ing on mental health care by promising cost savings in some other area of health or social services? Adequate spending on the mental health of our populations should be a worthy goal in and of itself.

Over the past few decades, psychiatry has come a long way in its efforts to address and overcome the stigma associated with mental illness, but recent critiques show us that our profession is still not immune from biases and systemic racism that can contribute to the stigmatization and oppression of vulnerable groups. It was the year 1974 when a pharmaceutical company marketing to American psychiatrists tapped into racist fears by running an ad featuring a black man with a raised fist and the title "Cooperation often begins with Haldol"[8]. It would probably not happen anymore today, but more subtle expressions of the above biases are still likely to exist in some contexts.

Mental illness and addiction have become recognized as leading causes of health-related disability worldwide, and we have much to learn from our colleagues around the world about different ways to understand mental illness, to address the stigma carried by those living with mental health and addiction problems, and about different approaches to treatment. Recent work on task sharing and collaborative care[9] suggests that we can help more people in need when we partner with colleagues in primary care and with team members who complement our own skills, and when we use technologies that allow us to provide consultation and supervision across distances and ensure that our patients do not fall through the cracks. The experience and joy that come from working together in a well-functioning team can become one of the most rewarding and satisfying aspects of a career in psychiatry.

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DOI:10.1002/wps.21005

Challenges and chances for mental health care in the 21st century

Stein et al[1] provide a comprehensive review of the potentials and pitfalls of mental health care in the 21st century. They discuss current models of diagnosis and classification, novel statistical approaches and digital phenotyping, developments in clinical neuroscience, personalized pharmacotherapy, and evidence-based psychotherapy, as well as perspectives for deinstitutionalization and for community and global mental health. The authors provide a balanced view and suggest that these developments will allow incremental changes rather than paradigm shifts. In light of the wide range of topics addressed by Stein et al, we discuss key challenges and chances for mental health care in a global perspective.

Challenges for global mental health include climate change, displacement of large populations due to war and poverty, income inequality, and inadequate health care services[1-3]. These challenges interact, as climate change can reduce food production and increase violent conflicts, which may displace large parts of the local population, who then face income inequalities and inadequate health care services in the host countries. Income inequality and local poverty are major risk factors for distress, which escalate the mental health burden[3,4]. The COVID pandemic is deepening these pre-existing challenges.

Psychiatric care has traditionally used a reductionist approach focusing on medication and confinement in large institutions[1]. Against this outdated practice of social exclusion, human rights and state-of-the-art treatment concepts demand social inclusion in the community and low-threshold availability of counselling, peer support, psychotherapy and specialized treatment[1,4]. As a medical discipline, psychiatry can address social inequalities and contribute to a call for change. However, a complementary view is required that includes the perspectives of users, families and friends, and the competence of other scientific disciplines, including social sciences and city planning[4].

In spite of widespread calls for improving global mental health care, funding remains inadequate from low- and middle- to high-income countries. Health care resources are often only available for a rich elite, who are mainly treated with medication, while low-threshold psychosocial interventions are lacking for the majority of the population. People with severe mental illness are too often incarcerated or left homeless without health care[4,5]. There is a widespread lack of resources for migrants, refugees, and other minorities.

Culture-, language-, class- and gender-sensitive treatment can be promoted using telemedicine and digital interventions[1]. Participatory and interdisciplinary approaches can integrate disciplinary diversity with stakeholder engagement to fight stigmatization, racist stereotyping, and social exclusion. However, systematic attempts to provide low-threshold treatment to all components of the population are not always successful. Stein et al[1] discuss experiences of substantially increased availability of psychotherapy in the UK, which however did not reduce the prevalence of mental disorders. The authors suggest that emotional distress may more often be diagnosed as depression, thus masking any drop in prevalence rates[1]. Even if psychotherapy resources are available to everyone, access barriers can still exist for those with serious mental illness, who can be hard to treat in outpatient practices.

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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DOI:10.1002/wps.21006

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-