991: 181).

Power in Global Public Mental Health

Shiffman (2015) suggests that one of the ways that power is maintained in global public health is the ways in which meanings and ideas are used to create categories, which in turn are used to influence the behaviour of other actors. Power and its realms of categories are integral to priority-setting in public health, as it starts to define what can be corrected. His use of the terms epistemic power and normative power also describe the ways in which global public health institutions gain legitimacy for their action. Epistemic power relies on expert knowledge for its legitimacy, whereas normative power relies on an ethical and moral superiority, which he argues happens with many rights-based approaches. It must be noted that his original commentary is limited to the biomedical. I wish to extend this to the biopsychosocial model since, as discussed above, it still relies on scientific methodological and experimental frameworks with an emphasis on objectivity.

However, this knowledge-based epistemic power and morality-based normative power are closely linked. Expert knowledge can reinforce claims of moral leadership. “Power that is not based on financial strength but on knowledge or experience (...) may provide the legitimacy to make moral claims on what is, or ought to be, on global health agendas”, although of course scientific studies and indicator measurements do take significant financial resources (Hanefeld and Walt 2015: 120). Therefore, I turn my attention to an approach that frequently takes its justification on moral and ethical grounds: the Human Rights-Based Approach.

The rights-based approach relies on claims of moral authority as it claims that there a person holds inherent rights and entitlements. A question of urgency based on humanitarian grounds is then made as legitimization for action. Moral and emotional urgency could be garnered as grounds for intervention (Uvin 2007).

Both the WHO and GAC take an interesting place here in that they both lay claims to epistemic and moral leadership. As I will discuss below, both claim to be leaders in epistemic knowledge and both claim to use a rights-based approach. The partnership between the two provide an interesting dynamic for these powers to manifest themselves.

Chapter 3 Justification and Context

The Author as the Scientific Creator of Two Dichotomous Selves

My relationship with scientific discourse and compassion in mental health is a complicated one. I completed my Bachelor of Science in Psychology at McGill University, an educational institution renowned globally for its history in neuroscience and medicine. I am still learning to be less sceptical about the Chinese healing methods that my family and I use, usually them with more confidence than me. Although I have extremely rarely sought formal medical and therapeutic assistance for many different reasons, I have mobilized scientific discourse to explain what may be considered to be symptomology consistent with anxiety and depression as defined by the American Psychological Association and the World Health Organization. I have used scientific experiments and data gleaned from scientific studies to explain that what happened to me has happened to other people too, that I am not unique in my suffering, and that my suffering was the result of the maladaptive firing of the neurotransmitters in my brain or some exogenous environmental factors, and that this source of suffering and abnormality was not inherent within me.

However, I have also had this language used against me. At its extreme, I have had close family members discount my perspectives and threaten me with institutionalisation and hospitalisation. The discourse I used to legitimate myself became the same one used to establish me as broken but fixable. My increasing discomfort in the dual effects of this discourse emerged along with the eventual realization that in my use of psychology as a defensive tool, there was a chance that I was also starting to conceptualize myself as a damaged object to be repaired. A question slowly unmasked itself in front of me, and it is one that I still struggle with to this day: do I want to be corrected if it means that in my current state, I am broken?

Mental Health and the World Health Organization

I acknowledge the possibility that mental health may be seen as a smaller niche concern of development, as spending on mental health is less than 1% of Official Development Assistance (ODA) in Canada alone. However, I will show that it is an emerging development priority and most integral to my overall argument, I will explain how it explicitly prioritizes a new sphere of development intervention on an intimate individual level: the psychological and or the cognitive. To achieve this, I will analyse the actions of the World Health Organization (WHO); Global Affairs Canada as the foreign ministry of the federal government of Canada; and Grand Challenges Canada (GCC).

I realize that the WHO is in a tenuous position right now, as its very legitimacy as a leading global public health governance agency is also being questioned (Lee and Pang 2014; Markel 2014). Despite various scholars' arguments that WHO as a global public health governance body has limited influence, I argue that within mental health, the WHO still holds much power especially considering its emerging partnership with the World Bank Group and the Government of Canada.

Emerging Development Priority

The World Health Organization

The United Nations (UN) Sustainable Development Goals (SDGs) established in 2015 have indicated in goals 3.4 and 3.5 the importance of mental health as an area of development (WHO 2017a). At the World Bank Group and World Health Organization (WHO) co-hosted conference Out of the Shadows: Making Mental Health a Development Priority in April 2016, global figures from governance institutions, which included but were not limited to those involved in public health, finance ministries, and other financial institutions, discussed the relevance of mental health to development and called to the widespread disease burden of mental illness and its economic costs (WBG and WHO 2016). The World Health Assembly (WHA), the governance arm of the WHO ratified Resolution 65.4 in 2012, which signalled the acknowledgement of the gravity of mental health by its 194 member states. It additionally requested the Director-General to produce a multisectoral comprehensive global action plan to respond to the issue. In the following year, Resolution 66.8 was ratified by the WHA, which signified the formal adoption of the Mental Health Action Plan 2013-2020 (WHO 2013).

The Canadian Actors

Financially speaking, mental health in development contexts has received much more funding from Canada as of late, especially in the 2016-2017 fiscal year running from 01 April 2016 to 31 March 2017.

The World Bank Group and the WHO have identified Canada as a leader in global mental health investment and innovation (WBG and WHO 2016, GCC 2017: 21), a role that the Canadian Minister of Finance has also reaffirmed and pledged continuing commitment to. Canada's funding and interventions are achieved primarily through the non-profit investment intermediary Grand Challenges Canada (GCC), who, in turn, specifies that it adheres to the outlines set by the United Nations Sustainable Development Goals and works in partnership with the WHO and the Mental Health Innovation Network (MHIN), an organization co-run by the respective mental health departments or programs of the WHO and the London School of Hygiene and Tropical Medicine (GCC ca. 2016).

Canadian funding for mental health development projects is funnelled primarily through the non-profit investment intermediary Grand Challenges

Canada² (GCC 2016: 29). Grand Challenges Canada states that its programs, of which the Global Mental Health Program is part, are funded primarily through Global Affairs Canada (GCC 2016: 29). In the 2016-17 report, they have reported contributing \$3.6 million CAD to MINH database initiatives in addition to \$42 million CAD to 85 projects and interventions in development contexts (GCC 2017: 20).

Reports from the 15/16 fiscal year³ did not specify how much funding was being invested into mental health innovations, but as of the 2014 their total contributions to date starting from their foundation in 2010 was stated to be \$29.9 million CAD. Needless to say, jumping from \$29.9 million CAD over four years to \$45.6 million CAD in one year is large increase in financial contributions and signifies a larger financial commitment to mental health interventions. Admittedly, this is still a small portion of total ODA in Canada, which amounts to \$5 billion CAD in 2016-2017. However, total ODA in 2014-2015 amounted to \$5.37 billion CAD (DFATD, Government of Canada 2015: 3), and \$4.82 billion CAD (GAC, Government of Canada 2016), with ODA as percentage of GNI fluctuating respectively from 0.24% to 0.28% and to 0.26% in 2016-2017 (OECD 2017). Both in terms of net funding and in terms of proportion of ODA, the funds diverted to mental health has increased substantially.

The Social and the Psychological as Emerging Sites of Development Intervention

The Author as a Student of the Psychological Sciences and Arts

During my completion of my Bachelor of Science degree in the late 2000s, I enrolled in three classes that specifically discussed mental health: Abnormal Psychology I and II, and Developmental Psychopathology. Two of the professors in these three classes emphasized the subjectivity of the checklist-like approach to mental illness that they were about to teach one. In essence, they were teaching us to question the abnormality and the psychopathology that formed the very title of the courses. One professor in particular taught at length the importance of contemporary political dynamics in the iterations of the handbook issued by the American Psychological Association, the Diagnostics and Statistics Manual (DSM). My professor pointed to what was a classic

² GCC, along with the Bill & Melinda Gates Foundation and USD, are founding partners of the Grand Challenges network promoting “innovative” frameworks of development (Bill & Melinda Gates Foundation 2014; GCC 2012). GCC activities subscribe to the Grand Challenges in Global Health, a collection of public health development initiatives launched by the Gates Foundation in 2003 (Grand Challenges 2016).

³ GCC states that as of July 2016, \$39 million CAD had been invested into mental health innovations since its founding (GCC 2016). I chose not to include these numbers in the main body of text for reasons of consistency: the other figures given in the annual reports of GCC and the GAC Reports to Parliament detailed the financial activity of the fiscal year, which runs from 1 April to 31 March each year for these agencies.

case warning of the dangers of psychology: the medicalization of homosexuality as a mental disorder as classified by the American Psychological Association in their diagnostic manual, the *Diagnostics and Statistical Manual for the Classification of Mental Disorders* (DSM) (Levin 2016)⁴.

Nevertheless, we students were required to learn the model, so I found myself memorizing the litany of symptoms and time requirements of the DSM-IV-Revised⁵ for multiple choice exams that did not leave room for a critique of the medical models of mental health despite our professors' repeated oral warnings.

Why is Mental Health in Development?

Clinical psychology and psychiatry enforces norms of behaviour and cognition. Foucault's *Madness and Civilization* (1988) has traced the enforcement of moral, reasonable behaviour using madness and mental illness through the Western European Middle Ages to the late nineteenth century. Reasonable behaviour is at the heart of madness and mental health, but what comes to be defined as reason is subject to social norms.

As argued above, empiricist and positivist bodies of knowledge are not innocently produced. As such, they are neither unbiased nor objective. Although I have found discussions of the dangers and limitations of mental health within developed contexts, such as the authors I have already cited above, I find that this discussion missing in the development context.

The critique is that the WHO's particular conception of well-being is based upon pre-existing perspectives, epistemologies, and knowledges that have never been innocent. When the medicalisation of behaviour crosses cultural contexts, I believe that it is worth examining how a scientific understanding of mental health figures into global sociopolitical contexts, especially with disparate power relations inherent in imperialism and colonialism.

All of these commitments signify the emerging importance that these particular influential development agencies are placing on mental health. This brings me to my second point, which alludes to a question I already posed above. When development projects bring mental health interventions, what happens when these projects use healing paradigms that can be culturally inappropriate? Context-specificity will aid the implementation of a project, but is it possible that the project proposes a solution in search of a problem?

Creating a culturally-appropriate, context-specific solution potentially elides over the crucial question: is the problem culturally appropriate as well?

⁴ Interestingly, although this same blog by the APA states that scientific research shows no proof that homosexuality was not a disease, it conveniently omits mentioning the political pressure mounted from sexual minority activists and movements

⁵ Now reformulated as the DSM-V, which is still quite controversial in its symptom definitions of mental illnesses (Collier 2010)

Chapter 4 Methodology

Objective

My RP started as a critical reading of the standards of behaviour and a questioning of the Eurocentric techniques employed, and uses Eurocentric ideals of what health looks like.

The information I gathered and reading that I had done led me in another direction. Consequently, my objectives and questions changed throughout the process as I confronted another question instead: what is an aid recipient?

I opened this new line of questioning because of the discomfort that I felt between the human rights based approach and the language of economic returns and lost productivity. The language of the potential labourer or economic burden operates counter to the obligation of the power-holder to a rights-holder.

Objective: To explore how mental health development agendas impose normative ideas of the modern human behaviour, health, and development on their targeted populations.

Research Questions:

How did mental health emerge as a development priority for the UN, the WHO, and the Government of Canada?

How do discourses of the rights-based approach development shape the approaches taken by the agendas? Where does the economic actor fit in within the context of a rights-based approach? What new conceptualisations of mental health could a post-development lens create?

What are the limits of contextualisation of Western-developed therapy techniques in challenging the medical framework of mental health?

Methods

Textual Analysis

Due to the argument that public health systems, institutions, and frameworks of action reflect ideological, political, and moral contexts (Storeng and Mishra: 862), I investigate how these ideological and moral contexts come through in these policy documents. I present a critical reading of WHO agendas through a post-structuralist lens to investigation the situation of the economic actor/subject. As mentioned above, I use Donna Haraway's socialist feminist critique of science, Michel Foucault's post-modern analysis of mental health and madness in Europe and France, Arturo Escobar's post-developmental critique

of planning, and Boaventura de Sousa Santos's post-developmental concepts of epistemicide and epistemological hierarchies to guide my analysis. These will be used to trace the emergence and implications of mental health on the economic actor.

The main document that I will analyze is the Mental Health Action Plan 2013-2020, which outlines general objectives and indicators for a rights-based approach to mental health development. Additionally, it includes proposed actions for the UN, the WHO, other global governance institutions, UN member states at multi-lateral levels, civil society actors, and the private sector.

As public health systems, institutions, and frameworks of action reflect ideological, political, and moral contexts (Storeng and Mishra: 862), I investigate how these ideological and moral contexts come through in these policy documents.

I will also analyze segments of annual reports from Grand Challenges Canada pertaining to their development strategy and more specifically, mental health interventions. This will be complemented with the Report to Parliament on the Government of Canada's Official Development Assistant produced by Global Affairs Canada to cross-reference what I will identify as Canadian increasing involvement in global mental health.

I will also be referring to projects that can be found on both MHIN and GCC websites in order to demonstrate the application of WHO, GAC, and GCC agendas. To be clear, this is not an explicit in-depth case studies design. My aim is to generate discussion using illustrative case examples as departure points, with the caveat that these examples will warrant much deeper analysis.

Autoethnography

As demonstrated already, I will be opening sections with autoethnographic vignettes from my personal experiences as a previous aid worker, an undergraduate student of psychology, a second-generation immigrant experiencing competing views of mental health and well-being, scholar, and a person with psychological aspects to her being. Given that the science of human behaviour and cognition invades into the most intimate parts of everyday actions and thought, I hope that this is a way of situating what can seem like very distant discourses. I hope that this deliberate use of my personal story will re-situate the real effects that these distant debates may have.

As Mosse (2011: 3) points out, "policy ideas are never free from social contexts. They begin in social relations in institutions and expert communities, travel with different interests of social/institutional worlds and local politics in ways that generate complex and unintended effects." My deliberate use of my personal story is an attempt to re-embed these expertise-generated discourses and processes back into more local and individual levels. Additionally, my intent is to reveal the struggles between these variant parts of my histories and

identities when I approached the development and the aid industries, and to highlight my personal struggles to prevent the person from disappearing in policy frameworks and scientific paradigms.

By reflecting on my personal history and the path that led me towards questioning mental health interventions, I risk turning this Research Paper, the one that I submit in compliance with the requirements towards a Master of Arts degree from the Institute of Social Studies in The Hague, into an examination of my complacency and complicity in the aid industry. I hope for this to be a critical reflection on the search for my existential self within the same technical documents and political statements that mask the same legitimisation of self and the same legitimisation of self of other development practitioners and scholars. Above all, this is my honest if flawed attempt to walk away from utilizing the idea of the Other to define the boundaries of my own identity, to legitimate my participation in social interventions, and to examine my own hand in constructing the identities of the people around me.

Chapter 5 Mental Health Action Plan 2013-2020

Structure

In the remaining sections to follow, I will apply my theoretical framework to more concrete examples. I will begin with my analysis of the WHO Mental Health Action Plan 2013-2020. As it is my longest document, I will present my findings from the readings first to allow for an overview of how the document is structured and to preview the mental health concepts that I will be critiquing. However, my main analysis will primarily be broken into two parts: first, I will discuss the global context and the WHO's partnership with the government of Canada and the GCC and how mental health figures into this. Then, I will bring the focus back down to the economic subject and how these development actors use their epistemic power and moral leadership to maintain existing power structures.

Mental Health Action Plan 2013-2020

General Description

As mentioned above, the World Health Assembly had ratified Resolution 65.4 in 2012. I now turn my attention to the document referenced and adopted in Resolution 66.8 in 2013: the Mental Health Action Plan 2013-2020 and the objectives and indicators that it outlines. In summary, they speak to: leadership and governance efforts; community-based service provision; prevention strategies; and the improvement and use of information systems (WHO 2013: 10).

The Action Plan has six broad principles: universal health coverage, human rights, evidence-based practice, a life course approach, a multi-sectoral approach, and empowerment of those with mental and/or psychosocial disorders and disabilities (WHO 2013: 10). The principles that are driving my analysis are the second and third: the presence of morality-based arguments including human rights, and evidence-based scientific practices. Additionally, given my theoretical framework analysing the role of science in maintaining economic hierarchies and power hierarchies in a more general sense, I have added to my analysis an economic dimension.

Accordingly, I have sorted my analysis of the Action Plan according to the three principles: human rights and morality-based arguments for intervention, scientific discourse and the medicalisation of well-being, and economic justification for intervention. I have attached Appendix I containing the original text obtained from the WHO website. In my main text, I will provide a brief summary of my findings and discuss the implications according to the framework described above.

Findings

Human Rights and Morality-Based Arguments

Every objective lists the importance of agendas and healing frameworks being in line with international and regional human rights instruments. Although Global Targets 1.1 and 1.2 are the only ones that explicitly refer to compliance with international and regional human rights standards, there are other repeated mentions of the importance of human rights instruments in a description of the other objectives as well. For example, Objective 2 references incorporating human rights principles in treatment; Objective 3 in paragraph 71 points to the human rights violations faced by those suffering with mental illness. Objective 4 does not explicitly reference human rights, but its focus is on the facilitation of exchanging frameworks, interventions, and policy strategies based on the preceding objectives.

Moral Urgency

Urgency is created using human rights through two ways. First, there is the designation of people with mental illness as a vulnerable and marginalized group, with the implication that these people need human rights protections, as can be seen in Paragraph 5. At times, this claim is made explicit, such as references to the potential of humanitarian law to protect people with disabilities and/or mental disorders as marginalized groups (paragraphs 13, 20, 71, 74). Secondly, there are multiple claims that people with mental illnesses or disorders are at risk for a broad range of human rights violations (paragraphs 13, 80).

Additionally, urgency is also created by statements that link mental health to other health concerns. The references to suicide (paragraph 5, 72, 85) especially in Global target 2.2, and comorbidity with other health concerns and other social vulnerabilities (paragraphs 12, 49 58, 72) also implies a grave situation where lives are at stake, adding urgency to the need to act. There is also the claim that marginalised people are at additional risk for developing mental health illnesses and disorders (paragraphs 11, 12).

Destigmatisation

I also identify multiple calls for de-stigmatisation, implied by competency training and attitude adjustments for healthcare workers or for general societal attitudes, especially Objective 2 Prevention and Promotion, paragraph 55. Additional references can be found in paragraphs 71, 73, and 80.

In Paragraph 5 already mentioned above in my discussion on vulnerability, there is also a hint of de-stigmatisation as the cause of their illness is placed outside of them “as opposed to any inherent weakness or lack of capacity” (WHO 2013: 6).

Use of Scientific Discourse

Knowledge-Production According to Scientific Rationalities

All objectives also mention the need for evidence-based approaches⁶ in policy planning, or mental health interventions (paragraphs 18, 30, 35, 36, 59, 67, 69, 71, 82, 85) and sharing knowledge of best-practices thereof (paragraphs, 39, 41, 46, 49, 59, 61, 62, 65, 71, 75, 82, 88) The actions of the Secretariat across all Objectives also situate around the ability to provide guidance and technical support to the member states.

Objective 4 points most directly to knowledge production, in its need to generate and share evidence-based practices. It also argues for the importance of indicators and disaggregated data (found on pages 14-16 of the annex).

Medicalisation of Well-Being

Each Objective advocates for the mainstreaming or integrating Mental Health into general health plans, policies, services, and databases (for example, see paragraphs 31, 32, 34, 43, 45, 48, 49, and 49). Additionally, all of the objectives also emphasize a recovery-based approach (paragraphs 50, 57, 58, 62), with the implication that mental illness and ill-being is something that can be corrected and healed.

In paragraph 6, the Action Plan states drawing its interpretation of mental and behavioural disorders from the International Classification of Diseases of Diseases and Related Health Problems, Tenth Revision (ICD-10) researched, issued, and published by the WHO (cite), with the 11th revision due for release and publication in 2018.

Economic Justifications

In setting the context and justification for the Action Plan, there are direct references to the economic burden and economic costs of mental health in US dollar amounts. Additionally, as mentioned above in my discussion of the term well-being, the Action Plan explicitly mentions contributions to one's community or society, and the capacity to work as part of their definition of well-being. Throughout the rest of the Plan, Objective 2 regarding service provision. Objective 3 for promotion and prevention strategies both contain explicit references in the ability to participate in work (paragraphs 50 and 78 respectively).

In addition, there are also multiple references to cost-effective interventions, especially within the context of low-resource settings (paragraphs 14, 18, 82, 83), cost-efficacy, or warnings of wasted resources (paragraph 30).

⁶ I acknowledge that the term evidence-based practice is an open-ended term, seeing as the standards by which observations which constitute legitimate evidence is socially, culturally, and politically defined (Haraway 1991). With this in mind, I take evidence-based practice to mean more empiricist and positivist observations derived from the scientific method (Fulcher and Scott 2006)

Although the Action Plan refers to various marginalizations and oppressions and vulnerabilities, I examined poverty as an examination because of my theoretical framework. I found that poverty in almost every case is mentioned in relation to each marginalization and oppression. Actually, poverty in almost every case is mentioned in relation to other sources of marginalization and oppression.

Chapter 6 Global Movements in Mental Health: Money Talks

Canada as the Humanitarian Philanthropist

In support of my overall post-developmental critique of planning and foreign aid or foreign development, there are two reasons that I believe that current debates surrounding Canadian foreign aid warrants deeper scrutiny: first, scholars have pointed to general disruption of a relatively stable approach to Canadian foreign policy from the post-war era to the mid-2000s under the Parliament of Prime Minister Stephen Harper (Brown et al., 2015; Paris 2014).

The current Parliament led by Prime Minister Justin Trudeau famously stated to Canada's national allies on 20 October 2015: "Many of you have worried that Canada has lost its compassionate and constructive voice in the world over the past 10 years. Well, I have a simple message for you: on behalf of 35 million Canadians, we're back" (Trudeau in The Canadian Press, 2015). His statements were followed up by claims to re-engage with the United Nations after an implied ten-year absence (Kwang 2016). His claims signal yet another shift with his commitment to a more globally-involved Canada (Brown et al. 2015: 3).

Secondly, these shifts are matched with justifications for Canadian development aid are not purely motivated by the poverty reduction and human rights principles the federal government's development agencies proport to stand behind.

Shifts in Canadian Development Policy

Canada's shifts in foreign policy will inevitably touch on its development policies. Canadian development aid is delivered primarily through Global Affairs Canada (GAC), the federal department that oversees diplomatic relations, foreign trade, and international development aid. Eighteen different agencies ranging diversely from the Royal Canadian Mounted Police to Canada Post to Health Canada have also contributed financial donations (GAC, Government of Canada 2017: 3).

The agency responsible for development aid had been under frequent restructuring in the 2000s and 2010s with one of the major shifts being a merger between what was previously known as the Canadian International Development Agency (CIDA) with the Department of Foreign Affairs and International Trade to become the Department of Foreign Affairs, Trade, and Development in 2013 (DAFTD, Government of Canada 2013). Another major shift occurred with the renaming of the Department to Global Affairs Canada (GAC) under the Justin Trudeau government in 2015, accompanied by a renewed commitment to foreign policy (Brown et al. 2015: 3).

Human Rights in Canada

Canadian foreign policy has also had a long history in using the human rights narrative, to the extent that devotion to humanitarian causes had become a core Canadian value (Akhavan 2016). Foreign policy can be a reflection, perhaps even an evangelical message of national principles (Hawes 2000). Hawes further argues that the presentation of Canada as an ethical peacekeeper became integral to a national identity and it became the blueprint for foreign policy, especially since the post-War era.

However, the discourse of a compassionate Canada focused on humanitarian aid has, at times, masked ulterior motives. For example, Canadian ODA in Latin America can be traced to corporate social responsibility initiatives of Canadian mining companies, generating social capital by which corporations could operate (Brown 2015). Canadian aid has also been accused of being suspect to other corrupt abuses (Rotberg 2017), and hypocrisy as its human rights commitments in development contexts are increasingly under question (Akhavan 2016). To be clear, I have not found any claims or evidence that co-opting ODA for CSR purposes has been seen in mental health interventions. What I propose is that the language of humanitarianism may not be as consistent or innocent as it may be portrayed.

Canada and Mental Health: Funding

Official Development Aid (ODA) in Canada amounts to \$5 billion in 2016-17⁷. According to the Official Development Assistance Accountability Act passed in 2008, funds must meet three standards in order to qualify as ODA:

1. contribute to poverty reduction
2. take into account the perspectives of the poor; and
3. be consistent with international human rights standards.

(GAC, Government of Canada 2017: 4)

What can be highlighted here is the congruency between ODA and the Mental Health Action Plan 2013-2020 humanitarian principles.

However, I would also argue that given the WHO's financial constraints and the repeated statements that Canada is an innovative leader in mental health initiatives beyond its financial supports, this Canadian definition of ODA would possibly figure heavily into the way that mental health development projects and agendas are formulated.

As can be seen in the excerpt, the values of development aid in Canada are emphasized along economic and human rights axes, with the implication of a more bottom-up approach, vaguely referenced by the "perspectives of the poor". Vagueness aside, I believe that the most pertinent point is the specific

⁷ The fiscal year for the Government of Canada runs from 1 April to 31 March (GAC, Government of Canada 2017)

distinction given to the perspectives of the poor. It is not the marginalized in general, as could be implied by a more encompassing rights-based approach looking beyond economic development; rather, it is the perspective of those living under poverty that at least on paper⁸ will be considered under any circumstance and under any project.

I acknowledge that poverty has been argued to be a risk factor for the development of mental disorders and vice versa. Additionally, as I have mentioned above, the Action Plan argues that people in poverty conditions are at additional risk of human rights abuses. However, my point remains that poverty is seen as the ubiquitous demon to be exorcised. All Canadian ODA must abide by these standards to be reported to Parliament as ODA. This still demonstrates another bias towards economic issues. Planning directives have used poverty as a way to open up the social as a site of intervention through which communities could eventually be colonised (Escobar 1992).

Canada, the WHO, the UN and Global Politics

The ODA Annual Report 2016-2017 states that it will invest in strategic areas of development aid “to ensure that Canada achieves significant results in sectors where it has a comparative advantage” (GAC, Government of Canada 2017: i, 1, 8, 46). Similarly, the GCC annual reports have listed global mental health as a primary strategic priority, focusing on where the organization can make the most impact (GCC 2016: 9; GCC 2017: 8). I cannot presume to answer the question of what is completely entailed in the phrase “comparative advantage”, but when I juxtapose this statement with the fact that mental health has been a relatively underfunded part of development, I have to ask if “comparative advantage” is limited to efficacy and success of the interventions, or if relates to carving out a niche space where Canada can claim its place as a leader, and how this relates to the sphere of international politics.

Canada has had a significant role in global humanitarian efforts, has engrained humanitarian principles into our national identity, and it also has an international reputation to prove. The entire situation could be summarized in a succinct example: the Trudeau government is also currently one of the rotating United Nations Security Council seats. Trudeau, in a media statement at the United Nations in New York City, stated that Canada would use its increased influence to lead the fight against poverty and defend women’s rights and other marginalized peoples. Through this, world peace would be achieved through a more stable world (CBC News 2017).

Similarly, on the other end, as I had stated, the WHO is suffering from a legitimacy crisis. In public health development private-public global health in-

⁸ Please refer to xxx for a discussion on empowerment and

itiatives have been on the rise since the arrival of the new millennium (McDougall 2016: 310), bringing with it not only new avenues for collaboration but also difficulties. Not only is there increased competition with the rise of private actors, but there is also increased competition within the UN with other health-related agencies such as UNICEF, UNDP, and UNFP (Lee and Pang 2014: 120). Together with the lack of policy enforcement powers and manpower (Markel 2014: 127; Lee and Pang 2014: 120), all of these strains have placed the WHO at risk for losing relevance as a relevant public health body. As it goes through a crisis of legitimacy, it also falls into a cycle of losing funding to other sources deemed to be more effective and/or less bureaucratic (Lee and Pang 2014).

Thus, this partnership with Canada in this relatively niche but growing field of mental health comes at a particularly interesting time. The dual struggles for increased international governance raises interesting questions.

When the WHO faces challengers from both within and outside its parent governance organization on multiple fronts, it needs to carve out its space in the landscape of public health development (Lee and Pang 2014).

Canada may be back, and I have argued that there are movements towards those ends in global mental health, but is it a compassionate Canada? The country reclaims a larger sphere in the global arena against a backdrop comparative advantages and strategic priorities; dual priorities of poverty reduction and human rights; CSR as development aid. This begs the question: where do mental health interventions fit into all of this? When Canada is signifying a shift back towards a more globalized Canada and seeks to reclaim its albeit questionable identity as a compassionate defender of humanitarian causes, are more human-centered approaches at the core of this messaging, or a governable subject? Trudeau's statement alone says it all: that human rights and economic prosperity would produce social order.

It is within this global political context that now I turn to how the governable subject is made into an economic actor.

Chapter 7 The Laboratories of Aid Discourse: Parallel Constructions of the Interventionist and the Aid Recipient

Vignette: The Author as the Aid Worker

I had a two-faceted experience with the Syrian refugee settlement response in Canada with the Canadian Red Cross. As frontline volunteers with the Disaster Management department, my colleagues and I heard of refugee's struggles with their resettlement process and with their past. We provided mostly psychosocial support services and attempted to connect them with counselling or psychotherapy supports within our financial constraints.

I glimpsed into the complexities of program design when our team with the Prevention and Safety department was asked by Disaster Management to deliver psychosocial interventions when frustrations started running higher among the refugees. Although I was not intimately involved in planning or implementing these particular responses, I was involved in meetings and discussions with the rest of the team. Our key questions of what emotional or psychological support looked like to the refugees themselves did not connect with the practicalities of the frontline work.

A need was identified by both the frontline humanitarian aid workers and the refugees, but at the planning phases, our team did not know if the location of the problem differed between Disaster Management and the refugees. The mandate of our program did not cover explicit psychosocial support, but rather was aimed at prevention efforts. We were unsure how we could help with the assimilation process given that harm had already been done. We wanted to resist the temptation to galvanize ourselves into action based on compassionate and humanitarian grounds. Our main fear was we would do additional harm. We also understood that not only was there the potential for competing definitions of needs and well-being, but there may also be incongruent priorities and expectations.

When the program was being implemented, my colleagues improvised new activities based on the immediate feedback from the refugees themselves. Our procedures and departmental priorities were thankfully flexible enough to allow us to have an outcome that did not produce the initially planned ones. In the end, the refugees enjoyed themselves and found a space to release some of their daily stress, which took priority over all else.

In retrospect, we fell into the same traps that other development workers and policy writers have fallen into (Mosse 2011:2). In our planning stages,

our team was required to justify our programming to the lead department according to what they had identified to be refugees' priorities. We were attempting to re-embed ourselves from the context and the realities, but may still have assumed solutions and therefore problems that may not have been there, or may not have been prioritised. The most important factor that kept our well-meaning intentions in check, in retrospect, was probably our mandate to do no harm and to create new sources of frustration.

Summary of the Plan

To briefly summarize the Mental Health Action Plan, I analysed it in terms of the rights-based approach in its use of moral urgency and destigmatization; the use of science in its medicalisation of well-being and its role in knowledge production; and how it related to economic justifications or burdens.

I saw that the language of human rights and science permeated far more than the economic justifications did. I also have to take into account that there was no special attention placed onto poverty concerns, given that it usually was mentioned along with other marginalizations and oppressions. However, even though I grouped the findings by theme in order to facilitate my analysis, my interpretation of this presentation of reality is that these themes feed upon each other. On a more superficial level, it does not seem like there is any blatant preference placed on poverty reduction the way that Canadian ODA regulations explicitly state it. I believe that what connects all of this is scientific knowledge-production, one of the values which appears across all objectives.

Science and Capital

Seeing as the language of evidence-based approaches permeated the entire document, I would like to point out that scientific discourse can be unpacked using socialist lenses that reveal systems of domination based on work and capital (Haraway 1991).

Evidence-based approaches are based on a wealth of medical and scientific knowledge that already exists, cultivated strongly with an emphasis on normativity and well-being with the healthy person as a productive economic actor. Perhaps there is potential for scientific discourse to be used to ease the suffering of persons suffering from ill-being with no economic motive in mind. However, contextually speaking, this wealth of knowledge was built with particular socio-political goals in mind (Haraway 1991), and these goals had very particular ontological lenses. It is imperative to explore how this question of the economic actor lingers, or perhaps is actively reinforced and reconstructed in mental health discourse.

This leads to two crucial points: firstly, the medical system is justifying intervention by implying that there is suffering that can be absolved. This interventionist is not simply an interventionist; they are a saviour. Secondly, when

placed against the context of poverty, it is claiming that there are deserved forms of poverty: poverty where someone is ill. This implies that the patient is not at fault for their disengagement with capitalist systems, but the healthy economic subject is. This is a moral judgment that is masked by an economic one.

Epistemic Power: Justified Interventions on the Basis of Illness and Poverty

Medicalisation of Well-Being: The Healing Powers of the Interventionist

There are dangers inherent within of medicalising well-being. In its own way, it is also creating urgency. Human suffering creates the need for intervention and a restoration of a positive state of being.

Paragraph 60 in Appendix I, found under Objective 2 and Global Target 2 relating to service coverage, goes as far as to state the need to “proactively identify and provide appropriate support groups at particular risk of mental illness”. This proactive act of identification is a blatant labelling of groups. Proactivity implies an active task of seeking to otherise, in this context along the lines of ill-being and well-being. These categorised targets may not have been aware of this status before. Given the entire language of vulnerability already existing the dialogue around people with mental illness, this is, in its way, creating a group of people that need to be saved, despite the possibility that perhaps in their own contexts and by their own standards did not need or want saving.

Categorising Madness: International Classification of Diseases-10

The WHO still maintains its status as a leader in epistemic knowledges. The very fact that it issues the ICD-10 is worth noting, as it provides guidelines for what is considered to be healthy and unhealthy behaviour, and what a functional or dysfunctional being is.

Social functionalism and evolutionary functionalism dominates much of the discourse in analyzing scientific observations (Haraway 1991: 33, 42). In a comparative analysis between four primatologists following different scientific traditions, Haraway underscores that these thinkers and researchers, including those coming from a more sociobiological background, all analyzed their observations in accordance with functionalism in terms of social hierarchies. Regardless of the nature of their observations or the minute details of their arguments, the researchers attempted to naturalize and cement the presence of dominance hierarchies according to functionalist principles. Evolution and social groups were explained in terms of utility. When a maladaptive behaviour emerged, it was explained it in terms of how it disrupted the social hierarchy and thus social order. Comparisons were then leveraged with human behaviours in an attempt

to naturalize and cement human dominance structures in biological determinism, where deviancy was discussed in terms of maladaptations that could possibly be medicated.

The worry, then, is that when scientific discourse has been used to preserve dominance hierarchies based on arguments of biological and social functionalism while claiming objectivity, it is easy for knowledge producers and learners alike to forget that these dominance hierarchies had to be created in the first place. When socially deviant behaviours are performed or physical deformations appear, other members around the actor may forget that these normative structures came from very motivated means which would have influenced how the data was observed and interpreted.

Epistemic Power: Data-Collection

WHO's role in collecting data to track progress on the indicators and facilitating knowledge of best-practices is also extremely significant. It forms impressions and facts based on their realities. The (falsely) objective gaze of science also lends legitimacy to their subjective claims. Knowledge dissemination is a significant task. By compiling information on so-called "best-practices", it is inherent within the term that the communicator is endorsing this practice and propagating it as something to emulate. These indicators are chosen for a reason: a need had been identified by the WHO and its partners. The definition of progress and normative functioning is in their hands.

The GCC also figures prominently in this space of knowledge-production. It funds projects that have published papers (GCC 2017: 6). Additionally, GCC is the main funder for the MHIN platform, which connects global mental health partners together through the provision of technical advice and a knowledge-sharing platform (MHIN ca. 2014). However, keeping in mind that there was an emphasis on evidence-based approaches in the Action Plan, the MHIN would only disseminate information as its employees see fit. Given the emphasis on evidence-based practice and the preclusion of other sources of knowledge, I believe I am quite justified in terming this to be small acts of epistemicide.

The Role of the Diagnostician

The field of mental health inherently questions the ability of one person to relate rationally to an objective reality. Madness was defined as the assignment of value and truth to imagination, as the status of reality is assigned to something that is, to the person judging their sanity, illusory (Foucault 1988: 94). The diagnostician or mental health worker then, has much power in determining if their patient had an illness or disorder.

To illustrate the subjectivity inherent within this process, I refer to ICD-10 diagnostics. Mood disorders describe a range of behaviours where one's emotional state is inappropriate for their context (WHO ca. 2016a). The umbrella of

anxiety disorders also provides an interesting example. Phobic anxiety disorders exist in a context of “certain well-defined situations that are not currently dangerous” while other anxiety disorders (meaning anxiety disorders not categorized under phobias) are “not restricted to any particular environmental situation” (WHO ca. 2016b). The implication here is that the fear, stress, or anxiety can be experienced in a healthy way if it can be attributed to either an immediate unsafe situation or any other discernible cause; in short, if it is a fear that follows logical patterns, then it is a healthy fear, a functional fear that does not need to be rectified.

I offer these examples, the two diagnostic categories constituting what the WHO defines as common mental disorders with high global prevalence rates (WHO 2017b: 6), as a brief exercise to demonstrate the power that a diagnostician has in segregating healthy from unhealthy behaviour on what is an inherently subjective practice. Although diagnostic criteria for mental illnesses and mental disorders are created through scientific endeavours as an attempt to approach treatments and research empirically and without bias (Kupfer et al. 2002: xv)⁹, it is important to note that the interventionist’s definition of rationality is at play, as are the producers of the diagnostic criteria.

If rationality is missing from those with mentally illnesses and disorders then the locus of decision-making is placed outside of the patient (Foucault 1988: 196), pushed out by an invading force that seems to increasingly be susceptible to the battlegrounds of health systems of medicine. Sanity must be something restored to the person by the interventionist. Mental health follows the trajectory of something to be exorcised, quarantined, punished, or healed.

Limits of Destigmatisation

The concept of destigmatising mental illness is not limited to the WHO. There have been increasing mainstream discourses around destigmatising mental health using human rights as a tool, including language issued by the World Bank Group, WHO, and mental health advocacy groups in Canada, the United States (WBG and WHO 2016; GCC ca. 2016; Hamilton n.d.). These same actors argue that mental health stigma prevents people from seeking aid, as they fear judgment from others.

I argue that this destigmatisation is an echo of the religious de-segregation and liberation of the Mad from the asylum that Foucault traced in nineteenth century France. Human suffering and calls for compassion are powerful discursive tools that have the potential to trigger humanitarian responses. If destigmatisation means opening up public discourse in a compassionate manner, then I offer, as a warning, moments when mental illness had not been confined but have been out in the public eye.

⁹ Granted, in the same chapter Kupfer et al. (2002: xix) also advocate for an aversion to checklist approaches when diagnosing mental illness and disorders. As Widgier and Clark 2000 point out, even the developers of the DSM-IV fully admit flaws to their diagnostic criteria.

Liberating madmen from the confining asylums of the nineteenth century, for example, are celebrated as treating those with mental illness with compassion rather than punishment (Foucault 1978: 243). However, the treatments proscribed to the patients became those that encouraged self-regulation. Asylums of the 19th Century were “organized so that the madman would recognize himself in a world of judgment that enveloped him on all sides; he must know that he is watched, judged, and condemned” (Foucault 1978: 267). Fear and guilt were weaponized to control the patient’s behaviour from within themselves. Welcoming those with mental illness and mental conditions back into society may or may not be dangerous for those with mental illness depending on the underlying power dynamics behind this shift. Through reintegration into society and under the watchful eye of the public, whomever deviates from social norms will be reformed and returned to normality.

The role of confinement and segregation in treating mental health has changed accordingly with historical sociopolitical contexts. Couched in discourses of compassion and self-sufficiency, the focus is still on resolving the abnormality.

Mental health professionals, whether biomedical or biopsychosocial, had situated the responsibility of judge and corrector within the physician. Those with mental illnesses are using cognitive techniques to train themselves. CBT has its interesting relationship with what Foucault terms “deep observation” of the madman (Foucault 1988: 247).

Techniques of Healing: Cognitive Behavioural Therapy as an Example

Cognitive Behavioural Therapy (CBT) is described by the WHO to treat those with “unrealistic distorted thoughts”. (WHO 2010: 82). It identifies the location of the problem in cognitive processes, where a treatment-seeker is taught to identify, evaluate, and possibly adjust or otherwise control the offending thoughts that offset symptoms (WHO 2010: 82, Gaudiano 2008: 6). CBT is also one of the more popular therapy techniques chosen by mental health workers in places like the US and the UK (Gaudiano 2008: 5).

I wish to highlight here that this element of monitoring can be echoed in CBT, as the patient must monitor the triggers that bring about their negative affect. It is significant that the judge is now internalized.

This emphasis on self-monitoring and agency in CBT needs to be examined carefully. This technique recalls the governmental subject who is taught to behave properly, without the need of an exogenous actor to correct their behaviour (Li 2007: 275). They are taught how to manage themselves.

Perhaps I may be accused of misrepresenting CBT, seeing as the goal is to alleviate thought processes that are deemed to be disruptive by the patient, and involves the patient in identifying their psychological or emotional triggers. In anticipation of this argument, I would like to point again to the phrase “unrealistic distorted thoughts” mentioned above. What is unreal and real is decided by the interventionist. Especially when the interventionist is held in esteem as a corrector of behaviours and a healer with epistemic power, this adds additional weight and legitimacy to their words. Perhaps there is some element of self-

sufficient agentic action in that the patient identifies the triggers and is not a passive recipient of treatment, but the interventionist is also heavily involved in deeming what is rational and what is not.

When behaviours are defined by cultural context, there is much potential for an outside “expert” to misinterpret if something is socially adaptive or not.

Science as a Dominant Epistemology

Interestingly, the Action Plan acknowledges in Paragraph 82 the presence of a “research imbalance” in that most of the knowledge produced is done in and by high-income countries, calling for more research on service provision and gathering information on indicators to be done by low- and middle-income countries. This notes the need for contextualised information for contextualised strategies and solutions.

However, I also would like to point to Oyēwùmí’s (1997: 17-19) warning that knowledge production itself, especially in academic settings, has been colonized too. These methodologies for knowledge production, especially of the evidence-based variety, and techniques for healing are developed in the West, with certain cultural assumptions. The question of abnormality and the drive for investigation into this abnormality is done with a specific frame of reference that was constructed in developed contexts. It is in this way that even the Other is encouraged to view themselves as outsiders through the normative gaze of Western academia.

Interestingly, among all of the language of context-specificity, culturally appropriate, and cultural considerations, there is one mention of the term “culturally validated research” in paragraph 88, which hints at the possibility of a more active process of engaging with epistemologies. Context-specificity and cultural-appropriateness imply an outside intervener presenting something to the passive aid recipient. Culturally validated, on the other hand, implies an active acceptance of the term, that science must pass the standards presented by contextual epistemologies. I must admit that this is the first time I have viewed this term and mention it as a passing curiosity. I am simply noting it as a potentially interesting finding for further review.

Example: The Friendship Bench in Zimbabwe

The Friendship Bench was developed by a team of psychologists, psychiatrists, and social workers based in Harare with the aim of integrating mental health services into primary care services (The Friendship Bench 2017). Interventions consist of culturally talk therapy sessions adapted from CBT and delivered by lay health workers, usually grandmothers, are based in care clinics. At first, the project focused on HIV/AIDS patients before scaling up into other clinics as well.

The use of the word “lay” is not mine. Grand Challenges Canada refers to them as “[l]ay health workers, known as community ‘Grandmothers’” (GCC ca. 2016b). This portrays them up as people devoid of the right kind of expertise, whereas the interventionists hold the knowledge.

Although the lead interventionists are based in the University of Harare (GCC ca. 2016), I would refer back to Oyēwùmí. The Friendship Bench contextualises mental disorders by translating from English to the local Shona language to describe what the DSM-V would term as Depression and Anxiety (Verhey et al. 2015: 5). Perhaps this facilitates research and healing, but I wonder if these concepts were something that was considered as serious as a DSM-V-defined pathological level in that particular context. This is a foreign framework that the locals must adapt to.

Example: Blended Care in Haiti: Spiritual Leaders and Culturally Adapted Therapy for Depression

This project is run by the Centre of Addiction and Mental Health based in the University of Toronto, Canada. Blended Care in Haiti uses a specifically-designed Culturally Adapted Cognitive Behavioural Therapy program to reach existing spiritual leaders in Catholic, Protestant, and Vodou traditions. Justification of partnering with local religious leaders can partially be attributed to a “long tradition of spiritual beliefs that attribute the cause of mental disorders to curses and spirits” (GCC ca. 2016c). This statement discounts local interpretations of behaviour. Perhaps this was also seen as deviant behaviour before, but what I would like to argue is that this particular framing has the additional effect of presenting Haitian spiritual leaders as backwards people who are untouched by the enlightening knowledge of science, as the interventionist brings them the tools of psychological modernity.

Side-Effects of Diagnosis

A label of mental illness or ill-being is an implication that people are broken and needed to be healed. However, when this is placed beside economic burden and productivity, this opens up the question of if we are being healed where the standard is an output-generating economic subject. Perhaps there is a certain humanity in placing the origin of the condition outside of the patient, but then the definition of humanity needs to limit itself to economic ends when there is an implication that the patient can be restored back into an productive economic actor.

I remind the reader that “[m]edical management of emotions maladaptive in ‘modern society’ seems justified to relieve pathological stress and maintain the social system?” (Haraway 1991: 33). Given that functionalist and evolutionary interpretations of social behaviours tend to legitimize them and create compelling reasons for a normative frame of behaviour, and given fear and anxiety that do not serve a function are deemed irrational, we must ask ourselves: what function is it exactly that we are supposed to serve?

The Ethical Imperative to Intervene... but only for an Economic Actor

The language of vulnerability, and marginalization human rights creates an emotional urgency for outside intervention. As I problematized in my discussion of the rights-based approach, explicit claims of vulnerability could be reflecting particular statistical realities, but the dual-edged sword is here: it creates the moral justification for intervention (Uvin 2007). After all, every compelling fundraising narrative requires a saviour and a sympathetic victim.

Moral urgency is not extended to everyone. It is extended to people whom donors deem to be deserving according to prevalent social norms.

Work, Poverty, and Mental Health: The Medicalisation of Morality, Poverty, and Well-Being:

Foucault traces the progression of madness being tied to poverty, and work to moral and ethical values in seventeenth century Western Europe, argued that “madness was perceived on the social horizon of poverty, of incapacity for work, of inability to integrate with the group” (Foucault 1988: 64). In the same era, ethical values were linked to labour, either supported or inspired by religious condemnation of sloth. The ethical powers of both the church and the state were used to criminalize poverty and to imply that poverty was mostly deserved. Thus, public ramifications were cast upon idleness, sloth, and unemployment.

Confinement in 17th Century Western Europe was a form of punishment for citizens who disturbed public order. Confinement within workhouses, however, were seen to promote economic growth and also provide steady labour for those who were unemployed. It must also be noted, however, that these same places housing the poor also indiscriminately housed anyone who was determined to trespass social values, including those who trespassed common laws and the mad. Thus, “...it was in these places of doomed and despised idleness, in this space invented by a society which had derived an ethical transcendence from the law of work, that madness would appear and soon expand until it had annexed them” (Foucault 1988: 57). An economic rationale became inextricably entangled with a moral and ethical one.

Foucault (1988: 274-278) further mentions that doctor-patient relationships emerged within the context of bourgeois societal values: authority, punishment and justice, and social and moral order. Freud had cemented this relationship outside of the positivist realm but reinforced the patient-doctor structure inherited from these bourgeois values. Thus, we see that in that time, mental health from both contemporarily analogous biomedical and biopsychosocial traditions, had situated the responsibility of judge and corrector within the mental health interventionist and allowed him to be the bringer of righteous morality.

This history of morality being tied together with the doctor is a deliberate act.

A label of mental illness or ill-being is an implication that people are broken and need to be healed. When this discourse placed beside economic burden and productivity, this opens up the question of if recovery is happening with the idea of an output-generating economic subject in mind.

Paragraph 5 of the Action Plan (Appendix I) itself makes that statement. Perhaps there is a certain humanity in placing the origin of the condition outside of the patient, but then the patient can be restored back into a productive economic actor. To put it bluntly, those with mental illness are unexplored resources. With just a little bit of investment, we can make them productive again – or, at the very least, we can ease their suffering so that they are not financial burdens or disturbances to social order anymore.

Development interventions and their role in social norms can be tied to economic growth theories in that economic policies can be “[shaped] (...) to meet scientifically ascertained social requirements” (International Bank for Reconstruction and Development in Escobar 1992: 135), although “scientifically ascertained social requirements” perhaps is now better euphemized as “evidence-based programs”. Perhaps this is better described, at least within mental health development agendas, as a dialectical process in which social requirements are used to meet economic policies, as much as economic policies produce social requirements.

After all, I would like to remind us that Canadian developmental aid towards mental health had to meet standards of reducing poverty. Social requirements were made with growth-oriented goals in mind. I remind the reader that “[m]edical management of emotions maladaptive in ‘modern society’ seems justified to relieve pathological stress and maintain the social system.” (Haraway 1991: 33). As long as our emotions are adaptive to survival in modernity, the existing hierarchical social system will persevere.

I would like to revisit the Haitian example to demonstrate an example to illustrate my point. GCC characterizes the Haitians patients who suffer from depression and post-traumatic stress disorder as earthquake victims who “strive to live productive lives and to contribute positively to economic recovery and development” (GCC ca. 2016c). Important to note is that the beneficiaries are not referred to in any other way in the site. It becomes easy for us readers to reduce this aid recipient to an economic actor who is suffering an exogenous setback due to a random natural disaster. A picture is painted of a faceless someone who is struggling to patriotically contribute to nation-rebuilding and economic development. We readers do not know anything else about these people and perhaps what their ideas of healing or being are, or if they are satisfied with the care they received from their spiritual leaders. All we know is that this person is going to heal and contribute to economic development.

I fully acknowledge, and will continue to do so, that economic justifications are persuasive arguments for the call for increased funding to mental health interventions especially in resource-constrained settings. Financially speaking, economic concerns cannot be avoided in a context where development aid needs to be justified to donors, funders, and citizens. Put bluntly, donors and funders want to see value for their money, as demonstrated by GCC’s internal strategies

“to Improve Value for Money” as outlined in their public annual reports (GCC 2017: 22).

What I question is its ubiquitous presence and importance, and how this drives how we view aid recipients as investments and potential economic returns. Fundamentally, I end with one last question: is the potential productive economic actor the one that is most deserving of human rights?

Summary

This question of economic justification is not a unique problem with mental health. Rather, this is a reflection of what is happening across multiple development claims. An argument can also be made that the human capital approach in mental health is simply a reflection of a broader movement in global development dialogues (WBG 2017).

However, rational economic justification is an incomplete description of these stories in mental health. The way in which work, labour, and productivity became tied to cultural mores and norms was a sociocultural and sociopolitical exercise meant to homogenise behaviours. Poverty and labour, in the context of seventeenth century European views of madness, were not exclusively tied to the language of lost productivity. Rather, discourses of work, labour, and productivity, legitimated through ethical and social norms, came to be associated with mental illness.

The subsequent implications for economic growth and the importance of economic justifications in mental health development interventions targeting people with mental illness is an heir of that same dynamic. Social hierarchies and capitalist relations became naturalized by an objective scientific discourse that can paradoxically be maintained with the miracles of technology and medicine. We are granted with new scientifically-derived or -validated tools: scalpels, pills, talk techniques, new ways of exercising power over cognitive and psychological thought, to influence human behaviour.

All the while, we forget that pre-existing ideas of social relations with others and ourselves and the world around us are slowly being eaten away (Escobar 1992; de Sousa Santos 2007; Kuokkannen 2000) in the name of a vague concept of well-being and human rights.

Chapter 8 Conclusion

I have argued two points here: that human rights also rely on a governable subject. I've also argued that mental health not only creates a governable subject, but that from a historical perspective, mental health emerged as a way to correct people towards economically productive behaviours. This was only made possible through a moral emphasis and ethical value placed on work.

I argue that in order to embrace a more human-centered approach to development, it is imperative that interventionists and researchers investigate deeper into the implied values inherent in their policy frameworks and project designs. In this context of mental health and development aid, we must look past the aid recipient as an economic actor. As science has been used to formulate all sorts of techniques to maintain dominance systems and capitalist systems, perhaps it is time to look to other ways of knowing and interacting with our realities.

The Author as an Infidel Searching for a Heteroglossia

As I conclude, I worry that I have created a totalizing critique of science and its role in legitimating the rights-based approach to development. I do not wish to risk creating a totalizing critique in response to a totalizing theory. The political conditions under which these knowledges are produced do not automatically preclude their findings or discount their contributions to a growing body of knowledge (Haraway 1991: 98), situated and positioned though they may be. I believe that scientific discovery has its place in a more horizontal framework of epistemologies and ontological perspectives. Additionally, I do not wish to discount the suffering of those around me and crudely delegitimize their experiences point-blank as a governmentalist, colonialist project.

This is simply something that I am thinking through as an earnest investigation of how illness and disability came to be. Almost as a thought experiment, I simply wanted to ask how suffering became qualified as suffering. I wanted to know why some types of pain were more deserving of sympathy than others. Perhaps my own multifaceted experiences with mental health where I held varying amounts of power and a range of cultural perspectives created multiple definitions and multiple realities; words and identities which, brick by brick, constructed a labyrinth from which I could not escape, and which cemented me further into these elusive partial wisps of me that refused to be bound by harsh borders. In my desperate search for a way out of these constructs, I was overlooking the possibility that I have the ability to dismantle the labyrinth itself.

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