Matthew Smith, University of Strathclyde

The Social Determinants of Mental Health and Transcultural Psychiatry

In my recently published book on the history of ADHD, *Hyperactive: The Controversial History of ADHD*, I have a chapter called 'Hyperactive Around the World'. In it, as you might expect, I describe the story of how ADHD, which first emerged as a childhood psychiatric disorder in the US, spread across the globe. International psychiatric recognition of ADHD is such that a team of Brazilian psychiatrists, most funded in part by pharmaceutical companies, have argued, on the basis of a meta-analysis of the medical literature, that 5.29 per cent of the world's children are hyperactive. The figure of 5.29 per cent, argue the researchers, is not an average of disparate rates found in different countries, but rather an accurate representation of the actual distribution of the disorder worldwide. In other words, 5.29 per cent of African kids are hyperactive; 5.29 per cent of South American kids are hyperactive; 5.29 per cent of European kids are hyperactive. If we get around to colonising the moon or Antarctica, most likely 5.29 per cent of the kids born there will be hyperactive, too.

If you read the previous paragraph fairly closely, perhaps the last sentence in particular, you probably get a sense of how valid I think this figure of global ADHD prevalence is. Drawing on Timimi's critique of universalism and essentialism in psychiatry - the notions that psychiatric disorders occur everywhere throughout the world and, where they exist, are characterised by the same features - I attempt to take apart such thinking when it comes to ADHD. I do so by highlighting how ADHD emerged in Canada and the UK, the two countries most similar to the US in terms of culture, medical history and psychiatric knowledge, and demonstrating how, even in these countries, American understandings of ADHD were negotiated, challenged and even rejected. In actual fact, I didn't have to go

as far as Canada and the UK. State by state, prevalence of ADHD varies considerably, with Nevada only diagnosing 5.6 per cent of its children and North Carolina topping the table at 15.6 per cent. Similarly, the take-up of ADHD varies widely across other countries; whereas Finland rarely diagnoses children with the disorder, Iceland now prescribes more Ritalin per capita than the US. While some ADHD advocates would argue that psychiatrists in many countries simply need to get their act together, I contend that this is ridiculous. Countries have different rates of ADHD for many reasons, but especially because they have different ideas about psychiatry, medication, education, and most importantly, about how they think children should behave.

So far so good. Psychiatric disorders like ADHD are culturally contingent - at least to a substantial degree - and we should rap companies like GlaxoSmithKline on the knuckles a bit more often. But does that mean that there is nothing universal or essential about mental illness? I have been thinking about this more and more recently as I have been developing a new project, this time on the history of social psychiatry. Social psychiatry, which peaked in the US in the 1960s, just as psychoanalysis was on the wane and biological psychiatry was on the upswing, was a psychiatric theory which posited that socioeconomic problems, such as poverty, violence and social isolation, were the fundamental causes of mental illness. Reflected in President Johnson's Great Society welfare programmes, endorsed by presidents of the American Psychiatric Association and reified in the community mental health movement, social psychiatry was an idea for the times. But times changed. With the Vietnam War sucking up welfare resources, a Republican in the White House and a resurgent biological psychiatry, the sharp, political edge of social psychiatry faded away during the 1970s, and what was left of the movement contented itself focussing on other issues, including, ironically, transcultural psychiatry.

Plus ca change. In June 2010, I attended a conference in Chicago. The title of the conference? The Social Determinants of Mental Health. Yes, like a zombie rising from a crypt, social psychiatry was seeking the light. Of course, the historian grumbles, they were scarcely aware that we had all been there before, especially in Chicago, the home of social psychiatry in many ways, but that's another story.

So, what does such renewed interest in the social determinants of mental health mean for those interested in transcultural psychiatry? Well, it seems to me that, quite rightly, transcultural psychiatry has focussed on seeking difference in comparing how different cultures define and respond to mental illness. Timimi is right to attack the banal idea that American concepts of mental illness should automatically become global ideas of mental illness. But perhaps instead of seeking difference, we should also look for commonalities. And as I think more and more about social psychiatry, I wonder if it is the social that is what's universal about mental illness.

A final note about ADHD. Although I critique the notion of ADHD, I certainly acknowledge that the behaviour of some children is so hyperactive, impulsive and unfocussed that it warrants becoming a medical problem. In fact, I used to work with such children and adolescents in a previous life. Moreover, in my first book, *An Alternative History of Hyperactivity: Food Additives and the Feingold Diet,* I certainly had to set aside my social constructivist tendencies in order to analyse the link between reactions to food chemicals and hyperactivity. And by the end of that project, I was convinced that food additives - and other foods - could trigger behavioural reactions in children. But in the course of the research, I also found that there was an elephant in the room, specifically, the much simpler relationship between plain old malnutrition - not getting enough for breakfast - and behavioural problems. And what could be more social than that?