Psychiatry has long been criticized for failing to define mental illness. Unlike somatic medical disciplines that list specific "diseases" in the ICD, psychiatry addresses "disorders" ranging from dementia to socially undesirable behavior. As a consequence, psychiatry has been portrayed as a social institution that aims to control and normalize behavior, and has more in common with the police and prison system than with medicine[6]. This criticism could actually be exacerbated by new statistical approaches to the assessment and mapping of mental health problems, including the Hierarchical Taxonomy of Psychopathology (HiTOP)[1,7].

Indeed, the HiTOP assesses associations between a variety of manifestations of mental disorders, including "antagonizing and externalizing" and "antisocial" personality traits such as "rebelliousness" and "flirtatiousness"[7]. However, there is a risk of confounding merely socially undesirable traits with symptoms of serious mental illness. If this approach is globally applied to persons belonging to a discriminated minority, who rebel against oppression and experience mental health problems due to social discrimination and exclusion, researchers may even find a genetic correlate and misleadingly reify social problems as mental disorders.

Accordingly, there is a need to define those mental health problems that should be globally addressed by psychiatry as a medical discipline. In medicine, clinically relevant diseases are usually defined by a) impairments of vital functions, i.e., functions relevant for human life and survival, which b) cause harm to the afflicted individual, i.e., individual suffering or impairments in activities of daily living that reduce social participation[8]. Mere deviations from statistical norms do not define whether a condition is a disease – caries can manifest in the majority of a population but is still a dental disease[9].

The impairment of a generally relevant vital function may not be sufficient to constitute a clinically relevant disease if the afflicted person experiences no individual harm. People hearing voices that offer spiritual guidance may not suffer from these experiences and may not be impaired in their activities of daily living. Thus, they can still be regarded as presenting with a dysfunction of the generally vital ability to distinguish between one's own thoughts and external sensory experiences. However, in the absence of personal harm, there is no need to diagnose a clinically relevant disease[8]. We suggest that psychiatry as a medical discipline should focus on clinically relevant diseases and abstain from promoting (historically changing) behavioral norms.

Impairments of vitally relevant mental functions traditionally addressed by psychopathology include clouding of consciousness (as in delirium), impairments of memory and executive functions (as in dementia) or failures to self-ascribe thoughts (as in psychosis)[9]. The first two examples show that there is not really a general lack of biomarkers for psychiatric diagnoses. Also, overlap of biological correlates does not invalidate clinical classifications: cardiovascular disorders and stroke share biological determinants, including high blood pressure, but are treated as separate diseases by distinct medical disciplines (cardiology and neurology).

Neurobiological correlates of mental functions transcend nosological boundaries and may best be conceptualized by a dimensional approach. Computational modeling of behavior can provide objective quantifications that are more easily correlated with neurobiological dimensions than subjective reports[9]. However, Stein et al[1] rightly emphasize that dimensional approaches can be transformed into a categorical classification system simply by providing cutoffs. Dimensional approaches thus neither invalidate clinical knowledge nor a traditional focus on vital mental functions.

But, how do we define which functions are indeed of vital importance for human beings and should be addressed within the health care system? Psychiatry can provide clinical knowledge and a philosophical tradition[9], but has no monopoly on defining what mental functions are universally relevant for human life. To improve global mental health care, representatives of patients and families have to be included when revising classifications, participatory research has to be promoted, and the civil society has to be engaged in all aspects of health care planning.

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From diversity to individualized care: Africa's contribution to psychiatry

The extent of diversity on the African continent is one of the greatest potential contributions of this continent to the world, with a multiplicity of cultures and traditions, religions and other belief systems that dwarf anything found anywhere else on earth. Naturally, therefore, one would be hard-pressed to identify a uniquely "African" viewpoint on mental health and the detection and treatment of mental illnesses.

Africans have lived with psychological distress and mental disorders for as long as humans have lived on the continent, with different cultures and traditions, including religious ones, having different explana-

tory models. Many African communities still utilize relatively culture-specific models to understand the causes of mental illnesses, including demon or spirit possession, or witchcraft[1]. *Jinns* (invisible spirits) in Islamic traditions, and other "evil" spirits in other communities, are considered responsible for conditions presenting with mood disturbances, anxiety, hallucinations, delusions and back pain, among other health problems[2]. These diverse local conceptualizations determine and affect access to and outcomes of care for those with mental illnesses[1].

In our opinion, current and emerging diagnostic and treatment systems must take into consideration these existing models, and endeavour to create a bridge between them and newer ways of understanding mental conditions and health. The extension of the biopsychosocial model to include sociocultural-spiritual components of illness and treatment[3] would encourage holistic and culturally sensitive approaches to addressing Africa's mental health care gap.

As Stein et al[4] point out, classification systems, at their very core, assume a universality of experience and the potential universality of response to investigations and treatments. Novel attempts at understanding mental illness – including the Research Domain Criteria (RDoC), the advances in neurosciences, and even personalized medicine – build upon certain "universalized" assumptions, including those on the nature of mind and the interaction between a person's inner world and his/her environment. From a purely practical perspective, we agree with the implicit notion that a global model of understanding mental health and illness is desirable in the context of a rapidly globalizing world, given the ease of mobility and the resulting complex cosmopolitan cultures that sprout whenever new human communities form. We must, however, remain cognizant of the fact that, even within the most homogeneous communities, every person's experience of the world is unique, and it may be difficult to generalize these experiences even to individuals steeped in the same culture and environment.

Diagnostic and treatment models are therefore required to use a "global" framework of understanding mental health, but ultimately apply this to an individual's unique experiences and background, in order to fully understand personal suffering and generate an explanatory model that makes sense to the individual and to the society from which he/she comes. To implement this approach, however, may be difficult[5,6], because many clinicians are ill equipped with the relevant social and anthropological tools, and because of the problems in creating appropriate research platforms, due to the variety of explanatory ideas.

There are inherent conceptual weaknesses in attempting to identify components of explanatory narratives, in much the same manner as it would be difficult to develop a global glossary of symptom contents for something like auditory hallucinations. Treating individual explanatory narratives as part of the diagnostic process as well as an integral component of treatment planning might yield better results than attempting an in-depth understanding of the subject through quantitative research methods.

Even with culturally sensitive approaches to diagnosis and treatment, there is no level of cultural understanding that can replace the information on an individual's own lived experience and perspectives, which vary widely even within a particular cultural context. Not everyone within a cultural or ethnic group subscribes to what is considered "traditional" to that group, and unquestioning acceptance of cultural or traditional practices in the context of individual patients runs the risk of alienating significant minorities and therefore compromising their access and response to care.

This individualized care model is already present in the management of psychological distress and behavioural problems in African communities that have different attributions for these conditions. In many cases, the practitioner collects information about the individual's context and beliefs, and uses this information to develop an explanatory narrative for the condition and to fashion a remedy that is unique for that person even while utilizing available generic components. For instance, personalized remedies have been described in Ghana, and categorized to include banishing evil spirits, protection from relapse/further attacks, and "awakening the mind"[7].

In these settings where current innovations in care are inaccessible, mainly due to the cost and investments required, attempts have been made to develop separate systems of care in the context of global mental health, including concepts of "task-shifting" or "task-sharing". Unfortunately, these "contextualized" approaches have sometimes resulted in low-income populations getting sub-standard care, while those that can afford it – even within the same settings – are able to access high-quality evidence-based care. We have previously criticized these approaches, as they endorse alternative systems of care based on the assumption that poor people or societies will always remain poor and incapable of accessing care that is of high quality and evidence-based[8].

We argue that global mental health must be truly global, through the application of a global knowledge framework to understand distress and suffering, while developing solutions that take into consideration individual histories, contexts and explanatory models. While an advanced knowledge of brain processes will help us in developing this global framework, an understanding of society and culture, and how individuals interact with and perceive their environment, will be more critical in the encounter with a given patient. The "global" in global mental health should not only be seen as addressing differences *between* societies, but also working with diversity *within* all societies.

In conclusion, we believe that a personalized diagnostic and treatment framework that is based on a core of globally applicable principles is the first step towards addressing inequities in access to care, and ensuring that even the most disadvantaged populations access the best available standard of care. African diversity provides the best example of how this can be approached, and the best substrate for the examination of this concept.

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