Globalisation means crossing borders. All of the social and economic forces driving globalisation relate to the opening or dismantling of borders: instant communication, easy travel, deregulation of commerce and widened access to information and technology. The internet is often hailed as a good example of globalisation, as it allows people in far-flung corners of the planet to communicate rapidly with each other regardless of their geographical location. Other examples include the establishment of supranational political bodies, enhanced cross-border cultural interaction and globalised approaches to environmental issues (Box 1).

From its inception, globalisation has attracted robust criticism, chiefly related to the social inequities it appears to accentuate. Critics point out that the internet, for example, remains the realm of a privileged minority as most of the world’s population have never made a telephone call, let alone sent an e-mail. The free flow of capital into and out of unstable economies also presents problems, often compounded by the waves of migration that tend to follow financial downturns (Stiglitz, 2002). Perhaps the greatest criticism of globalisation, however, relates to the management of cultural diversity, a phenomenon that presents very great challenges, as well as opportunities, in many societies around the world. These criticisms, along with the terrorist attacks of 11 September 2001 in the USA, have stimulated a worldwide re-evaluation of globalisation and a reconsideration of the strategies that societies and individuals use to manage global change.

In this article, I examine the effects of globalisation on the practice of psychiatry and suggest strategies for their optimal management in relation to mental health with a view to exploiting the opportunities it presents for the development of psychiatric services.

Socio-economic effects and their impact on mental health

There is considerable disagreement among economists about the likely long-term economic effects of globalisation. On the one hand, it is argued that the process of globalisation offers individuals more freedom to choose how they live, where they work and what they buy (Economist, 2001). Opening borders, deregulating trade and using government chiefly to maintain social justice should, it is argued, lead to a more integrated, more equitable and more sustainable global society. This view actively informs the current policies of international organisations such as the World Bank, the International Monetary Fund and the World Trade Organization.

Abstract

Globalisation means crossing borders. It is a complex, large-scale social phenomenon that presents to mental health services both challenges and opportunities. These relate to the increased cultural diversity of service users and service providers; the effects of migration on mental health; and the implementation of international protocols in relation to training, policy and education. In the aftermath of 11 September 2001 in the USA, the relationship between large-scale social change and mental health has also focused attention on the concepts of anomie and social capital. An explicit return to the principles of biopsychosocial psychiatry and a positive engagement with globalisation will advance the development of effective, evidence-based models of care appropriate to the changing needs of patients.
Critics of globalisation argue the opposite case, maintaining that current globalisation policies serve to widen the gap between rich and poor (Stiglitz, 2002). Market deregulation favours the dominant, strong economies of the West and fails to offer developing countries an opportunity to strengthen their infrastructure sufficiently to compete in a global economy. Globalisation, by this logic, will lead to further poverty, inequality and social injustice.

The majority of commentators from both sides, however, are united on one point: that globalisation presents opportunities that could, at least in theory, be used for the greater good. The chief point of disagreement is the sequencing of change, with certain critics arguing that it is wrong to deregulate markets without first preparing an economy and a society for change. They point to evidence from the World Bank that shows little decrease in world poverty and a possible increase in inequality between countries in recent years (World Bank, 2001).

Socio-economic and other inequalities are significantly related to mental health. Psychiatric disorders are more common in people from lower socio-economic groups (Goldberg & Morrison, 1963; Wiersma et al, 1983). This relationship is likely to be bi-directional, with health affecting socio-economic status and socio-economic status also affecting health (Lewis & Araya, 2002). Thus, if globalisation truly increases poverty, it is likely to have a proportionately negative effect on mental health. This effect would be compounded by the decreasing ability of an increasingly poor country to provide adequate health care to its citizens. An effect on social capital would also be evident, with reduced community cohesiveness, resulting in weakened social support and increased psychosocial morbidity (Putnam, 2000).

It is likely that a disproportionate part of this burden would be borne by women, who, in addition to performing the majority of domestic and childcare tasks, may find themselves satisfying a growing need for relatively low-paid labour (Lewis & Araya, 2002). In light of the particular importance of psychosocial stressors in relation to depression in women (Avotri & Walters, 1999), such a change would be expected to increase the incidence of depression and anxiety among them.

This is the worst-case scenario: increased poverty, increased illness burden and decreased ability to provide mental health care. The socio-economic effects of globalisation, however, need not be entirely negative. Indeed, several important features of this process suggest that globalisation, if properly managed, can serve as a force for the promotion of economic growth and the enhancement of social capital in both developed and developing countries. Communication technology is a good example.

At present, advances in communication technology are not equitably distributed around the world. However, this technology is spreading rapidly from developed countries to developing ones and it has a strong enabling power when it arrives. The internet, for example, can be used to inform farming and fishing practice by providing information relating to prices, markets and weather forecasts (Economist, 2001). In countries such as Bangladesh, mobile telephone networks are proving far more efficient than traditional terrestrial telephones, as each person in a village might make only one or two calls per week and terrestrial telephone systems are either unavailable or administered by inefficient, bureaucratic government bodies. Advances in communications technology have much to offer developed nations too: even critics of globalisation use the internet extensively to organise protests and coordinate campaigns.

There is no compelling reason to believe that globalisation must necessarily increase the gap between rich and poor. Globalisation on this scale and at this speed is a new phenomenon. Our economic and social policies in response to it are probably responsible, at least in part, for any perceived negative effects. Just as Stiglitz (2002) argues for an urgent reconsideration of economic policies in response to globalisation, there is a similar need to re-evaluate social policy. There is a strong relationship between socio-economic change and mental health, and this relationship should form an important part of social, economic and health planning. This point is well illustrated by the significant challenges that increased migration currently presents to mental health services.

Migration and mental illness

Globalisation has led to a significant increase in migration. People are now moving further, faster and in greater numbers than ever before. Each year, 1.5 million people emigrate permanently and a further 1 million seek asylum abroad (Stalker, 1994). Migration is known to have significant effects on health, with migrants showing higher rates of both physical (Gleize et al, 2000) and mental illness (Gavin et al, 2001).

In the UK, Irish, Caribbean and Pakistani immigrants have significantly higher rates of suicidal thoughts and deliberate self-harm (Nazroo, 1997). Egyptian and Asian immigrants have increased rates of bulimia and anorexia nervosa (Bhugra & Jones, 2001). Asylum-seekers present particular challenges to mental health services as they come from a wide variety of cultural backgrounds and have sharply diminished social
support. Many have experienced human rights abuse, torture or displacement in their homeland (Box 2). On arrival in a new country, they might face confinement in detention centres, enforced dispersal and ongoing discrimination (Silove et al, 2000). In Oslo, post-traumatic stress disorder affects 46.6% of all refugees (Lavik et al, 1996).

Schizophrenia is six times more common in African–Caribbeans living in the UK than in the native population (Harrison, 1990) and four times more common among migrants to The Netherlands (Selten et al, 1997). This is difficult to explain: incidence of schizophrenia is not increased in migrants’ countries of origin (Hickling & Rodgers-Johnson, 1995), nor do migrants have increased exposure to environmental risk factors such as obstetric complications (Hutchinson et al, 1997). It is notable, however, that the increase in risk of schizophrenia among migrants shows a powerful inverse relation with the size of the migrant group, a finding that, at the present state of biological psychiatry, lends itself more readily to psychosocial explanations than to biological ones (Boydell et al, 2001).

Globalisation, then, affects the pattern of occurrence of mental illness and, through migration, has had a significant effect on the epidemiology of schizophrenia. The increased diversity of mental health service users presents an urgent challenge to service providers in developed countries. People from different ethnic backgrounds often have different views about mental health and are accustomed to substantially different models of care. This can result in a damaging mismatch between the needs of patients and the services provided. In London, for example, the pathway to care for migrants is characterised by a high rate of involuntary admission and increased involvement of police, as opposed to general practitioners (Davies et al, 1996).

Globalisation and human rights in psychiatry

Opponents of current models of globalisation often claim that it has negative effects on human rights, particularly in relation to financial well-being and economic stability. This is an issue of special concern in relation to people with mental illness – particularly those with long-term illness who have reduced ability to advocate for themselves. In 1991, the rights of those with mental illnesses were ‘globalised’ in the United Nations’ Principles for the Protection of Persons with Mental Illness (United Nations, 1991) (Box 3). These principles, however, do not have the status of a formal international treaty and there is no obligation on UN member states to use the principles to define a minimum standard of care (Harding, 2000).

In 2001 the World Health Organization renewed its emphasis on human rights and mental health by devoting World Health Day 2001 to global advocacy on mental health issues. There were compelling social, political and legislative reasons for this choice, many of which relate to the effects of globalisation. Migration, for example, presents particular challenges in terms of both health care

### Box 2 Mental health of asylum-seekers: particular challenges

**In their home country**
- Human rights abuse
- Torture
- Displacement
- Poor mental health care

**In their new country**
- Diminished social support
- Confinement in detention centres
- Enforced dispersal
- Ongoing discrimination
- Adjustment disorder
- Post-traumatic stress disorder
- Depression
- Increased rates of other illnesses

In response to these problems, it is necessary to address issues in psychiatric training, service provision and social policy. In the first instance, it is important to increase the emphasis placed on transcultural psychiatry in mental health curriculums. To assist with this task, the World Psychiatric Association is developing a core curriculum that places significant emphasis on transcultural issues (World Psychiatric Association, 2002). An enhanced appreciation of cultural factors as they affect mental health will serve both to deepen the understanding of cultural diversity and to enhance the quality and acceptability of the mental health care provided to all.

The development of ethnically segregated services, however, would tend to maintain racism and compound psychological stressors, and thus represents an inappropriate model for service development (Bhui et al, 2000). It is generally more helpful to increase knowledge of mental illness among migrants themselves and to provide appropriate training for mental health team workers to provide effective, needs-based interventions for specific migrant communities. There is also a strong need to reconsider the effects of social policies on the psychological well-being of migrants, as current policies of dispersal may serve to increase the psychological stresses and social disadvantages experienced by certain migrant groups.
Globalisation and psychiatry


and human rights. In the first instance, there is a basic human right to adequate health care and it is likely that migrants are being denied this in many countries around the world. Indeed, quality and availability of mental health care for both migrants and native populations present a real problem in many countries. In 2000 in Ethiopia, for example, a population of 55 million was served by 11 psychiatrists and one psychiatric hospital.

Alleged abuses of psychiatry around the world also provide cause for increasing concern. At the 2002 World Congress of Psychiatry in Yokohama, Japan, the World Psychiatric Association resolved to arrange a mission to China to investigate allegations of abuse of psychiatry there. It was agreed that the investigation of specific allegations would be set in the context of an examination of the overall quality of the psychiatric service in China. Issues relating to training, access to service and quality of care are important considerations in this context.

The evolution of a globalised approach to these issues, as demonstrated by the World Psychiatric Association, has many advantages. Most importantly, it provides a unified, authoritative voice with which to advocate for change. However, it is important to recognise that definitions of ‘mental health’ and ‘psychiatry’ can vary considerably between cultures. A solution that meets the needs of one country may not be appropriate for others. Furthermore, most legislatures have their own mental health laws, which often have substantially different approaches to issues such as involuntary admission and quality assurance. This is also a time of considerable legislative change in Europe, with many countries debating amendments to existing laws and at least one country (Ireland) introducing a completely new Mental Health Act.

The best way to ensure that human rights are respected on a global scale is to increase awareness and implementation of the United Nations’ principles regarding people with mental illnesses (United Nations, 1991). These principles provide a framework that can usefully inform legislative change in individual countries. They should also form an important part of psychiatric education and can be used to help shape service developments and planning. The implementation of these principles is a challenging task, which is best accomplished when mental health professionals and policy makers work in partnership with advocacy groups and service-user representatives.

One of the central contributions that psychiatrists can make to this process is the continued provision of high-quality, evidence-based mental health care. Health care, however, is delivered in a specific social and political context, which is often largely determined by policy makers and politicians. Nevertheless, psychiatrists are well placed to educate colleagues, policy makers and the public about mental health and human rights. International

<table>
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<th>Box 3</th>
<th>Key rights of people with mental illnesses and principles regarding their mental health care (United Nations, 1991)</th>
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<td>•</td>
<td>All people are entitled to receive the best mental health care available and to be treated with humanity and respect</td>
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<td>•</td>
<td>There shall be no discrimination on the grounds of mental illness. All people with mental illnesses have the same rights to medical and social care as other ill people</td>
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<td>•</td>
<td>All people with mental illnesses have the right to live, work and receive treatment in the community, as far as possible</td>
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<td>Mental health care shall be based on internationally accepted ethical standards, and not on political, religious or cultural factors</td>
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<td>•</td>
<td>The treatment plan shall be reviewed regularly with the patient</td>
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<td>•</td>
<td>Mental health skills and knowledge shall not be misused</td>
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<td>•</td>
<td>Medication shall meet the health needs of the patient and shall not be administered for the convenience of others or as a punishment</td>
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<td>•</td>
<td>In the case of voluntary patients, no treatment shall be administered without their informed consent, subject to some exceptions (e.g. patients with personal representatives empowered by law to provide consent). In the case of involuntary patients, every effort shall be made to inform the patient about treatment</td>
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<td>Physical restraint or involuntary seclusion shall be used only in accordance with official guidelines. Records shall be kept of all treatments</td>
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<td>•</td>
<td>Mental health facilities shall be appropriately structured and resourced</td>
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<td>•</td>
<td>An impartial review body shall, in consultation with mental health practitioners, review the cases of involuntary patients</td>
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psychiatric organisations such as the World Psychiatric Association have a particular role to play as powerful advocates for improved psychiatric care and for improved working conditions for mental health workers around the globe.

**Psychological effects of large-scale social change**

On 11 September 2001 the city of New York experienced the largest act of terrorism in the history of the USA, which took the lives of about 3000 people in New York alone (‘Dead and missing’, New York Times, 26 December 2001, B2). While certain commentators stated that these events heralded the ‘end of globalisation’, many others took the opposite view and concluded that there was now an even more urgent need for globalisation to proceed in a timely and equitable fashion (Economist, 2001).

In the months following the attacks, Galea et al (2001) studied the prevalence of post-traumatic stress disorder (PTSD) and depression in residents of Manhattan, the area most affected by the events. They interviewed over 1000 adults and found that 7.5% reported symptoms consistent with PTSD related to the attacks and 9.7% reported symptoms consistent with current depression. These prevalences were double those described in similar populations in the previous year. The authors then examined predictors of psychopathology and found that Hispanic ethnicity was associated with both PTSD and depression and that this association was independent of other covariates. PTSD and depression were also related to low social support. The authors emphasise that social ties have a positive and protective role in mental health.

Social ties, however, are rapidly decreasing in the USA, as evidenced by reduced participation in community organisations, local representation and national politics (Putnam, 2000). The events of 11 September were devastating not only because of their nature, magnitude and unpredictability, but also because they occurred in the context of a society with rapidly depleting social capital.

The combination of poor social ties and large, unpredictable events evokes the concept of ‘anomie’. This term was famously used by Emile Durkheim, a French sociologist, to describe a state in which norms are confused, unclear or absent, and where there are large-scale social changes that the individual cannot understand, let alone control (Durkheim, 1947). Anomie is traditionally related to suicide, but the concept has also been suggested as one of a range of factors that might help to explain the increased incidence of schizophrenia in progressively smaller migrant groups (Boydell et al, 2001).

The concept of anomie has renewed importance in an era of globalisation. Changes in society are increasingly occurring on a global level and the magnitude of such change is greater than ever before. International political bodies are introducing directives and legislation over which many individuals feel they have little or no control. The threat of international terrorism is greater than ever and many individuals feel that they cannot effectively defend themselves or their families. Increasingly, the world of the individual is shaped by global events that appear to lie beyond the individual’s control.

Rebuilding social capital is a key stage in reducing feelings of anomie. This is important for society in general, but has added urgency in relation to mental illness. The reduction of the stigma of mental illness is a particularly important step and is best accomplished through a multi-disciplinary approach over a sustained period. Community treatment programmes and social skills courses have critical roles to play in reducing stigma, increasing community reintegration and rebuilding social capital. This process would be advanced by a strong return to the principles of biopsychosocial psychiatry, which takes a systematic, multi-dimensional approach to treating mental illness (Gabbard & Kay, 2001).

**Conclusion**

Globalisation is a complex, large-scale social phenomenon which is intrinsically neither good nor bad. The effects of globalisation depend largely on our engagement with it. There is a strong need to re-evaluate our economic and social policies in response to globalisation, particularly with regard to the effects of socio-economic change on mental health. There are overwhelming humanitarian reasons why the relationship between socio-economic change and mental illness should form an important part of social, economic and health planning. There are also financial reasons: schizophrenia, for example, already costs the US economy some $40 billion per year – three times as much as the entire US space programme (Torrey, 2001).

The likely effects of globalisation on clinical practice in psychiatry are summarised in Box 4. Globalisation presents significant opportunities for the development of psychiatric services. Whether or not we take advantage of these opportunities depends largely on our responses to phenomena such as increased migration and the increasingly diverse needs of mental health service users. The World Psychiatric Association’s introduction of a ‘core curriculum’ for psychiatric training should assist in placing new emphasis on transcultural
the stigma of mental illness, enhancing community reintegration and increasing social capital.

Rebuilding social capital is a challenging task that depends on a careful interplay of local, national and international strategies. Globalisation can contribute positively to this process, provided social and economic policies in response to globalisation are planned with care. As mental health professionals, we are well positioned to advocate that such planning takes adequate account of the needs of people with psychiatric illness and facilitates the delivery of mental health care that is effective, acceptable, evidence-based and appropriate to the needs of patients.

References

Avotri, J. Y. & Walters, V. (1999) ‘You just look at our work and see if you have any freedom on earth’: Ghanaian women’s accounts of their work and their health. Social Science and Medicine, 48, 1123–1133.


Multiple choice questions

1 In relation to migration:
   a 5 million people emigrate permanently each month
   b 1 million people seek asylum abroad each year
   c migration has reduced in recent years
   d 1.5 million people emigrate permanently each year
   e migration is not a key feature of globalisation.

2 In relation to migration and health:
   a migration is related to risk of mental illness
   b migration improves physical health
   c asylum-seekers rarely present with post-traumatic stress disorder
   d migrants have higher rates of involuntary admission than native populations
   e schizophrenia is less common in migrants than in native populations.

3 The United Nations’ Principles for the Protection of Persons with Mental Illness:
   a were introduced by the World Health Organization
   b date from the 20th century
   c have the status of a formal international treaty
   d provide a framework for legislative change in individual countries
   e could usefully inform programmes of psychiatric education.

4 Following the events of 11 September 2001 in the USA:
   a the prevalence of post-traumatic stress disorder in Manhattan increased
   b the prevalence of depression in Manhattan increased
   c psychopathology was unrelated to Hispanic ethnicity
   d psychopathology was related to pre-existing social ties
   e commentators began to re-evaluate policies related to globalisation.

5 The concept of anomie:
   a was introduced by Putnam
   b is unrelated to suicide
   c relates to the belief that aliens are taking over the earth
   d is related to psychosocial distress in times of change
   e has added significance in the context of globalisation.

INVITED COMMENTARY ON
Globalisation and psychiatry

Dr Kelly’s paper (Kelly, 2003, this issue) is a timely review of the effect of globalisation on mental health and its impact on psychiatric services and of the role that psychiatrists and their professional organisations can play in responding to this phenomenon.

Globalisation, defined by Kelly as ‘crossing borders’, is, as he points out, not a new phenomenon. Indeed, peoples have moved around the world, probably since time immemorial, and one need look no further than the Bible for confirmation that many of the reasons for these movements were...
the same then, millennia ago, as they are today: economic, to seek a better way of life and a higher standard of living (economic migrants); fleeing conflict and persecution (asylum-seekers); and to conquer and colonise. Nor is it only people that have moved across borders. Trade has been international for many centuries, imbued with the romanticism of the Silk Road, the Spice Islands and the tea clippers.

Why is globalisation so important?

So what is so different today, that globalisation is now thought to be important enough to warrant conferences and learned papers? And, specifically, what is its impact on mental health and the consequent role of psychiatry?

The perceived problems of globalisation are related to a number of different factors.

The magnitude and speed of migration

First, there is the combination of scale, speed and distance of migration. This now results in influxes of large numbers of people into distant and often very different cultures. The consequent cultural diversity can justifiably be lauded as enriching, but in practice it can be very difficult for the individuals concerned – both the immigrants and the indigenous population – to cope with. Such differences are often accentuated by the comparative poverty of immigrant communities. Traditionally, immigrants have arrived with little or nothing and, although they might have had high social and educational status in their own countries, often they have no choice but to undertake poorly paid, menial labour in the receiving country. This can be an immensely stressful experience for these individuals, who find themselves on the wrong side of a socio-economic divide in a strange and often unwelcoming country. It is important also to acknowledge that the sudden arrival of a large number of people who are perceived as competing for limited resources (benefits, housing, education, health care) can be worrying and it is unfair to dismiss such anxieties as racism.

Global trade

In contrast to migration, which in its essentials has changed little over the centuries, global trade, in its broadest sense, has changed dramatically, not just quantitatively but qualitatively because of the growth in the number and size of multinational corporations. This has resulted in a worldwide homogeneity of consumer goods and brand names that appears to threaten local traditions. Simultaneously, it has become evident that the real increase in international wealth has not been equally distributed and that some countries are now vastly wealthier than others (World Bank, 2001). Among many possible examples of such inequalities, the following are particularly striking:

- the wealth of the world’s three richest billionaires exceeds the combined assets of the 600 million people in the world’s poorest countries (Sacks, 2003);
- Americans spend more on cosmetics, and Europeans on ice cream, than it would cost to provide sanitation and schooling for the two billion people who currently go without (Sacks, 2003);
- 10 countries account for more than 80% of global analgesic morphine consumption, and more than 120 countries report little or no opioid analgesic consumption (Ghodse, 2003).

Information technologies

In theory, information technologies could and should help to narrow this gap; as Kelly points out, they are spreading rapidly from developed to developing countries and they are enabling and empowering (Mandil, 1998; Sharma, 2000). But there is also a risk that the current ‘digital divide’ will increase inequalities, with wealthy economies utilising new technologies to speed even further away from those at subsistence level.

Inequalities: acknowledging and redressing

These inequalities between nations are relevant to this discussion because of their acknowledged effect on health in general and on mental health in particular (Saraceno & Barbui, 1997; World Health Organization, 2001). And a significant difference now is that the world knows about the inequalities. Globalisation of communication, in all its diverse forms, means that people in rich countries do know of others’ poverty. More significantly, it also means that those in poor countries know what they are missing; they know that people are better off elsewhere. And combined with this painful knowledge there is often an inability to do much about it, partly because the world’s international monetary systems do not favour weak economies and partly because the commercial decisions of huge multinational companies, in terms of movement of money and shifts of production, can work against governments’ policy decisions anyway. Small wonder that such powerlessness
generates anger, frustration and mental ill health, which are at risk of being channelled, often via the new information technologies, into powerful and violent responses that threaten national and international security (Global Forum for Health Research, 2002).

**Effects on psychiatry**

What then of psychiatry? What role can psychiatrists play in ameliorating the current position? Clearly, they cannot alone rectify the mental health problems associated with globalisation, but their unique knowledge and skills can be used to make a valuable contribution in many areas. For example, with their well-honed communication skills, they should be leading the way in facilitating and enhancing communication between immigrants and others in their local community, developing an environment in which diversity and difference are acknowledged, respected and cherished.

**Displacement is a global problem**

Psychiatrists need to be prepared to treat the higher rates of mental illness that occur in the immigrant population (Bhugra & Jones, 2001; Gavin et al., 2001). This preparation must include adequate education and training, so that the particular cultural features of mental illness in specific populations are fully taken into account. Kelly’s paper explores a number of such issues, but adopts a somewhat Eurocentric/UK-centric stance. In the face of frequent headlines about the number of asylum-seekers and targets for their reduction, it is easy to forget that the number of immigrants from, say, Afghanistan to the UK is a tiny fraction of the number crossing the land borders into neighbouring Iran and Pakistan. Those millions of people might not have travelled so far, but they too have given up their homes, their possessions and their jobs, then to live in comparative squalor in refugee camps. They too will be stressed and unhappy and have higher rates of mental illness, but in a situation in which there are far fewer resources with which to treat them – and because such patients generate few scientific papers, they tend to be overlooked in accounts of globalisation and mental health.

**International collaboration**

Another role for psychiatrists, therefore, is to develop a dialogue with colleagues who might be dealing with similar issues in very different circumstances. The increased speed of communication that has developed as part of the globalisation process will facilitate this dialogue, but it must be a true dialogue, that acknowledges contributions from all participants and provides a learning environment for all. A well-intentioned willingness to share the knowledge and educational courses developed in the West should not become a patronising attempt to impose the findings and practices of industrialised countries on those working in very different situations. Part of the solution might be to use the full the knowledge and experience of mental health professionals who are part of the immigrant community and to remove some of the barriers to their professional integration.

**Human rights**

Finally, of course, there is the role of psychiatry in human rights issues. In the past, most attention has been paid to the treatment of victims of torture and also to the abuse of psychiatry for political purposes. What has been lacking is a willingness to expose gross socio-economic inequalities, to explain how they lead to ill health, and specifically to mental ill health, and how this, in turn, is a fertile breeding ground for terrorism.

**Conclusion**

In summary, as Kelly’s article demonstrates, the impact of globalisation on mental health and mental health services is complex. Although globalisation offers enhanced opportunities for sharing knowledge and improving treatment, there is a real risk that it will further widen the existing gap between rich and poor, with adverse effects on mental and physical health. The role of psychiatry in advocacy for the most deprived has not been fully developed.

**References**

INVITED COMMENTARY ON
Globalisation and psychiatry

The responses of nations and individuals to globalisation and the effects of the phenomenon on the mental health of the population are many and varied, according to its critics’ perceptions. Kelly (2003, this issue) highlights the greatest criticism of globalisation – the management of cultural diversity. This is related to homogenisation of cultures across the globe and to how that process leads to loss of individual and kinship cultural identities. The act of globalisation is based simply on a capitalist mode of production – moving it around the world to use cheap labour – and on increased access to global media. Both of these influence cultures in the context of industrialisation and urbanisation. Berger (2002) suggests that the dynamics of globalisation are related to diffusion of culture through both elite and popular vehicles: business and the media.

Kelly argues for a return to the biopsychosocial model of psychiatry, and he is right. However, biopsychosocial models never went away – only the biosocial psychiatrists did, in their rush to identify genes leading to schizophrenia or to study brain scans to identify areas that contribute to mental illness. Unfortunately, neither pathway has led to a psychiatric utopia. Today, the social has given way to cultural, spiritual and anthropological aspects of new aetiological models trying to enter the nosology.

This leads to an itinerant capitalism that demands the cheap production of goods, which in turn results in the industrialisation of nations that have the workforce but not the infrastructure to cope with it. The consequent rural-to-urban migration brings with it a series of problems and expectations. Blue et al (1995) have elegantly demonstrated increased rates of common mental disorders in the urban slums of India, Brazil and Chile. This increase is related to social factors – poor housing and its related infrastructure and economic problems. The loss of social support resulting from migration to urban areas brings its own problems.

There is considerable evidence to suggest that migrants are prone to particular psychiatric illnesses (Bhugra 2001; Bhugra & Jones, 2001). The acculturation due to globalisation may lead to loss of original cultural identity, thereby giving rise to certain psychiatric conditions.

We know that ‘culture shock’ and conflict of cultures also lead to increased psychological morbidity. Kelly places poverty at the top of the list for increase in morbidity, but increasing awareness of discrepancy between what individuals thought that they could achieve as a direct or indirect result of globalisation and what they actually attain is more likely to produce alienation and hopelessness.

Migration in the era of globalisation

Globalisation not only leads to migration of individuals across national boundaries: the borders themselves are ‘disappearing’ because of the internet. Globalisation is seen as the intensification of global interconnectedness (Inda & Rosaldo, 2002).

Urbanisation and industrialisation

The urbanisation and industrialisation arising from globalisation both lead to a loss of personal identity. The individual and cultural voice of the ‘other’ expected to provide the labour of globalised industry is lost. Gupta & Ferguson (2002) enquire about the identity of the ‘we’ as well as of the ‘other’. A cultural
landscape for and of tourists and the presence and worries of the migrants, the refugees, the exiles and the guests affect nation states and the national character.

It is unfortunate that Kelly did not focus more on the impact of political abuse on the migrants forced to flee when the interference of world superpowers allows tyrants take control. The new global cultural economy has to be seen as a complex, overlapping, disjunctive order that can no longer be understood in terms of existing centre–periphery models (Appadurai, 2002), but in the total cultural context. The centralised sources of economic and social power are now giving way to a model in which power and goods move across nation states. The globalisation of culture is not the same as homogenisation.

### Impact on mental health

The altering patterns of culture as a consequence of globalisation and media homogenisation have been illustrated by Becker et al (2002), who found that rates of eating disorders in Fiji went up as a result of the introduction of television. To make sense of what Appadurai (2002) calls ethnoscapes, mediascapes, technoscapes, financescapes and ideoscapes, the long-term impact of globalisation on the human psyche must be studied by psychiatrists in conjunction with economists, geographers, anthropologists and sociologists. Appadurai’s ‘scapes’ can be understood at both the individual and the collective level, and the world view of individuals and of groups is likely to change with globalisation. Clinicians must be prepared for this.

Mahadevia (2002) highlights an important factor relating to urbanisation by suggesting that the loss of public space to private owners contributes to urban stress.

Another danger of globalisation worth bearing in mind is the drive to homogenisation that derives from the culture of consumerism (Moreiras, 1998). Clinicians must also be aware of the relocation of languages in cultures as a result of globalisation (Mignolo, 1998). The links between languages and the boundaries of humanity have shaped the ideas of literature, the cultures of scholarship and civilisation itself. The articulation of languages and their cultures have reduced barriers to communication. The growing ‘Anglicisation’ of the world is obvious. It is possible that such globalisation may be causing cultures to become more fundamentalist and restrictive, which might in itself contribute further to stress and psychological morbidity.

### Conclusion

Kelly is right to caution us that human rights should be a priority, but as Ghodse (2003, this issue) points out, he is offering a Eurocentric view. The attack on New York’s ‘Twin Towers’ was not a result of globalisation. Kelly also proposes that the loss of social capital resulting from increased globalisation might be inducing a wave of anomic in Western populations. However, he says little regarding the positive implications of globalisation for world mental health. The international action that the World Health Organization recently took to control the spread of severe acute respiratory syndrome (SARS) shows just how globalisation can benefit people. The dissemination of preventive and public health medicine is clearly a positive aspect of globalisation. Nevertheless, the impact of globalisation on individual migrants is likely to be long lasting in both economic and psychological terms.

### References


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