Just Pluralism: Thinking About Concepts of Mental Disorder in Global Context

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Abstract

This paper will investigate justice requirements that a pluralist stance on concepts of mental disorder should meet for use on a global scale. This is important given that different concepts of mental disorder are connected to particular interventions which may be more or less successful in specific contexts. While taking a broadly normative view on mental disorders, I will describe relevant concepts in a more fine grained manner, referring to their connections to particular approaches to biology, the self, or community. Drawing on research on epistemic injustice, I highlight the requirement that the set of multiple concepts be sufficiently flexible to enable the participation of those possessing relevant local knowledge. Using insights from health justice, I point out that the set of concepts should be conducive to distributive and procedural justice with regard to mental health and should support interventions on social determinants of health. These requirements apply to two dimensions of pluralism: regarding what concepts to include and how to relate them to one another. I conclude by explaining how an ontology of partial overlaps connected to a concept of health as metaphysically social can help address the challenges arising particularly regarding the latter dimension.

Keywords: mental disorder; epistemic injustice; health justice; global ontologies; pluralism

1. Introduction

Following an account of his experience undergoing ritual healing (*ndeup*) in Senegal described in *A Noonday Demon*, Andrew Solomon (2008) comes back to questions regarding traditional approaches to treating depression. Mentioning this episode in conversation with a mental health professional in Rwanda yielded a description of a case regarding psychiatric support after the genocide as follows:

> Well, they [the international mental health workers] came here and their practice didn't have any of the strengths of the ritual you just described. They did not identify the illness as an invasive external thing. They did not get the entire village to come together and acknowledge it together and all participate in trying to support the person who was getting treated. Treatment was not out in the bright sunshine where you feel happy. There was no music or drumming to get the heart running as the heart should run. Instead, they took people one at a time into sort of dingy little rooms for an hour at a time and asked them to talk about the bad things that had happened to them. Which, of course, just made them feel much worse, almost suicidal. We had to put a stop to it (Solomon 2008: 522).

Unpacking this, there seems to be a tension between two different concepts mental disorder: one as external to the self and another one occurring (at least in part) within the self. As one may question whether the

former would even count as a mental disorder, I should clarify that henceforth by 'mental disorder' I mainly mean 'what mainstream psychiatry conceives as mental disorder'. This should also help address further issues, such as deciding to count certain things as mental disorders within a particular context or culture, but not under different ones. Nevertheless, I believe that for this particular example, although the local understanding of the condition is not a disease in the biomedical sense, the use of 'disorder' or 'illness' may be justified by the fact that it is treated or it is subject to healing, although, as I shall discuss, through methods outside mainstream psychiatry or biomedicine.[1] Independent of these terminological issues, several clashes emerge, notably the different treatments: ritual healing versus psychotherapy. The former involves community participation, while the latter targets the individual and requires privacy. As the example shows, the success of a policy that aims to improve mental health will depend on choosing the correct intervention. Moreover, assuming that interventions typically used in Global North countries will automatically work elsewhere can have serious ethical consequences. For critics of one-size-fits-all policies and particularly initiatives such as Global Mental Health this could be a textbook example illustrating the need to look for interventions that work locally instead of exporting psychiatry. While I will be referring to this example in what follows, it is worth pointing out that similar worries have been raised in other contexts. For instance, the marginalization or exclusion of local approaches to favour biomedical psychiatry has been discussed in India (Davar & Lohokare 2009; Halliburton 2023). Taking these critiques as starting points, I will focus on philosophical issues about justice and pluralism regarding concepts of mental disorder which have not drawn sufficient attention thus far.

The example above shows that differences in what interventions work can be traced to different concepts of mental illness. The connection between what kinds of things mental disorders are and specific interventions has been discussed in the philosophy of psychiatry but less so in connection to cultural differences. For my purposes here it is important to stress that, in line with Tekin (2016) and Zachar (2014), I take mental disorders to be practical kinds meant to address multiple, sometimes conflicting goals. My focus here is mainly on the connection between specific concepts of mental disorder and interventions following from them. Both Tekin and Zachar emphasize that while the features of mental disorders are important for developing effective interventions, they are not meant to be universally applicable. While this opens the door for political negotiation, an important philosophical question emerges: how to work with fundamentally different and sometimes conflicting concepts of mental disorder (and resulting treatments), which would come up in the context of political deliberations? Here one could simply deny the possibility of such encompassing perspective and hold that there are only multiple, locally-specific psychiatries. Yet that would hardly satisfy the ambitions of (mainstream) psychiatry as a science. Interestingly, it would also go against the quest of universalism also present in the development of ethnopsychiatry (Delille 2020). One may still press on and question the desirability or helpfulness of such encompassing perspective on the grounds that it may marginalize or undermine the local approaches. My answer is that an encompassing perspective is

[1] The tension can be explained through the fact that, unlike in the case of mainstream, Western psychiatry, local psychiatric knowledge systems are tied to religious or cultural beliefs or practices (Fernando 2010)

needed given that (mental) health is affected by factors that cut across multiple contexts (e.g., socio-economic developments, political tensions) and that local approaches have themselves interacted with mainstream ones in the past (e.g., during colonial history) or between themselves in the case of more diverse societies. At the same time, the worry whether this encompassing view is able to give local practices their rightful place is important, and I aim to address this through exploring pluralism along ethical and political dimensions.

The kind of pluralism I will defend takes a broad common framework that encompasses different conceptualizations of mental health and illness that have a degree of independence which allows, among others, for conflicts between them. This view can be better spelled out by looking at controversies over Mitchell's (2003, 2008, 2009) integrative pluralism. While integrative pluralism runs the risk of 'minimizing dissent, overlooking diversity, eliminating differences and/or a homogenization in terms of the bigger one' (Van Bouwel 2014: 111), it is not clear how the alternative provided by isolationist pluralism could help advance knowledge if it is unable to account for interaction between the concepts involved. Interactive pluralism, introduced by Van Bouwel in the space between integrative and isolationism pluralism, leaves open both the reconcilability and irreconcilability options. Still, for this stance to work in connection to psychiatric concepts in cross-cultural contexts, additional conditions should be met. I will sketch out ethical and political requirements for what I shall call just pluralism using as examples injustices arising from current approaches. I will then look at how these requirements can be met by specific ontological approaches to local knowledge systems and to defining health.

In what follows, I will start by sketching out a rough picture of pluralism and discussing examples of concepts of mental disorder it would contain. I will also highlight two dimensions of pluralism relevant in global context: *what concepts to include* and *how they relate* (section 2). In section 3, I will explore what kinds of injustices arise in cases when approaches prevalent in Global North setting are deemed as default, drawing on work on epistemic injustice in science and health justice. In section 4, I will look at how the questions stemming from these notions of justice can help decide what kind of concepts or relations to include within a pluralist stance. I will argue for an ontology of partial overlaps together with a view of (mental) health as fundamentally social, which allows variations in the manifestations of mental disorders and effective treatments according to context.

2. Pluralism about concepts of mental disorder and mental health interventions

In this section I will articulate pluralism about concepts of mental disorder in a loose sense. I will later come back to this view and refine it through the justice requirements to be sketched out in following section. To broadly spell out pluralism first, I take it to hold that there are multiple legitimate ways of making sense of the world (Dupré 1993). In connection to concepts of mental disorder, I take multiple concepts of mental disorder (as well as entities that would not neatly fit the 'mental disorder' label of mainstream psychiatry but are still subject to local interventions) to serve various goals, which may also be in conflict sometimes (Zachar 2014; Tekin 2016). My focus will be particularly on their usefulness for effective psychiatric

interventions. To further articulate this broad account of pluralism, more clarification is needed regarding what mental disorders are.

One important debate when talking about concepts of mental disorder is that between naturalism and normativism (see Radden 2019). Briefly put, naturalism defines mental disorders by reference to facts, in a value-independent way. Normativism denies this, holding that the concept of mental disorder is inherently value laden. I should stress that normativity here amounts to more than appropriate biological functioning and may include social, political, moral, even aesthetic values. At the same time, there are also the so-called 'weak normative' views that include both a naturalistic and a normative component (e.g., Wakefield's 1992 harmful dysfunction account). It is worth pointing out that normativism plays a prominent role in cross-cultural contexts, where one may be tempted to explain differences in prevalent concepts of mental disorder and corresponding interventions through different values being more important within the respective types of society and culture (see Popa 2020). In connection to this, an analogy can be drawn with Alexandrova's (2017) analysis of a normative concept of well-being and the imposition problem it raises, i.e., defining well-being in a way that does not represent the interests of those concerned. This problem and the solution in terms of social objectivity have further been discussed in connection to mental disorders by Gagné-Julien (2021). A similar problem can be pointed out for normative concepts of mental disorder based on features of societies in the Global North taken to be universal and then 'exported' to Global South contexts. Thus, in order to prepare the ground for deliberations on potential interventions, pluralism would need to incorporate multiple concepts of mental disorder, laden by values specific to the relevant contexts. In turn, this would enable the consideration of different interventions: for instance, the appropriateness of going to psychotherapy individually or opting for group therapy or another type of treatment involving community participation may depend on how important community is within a given setting.

Acknowledging the importance of normativity, however, does not rule out issues arising for naturalistic views in cross-cultural contexts. For instance, Boorse's (1997) definition of health as a statistical notion connected to a reference class raises questions about how to choose the reference class. Beyond sex or age one may look at culture, ethnic group, socio-economic status, and these raise value related concerns on their own. Furthermore, and perhaps more importantly, there is a question whether one's choice of reference class one ends up representing the relevant biological features of particular members of the population. In the case of mental disorder, the presence of somatic symptoms of depression in East Asia pointed out by Kleinman (1977) is a relevant example. Thus, concerns about justice arise even if one were to take mental disorder to be (mainly) a statistical notion. Furthermore, notions of mental disorder referring to biological functions may serve various intervention-related purposes, such as helping patients understand their predicament in a context where psychological symptoms are stigmatized. Thus, while the global context I am investigating brings the normative aspects into the spotlight, and especially the concern about whether mental disorders may be different according to context, it is also worth emphasizing that concepts drawing

on naturalistic insights have their uses. In what follows I will include these concepts in a broadly pluralistic perspective, but not consider them entirely value-free due to the concerns mentioned above.[2]

Another strand of research worth discussing here amounts to attempts to move beyond the naturalism – normativism clash. The account of diseases as social problems, for instance, 'makes it possible to address the diversity of conditions defined as diseases by locating them on a continuum ranging from the material to the symbolic' (Saborido & Zamora-Bonilla 2024: 55-56). While this approach, similar to institutional definitions of disease (Kukla 2015) or mental disorder (Knox 2023), looks at what warrants the medicalization of specific conditions (including historical changes in classification), I will investigate this from a cross-cultural perspective. Going with the Saborido-Zamora-Bonilla account, the need to improve the provision of mental health support in particular contexts shows that the state of mental health within the particular population is a problem. Nevertheless the weight of the material and the symbolic may differ not only from one disorder to another, but also from one context to another. Choosing an intervention that works also requires getting this ratio right. The kind of pluralism I am investigating here would come into place when formulating the problem, namely being open to several possible descriptions of mental disorders in order to enable finding a solution that best fits the context.

Thus far I have looked at debates around naturalistic and normative concepts of mental disorder and their bearing on pluralism. Nevertheless, one may need to go in further depth about what mental disorders are taken to be ontologically speaking. For example, according to a biomedical definition in terms of the hormonal imbalance in the brain, mental disorders involve a dysfunction at a biochemical level. A psychodynamic approach, by contrast, would refer to interacting psychological processes within the individual. The example in the beginning illustrates a concept that departs from both of these definitions: mental disorder refers to a negative state originating outside the individual. This could include explanations in terms of demonic possession, but also exposure to adverse social circumstances and perhaps environmental explanations too. Untangling the former from the latter two also involves the presence of supernatural entities that may or may not be part of the belief system of a patient or a group. All of these examples are connected to different interventions – medication, psychotherapy, ritual healing or addressing the negative circumstances or even having patients spend some time away from their usual (traumatic or stressful) life circumstances. Thus, it is important to include them in a pluralistic stance of thinking about mental disorders. Another important thing to point out is that while my interest lies in cross-cultural contexts, these more fine grained and sometimes conflicting concepts of mental disorder also operate within a single tradition, such as mainstream psychiatry encompassing both pharmaceutical and psychological interventions whose theoretical reconciliation is not straightforward (Obeyesekere 1977: 177).

Zooming in on specific features of mental disorders, particularly their link to human cognitive mechanisms, adds another layer of complexity to the discussion above. In this sense, Washington holds that 'variance in the underlying causal structure of the human mind implies variance in illnesses' (2016: 171). This is also a claim about cultural variation, but not in terms of values as discussed above, but in terms of

[2] This notion could be characterized as value-dependent realism (see Broadbent 2019a).

cognitive processes and mechanisms in connection to a descriptive stage in identifying mental illnesses. Washington challenges Murphy's (2006) account, which relies on a notion of human nature for the descriptive stage. The kind of pluralism I will be defending here is not incompatible with multiple cognitive mechanisms linked to mental disorders having different manifestations across cultures. Nevertheless, I should point out that it is unlikely that cognitive mechanisms operate in isolation from social interactions and environment, and as such, as much as Washington and Murphy are trying to move away from normative accounts of mental disorder, values may come in when attempting to explain the statistical variation in cognitive processes. If that is the case, then adopting a version of pluralism that focuses on different values may also help account for cognitive diversity. If one rejects this solution, then the model of partial overlaps to be discussed in section 4 can also account for radically different cognitive mechanisms coexisting with seemingly universal ones. As for examples of connected psychiatric approaches, Washington (2016) refers to Research Domain Criteria (RDoC). Nevertheless, RDoC has been subject to critique particularly from cultural psychiatry for focusing too much on neural activity and neglecting social interaction (Paris & Kirmayer 2016). As such, finding relevant interventions is contingent on identifying cognitive mechanisms that are radically different across cultures that fit within the RDoC matrix and in need of further empirical work, particularly in cultural and social neuroscience.

The review above is by no means exhaustive, but I hope it is illustrative for my preliminary sketch of pluralism: the idea is to include multiple notions of mental disorder connected to different interventions in order to represent different manifestations of mental disorders across cultures. Going back to the example in the beginning, the approach was unsatisfactory because of its narrow focus on concepts working elsewhere and not considering a concept where mental disorder is the result of external influences and can be treated through a healing ritual involving the community. Thus, the first concern for pluralism is *what concepts of mental disorder are included*. There is, however, one more possibility: that a pluralistic stance comprises the relevant concepts of mental disorder, but due to conflicts or attempts of integration it has to prioritize specific ones. Thus, in cases where local approaches are marginalized or neglected it is a matter of *how different concepts of mental disorder relate* within a pluralistic stance.

Having sketched out a broad picture of pluralism, I can now move on to the justice requirements that, I shall argue, global approaches to mental health should meet. These will later help further specify the notion of pluralism introduced above. One last question here is how do concepts of mental disorder relate to justice beyond simply noting episodes of failure such as those mentioned above? I answer this by reference to the idea that scientific methods, concepts, or approaches are not only value-laden, but also value-promoting (Russo 2022; Ratti & Russo 2023). A relevant example are narrow biological models of health that promote biochemical over socio-economic interventions (Ratti & Russo 2023: section 3). In the case of the examples discussed here, employing a narrow concept of mental disorder that is not well suited to the local context can be said to promote injustice towards the local population in need of mental health assistance. However, as I will be taking a pluralistic perspective, I will further extend this point to choices regarding the prioritization of specific concepts of mental disorder as being justice-promoting.

3. Global perspectives on mental health and (in)justice

I will now sketch out a set of justice requirements for employing concepts of mental disorder and approaches to psychiatry on global scale. While justice has been a central topic in political philosophy with important uses in areas such as applied ethics, the link between global psychiatric approaches and philosophical analyses of justice has been subject to little exploration thus far. For my purposes here, I will review two relevant notions of justice – epistemic and health justice - and sketch out relevant questions that should arise when employing a pluralistic stance towards global psychiatry.

2.1. Epistemic injustice

As the example above involves a clash between what counts as the most appropriate approach according to local knowledge as opposed to mainstream psychiatric knowledge, one can spell out the ethical issue arising in terms of epistemic injustice. Broadly, epistemic injustice has been defined as tying someone's credibility to their social standing (Fricker 2007). In this broad sense, examples include considering testimonies by those oppressed on various grounds (e.g., gender, race, ethnicity) to be less reliable. As discussed by Fricker, epistemic injustice can be testimonial, when the account of the person concerned is not deemed credible, or hermeneutical, when the person concerned does not have access to the conceptual resources necessary to express their experiences of oppression. Epistemic injustice has been discussed in medical context, particularly with regard to patient testimony (Carel & Kidd 2014), the prioritisation of biomedical concepts of disease (Kidd & Carel 2019), instances of obstetric violence (Shabot 2019), and the omission of the patients' input in psychiatric classification (Bueter 2019).

Looking at the example above and the broader context of exporting interventions from Global North context into the Global South, there are several affinities with patterns singled out by the above-mentioned analyses of epistemic injustice. Very broadly, the relation between mainstream psychiatry and local approaches is an asymmetric one, with the latter typically being given less credibility, because of what Summerfield (2013) has deemed 'medical imperialism'. Nevertheless, this relation it is difficult to pin down in terms similar to cases when a patient's testimony is considered unreliable, as the process of policy-making is different from the encounter between patient and medical professional. One can also point to hermeneutical injustice when looking at the lack of studies regarding the efficacy of local interventions and even broader concerns about whether evidence-based medicine is at all suitable for investigating local approaches (see Popa forthcoming). Yet again, this plays out at the level of the current research and science as opposed to interactions between patients and mental health professionals.

Another affinity can be pointed out between pathogenic epistemic injustice (Kidd & Carel 2019) and the focus on a narrow biomedical model of mental illness and its expansion to Global South setting with no clear idea about the benefit of those needing mental health support, but with certain benefit for pharmaceutical companies (Fernando 2011). Yet, as the example in the beginning refers to psychotherapy, it shows that injustices regarding prioritizing ineffective mainstream psychiatry interventions need not come

down to biomedical approaches only. Furthermore, naturalistic explanations need not always result in epistemic injustices and may work better is some circumstances, e.g., when psychological explanations place the responsibility on the person suffering from the disorder (Degerman 2023). In global context, it is also important to stress the prevalence of somatic symptoms in cultures where mental disorders are highly stigmatized and presumably naturalistic explanations may help patients better express their suffering (Kleinman 1977).

Given the broad affinity with epistemic injustice, but also divergences from work on epistemic injustice in healthcare, another place to look is epistemic injustice in science. Grasswick holds that in addition to testimonial and hermeneutical injustice, there is also participatory epistemic injustice, which amounts to excluding perspectives from disadvantaged individuals or groups which is not necessarily tied to a deficit of credibility (2017: 316). In the context of science, this can occur between scientists or between scientists and laypeople. The latter appears to be more important for the case here, as local interventions and traditional psychiatric knowledge is typically not possessed by those that are part of the scientific community. Nevertheless, when looking at the community of mental health workers and international teams one can also point to the former for cases when input from workers familiar with the local methods successfully employed in the past is not taken into account. A parallel example is the kind of knowledge that had a bearing on policies during the COVID-19 pandemic and the neglect of the interests and problems of groups such as the global poor (Broadbent 2022). Another important point to stress is the connection to what Irzik & Kurtulmuş (2021) deem ‘distributive epistemic injustice’: discriminatory epistemic injustices such as those described above generate a knowledge gap that disproportionally affects the respective parts of the population. In this case, the gap lies in the ability of mainstream psychiatry to deal with manifestations of mental disorders in contexts outside the Global North.

Concluding the discussion of epistemic injustice prompts the first question relevant to the use of multiple concepts of mental disorder:

a) Is our set of concepts of mental disorder sufficiently rich to allow for the participation of those possessing local knowledge?

2.2. Health justice

While the discussion above has referred to justice concerning epistemic resources, such as scientific knowledge and research, there is also a question about justice regarding health as a good. In this sense, work on health justice is relevant. The literature on this is quite vast, as shown by a recent review by Smith (2022), including the following views:

- Approaches emphasizing both distributive and procedural aspects regarding health benefits and burdens. These originate in public health ethics (Kass 2001; Childress et al. 2002).
- Relational approaches calling for fair access to social goods relevant to health (Kenny et al. 2010).

- Views focusing on the link between health to equality: either through the contribution of health to equality of opportunity (Daniels 2007) or through the need to compensate for differences in equality of opportunity due to bad luck, including one's state of health (Segall 2009).
- Capabilities approaches applied to health including a focus on health policy specifically (Ruger 2010) or on social determinants of health (Venkatapuram 2011; Marmot 2022).
- Views focusing on health as an essential component of well-being, which should be provided in sufficient amount to everyone (Powers & Faden 2019).

Due to the different concepts of justice present in these approaches and the complexities of the debates, I will not engage with each of them individually here. Instead, I will look at aspects relevant to concepts of mental disorder and their connection to justice with regard to clashes between approaches in global context. Firstly, the distributive and procedural aspects should be noted beyond the discussion of epistemic goods above. Employing concepts of mental disorder and corresponding interventions in a context where they do not work leads to an unjust distribution of health. This is especially striking in the context of Global Mental Health being introduced as a way of closing the gap between Global North and Global South countries (WHO 2008). Concepts and approaches that do not work locally do little to address this gap, and may even widen it, as in the case of interventions that do more harm than good, such as the example mentioned in the beginning. Furthermore, there are cases where the gap lies within the Global North setting, such as the incidence of schizophrenia (Sartorius et al. 1986, 1996). One could suggest learning from approaches available in the Global South (e.g., Raguram et al. 2002), but that is hardly considered in mainstream psychiatry. Regarding procedural aspects, the requirement would be that those affected by the employment of a concept of mental disorder or intervention have a say in this respect. Once again, this goes beyond participating to the knowledge-generating process, to having a say in processes that lead to the availability of mental health interventions that work for the group or person in question.

Looking at ways of ameliorating health injustices such as those discussed above yields the following questions:

b) Does our set of concepts of mental disorder lead to a fair distribution of mental health among relevant populations?

c) Is our set of concepts of mental disorder conducive to the participation of those most affected by the adoption of a specific concept or intervention?

A further important point to stress is that many of the approaches to health justice above, such as the public health ethics one or capability approaches, emphasize the link between social justice and health outcomes. An implication of this is that ensuring social justice is a crucial way of improving health outcomes. One may leave this aside, as it does not directly concerns medical interventions. Yet, the connection to ways in which mental disorders are defined should be stressed. The biomedical concept has been criticized for neglecting social and psychological determinants, and thus closing the door to relevant social or economic interventions that may improve health. Nevertheless, it is worth stressing that other notions of mental disorders, such as those that define it as a problem within the self and forms of therapy that

only seek changes within the thought processes and behaviour of the individual, without looking at social context may have similar effects. Thus, in light of the close connection between social justice and (mental) health outcomes another relevant question is as follows:

d) Is our set of concepts of mental disorder compatible with broader notions of health and illness and corresponding interventions to increase social justice that also improve mental health?

In the following section I will use these questions to analyse ontological questions regarding pluralism about concepts of mental disorders from a justice perspective.

4. Just pluralism about concepts of mental disorder and interventions

I will now use the questions above to sketch out ways of dealing with a plurality of concepts of mental disorder from an ontological point of view. To put it another way, these requirements can help determine *what concepts are included* within a pluralist stance and *how they relate*, in order to achieve a just form of pluralism. Before moving on, I will also briefly compare my project here with Ludwig's considerations on science as a site of justice (2023: section v). Drawing from Fraser's (2009) considerations on global justice, Ludwig highlights distribution, recognition, and representation as ways of moving towards a more just science within a global setting. While in broad agreement with the points regarding the role of science in a fair distribution of relevant resources and engagement in an intercultural dialogue, my focus will not be on science itself, but on the ontological assumptions underlying a subset of scientific practices, namely those used in psychiatry. In a sense, the framework I bring forward here can help by making metaphysical assumptions explicit and aligning the use of concepts with justice requirements, but the project of making science more just goes farther than the scope of my argument here.

Summarizing the discussion in the previous section, I have depicted the questions and corresponding notions of justice together in the table below.

<table>
<tr><th>Epistemic justice</th><th>Health justice</th></tr>
<tr><td rowspan="3">a) Is our set of concepts of mental disorder sufficiently flexible to enable the participation of those possessing local knowledge?</td><td>b) Does our set of concepts of mental disorder lead to a fair distribution of mental health outcomes among relevant populations?</td></tr>
<tr><td>c) Is our set of concepts of mental disorder conducive to the participation of those most affected by the adoption of a specific concept or intervention?</td></tr>
<tr><td>d) Is our set of concepts of mental disorder compatible with broader notions of health and illness and corresponding interventions to increase social justice that also improve mental health?</td></tr>
</table>

Looking at what concepts of mental disorder to include in a pluralistic stance first, question (a) about participatory justice is relevant. There are two relevant possibilities here, depending on whether concepts of mental disorder broadly compatible with the local ones are already part of the set or when local concepts are completely new relative to the set. The former possibility stresses the need for incorporating a diversity of concepts and approaches, as well as exploring the overlaps with other concepts. For instance, emphasizing the role of community support can be linked both to notions focusing on the social dimension of mental health as well as ritual healing or interventions involving religious institutions in addressing mental health problems. The latter possibility is more challenging, as it involves cases when there appears to be little or no common ground between the available concepts and the ones grounded in local concerns. Here something along the lines of epistemic humility, discussed by Broadbent (2019b) as part of medical cosmopolitanism as a stance towards medicine can help. Epistemic humility requires that one be open to changing one's views in light of new evidence. Applying this to managing the set of available concepts of mental disorder in a pluralistic stance means that the set should be flexible and open enough so as to incorporate concepts that do not resemble those already present when there is evidence of their importance for local concerns or of them working in local context.[3]

Regarding the questions about health justice, perhaps the simplest illustration is the narrow use of a biomedical concept of mental disorder. In the context of low-income countries, having an approach based only on a biomedical concept may leave out those who lack the resources to access formal medical institutions and mainstream psychiatry (question c). This would further result in increasing disparities in the distribution of mental health and may be exacerbated if accompanied by the removal of local concepts and approaches, which may well constitute the only options for the respective parts of the population (question b). A relevant example of such approach is 'spiritual therapy', widely used in India but with no ties to officially accepted practices of Western psychiatry or Ayurveda (Bode 2019: 3-4). Regarding question (d), a purely biological concept of mental disorder has no link to approaches stressing the effects of adverse socio-economic circumstances on mental health. This holds in many contexts, but it is especially pressing in settings where such conditions have been impacted by colonial history, as the following statement by Summerfield helps illustrate: 'one quarter of the global population lives in utter poverty, and two thirds of those born today have been condemned on the first day of their lives, destined to join what the philosopher Frantz Fanon called "the wretched of the earth." Would antidepressants and Western talk therapy improve their lot? Who is asking for this? Indeed, the evidence base for these treatments is non-specific or weak even in the West' (2013: 1). This example also highlights that not only a narrow focus on biomedical concepts undermines concerns about health justice, but also concepts based on psychological features prevalent in the Global North.

At this point, I can sketch out a clearer picture regarding which concepts of mental disorder should just pluralism incorporate. Given the discussion so far, I have mapped different dimensions comprising

[3] This last point is also in line with the practical stance within medical cosmopolitanism, i.e., prioritizing agreement about whether an approach works in practice over theoretical disagreement (Broadbent 2019b).

different concepts of mental disorder in the table below. This is not meant to be exhaustive, but rather to point to ways forward once the list is expanded through, e.g., further empirical work. As discussed above, mainstream psychiatry operates with at least two concepts: a biomedical one and a psychodynamic one. These two concepts have much in common: assuming an individual notion of the self, taking mental disorder to occur within the self, and assuming a naturalistic ontology. At the same time, the biomedical notion refers to lower-level (i.e., subpersonal processes) in contrast with the psychodynamic one, which uses psychological explanations that cannot be reduced to the entities referenced by biomedical approaches. To this, one may add concerns about whether certain experiences should be classified as disorders at all if they do not produce any noticeable harm. Here one could include perspectives from the neurodiversity or Mad Pride movements, but also experiences which would not count as pathological in different cultures or environments. At the same time, as discussed above, there are views according to which mental health problems do not take place within the self, but outside of it. This could involve spirit possession framings but also broadly social ones, depending further on whether purely naturalistic explanations are present or also explanations involving supernatural entities. Similarly, if the self is viewed as relational as opposed to individual, collective framings of mental health problems can gain a more prominent role.

Dimension	**Mental disorders understood as**	**Interventions**
Where mental disorders are said to take place in relation to the self	Within the self	Psychotherapy, training of relevant abilities (e.g., social cognition), medication
	Outside the self	Life advice, community support, opportunities to escape a stressful life circumstances
Notion of self	Individual	Psychotherapy, medication, diet, exercise
	Relational	Group therapy, community support, opportunities to escape stressful life circumstances
Ontology	Natural phenomena	Medication, diet, exercise
	Supernatural phenomena	Religious rituals, support from religious community
Need for treatment	Harmful	Any of the above
	Not harmful	De-pathologization, political negotiation

In order to judge which of these are appropriate for a particular context or case, one needs further knowledge about the context or the life of the individual. This background knowledge, which is social and cultural rather than biomedical and has a crucial qualitative aspect, allows for deploying the relevant concepts, thus countering a potential worry about relativism. Accepting that different concepts of mental disorder are adequate for different context does not mean that ‘anything goes’ with regard to using them. The adequacy is determined by broader features of the situation which have often been outside the scope of mainstream psychiatry (or medicine). The justice requirements introduced above highlight the need to include locally relevant understandings in one’s toolkit, while adequacy requires further empirical work.

Moving on to the problem how different concepts of mental disorder relate within pluralism, one particular concern with regard to participatory epistemic injustice (question a) is the prioritization of concepts and interventions that are closer to those that work in the Global North. This is particularly a problem for approaches attempting at integrating indigenous knowledge with scientific one, as pointed out by Ludwig: 'while [...] discussions about bringing Indigenous standpoints into a pluralistic community of researchers are clearly valuable, one may worry that they leave the question open how we should understand knowledge that resists integration into Western science because it is shaped by the goals and domains of local communities' (2016: 42). At the same time, the prioritization of these views can have consequences for the distribution of health and for the involvement of those affected comparable with those spelled out above in cases when relevant concepts are lacking (questions b and c). There is a difference in degree here, as some concepts sufficiently similar to those that work in the Global North may be used, but the ethical concern still remains. Again, while biomedical concepts of mental disorder can be pointed out here, psychological features are also important, particularly the culturally different understandings of selfhood and the prioritization of those that match the Western one more closely (Cox & Webb 2015). Regarding question (d), simply having concepts of mental disorder that highlight the socio-economic aspects does not guarantee that the social determinants of poor mental health will be addressed. One typical counter to this concern from the side of mainstream psychiatry is that it is not the business of medicine to address these upstream causes. This is also an illustration how one may end up inadvertently neglecting the requirement of acting on social justice as a way of improving overall health, i.e., by prioritizing a particular concept because that is the tool of one's trade, so to speak. For the remainder of this section I will look at how this problem alongside the earlier one regarding the tension between integration and acknowledging ontological difference can be addressed by adopting particular ways of thinking about ontology.

Firstly, Ludwig & Weiskopf's partially overlapping ontologies framework has been introduced in the context of biological classification in order to address the concerns raised by integration: 'on the descriptive level, cross-cultural evidence requires acknowledgement of "partial overlaps" that include common ground in converging categories as well as diverging elements that lead to distinctly local ontological systems' (2019: 5). The idea is that acknowledging partial overlaps and divergences instead of seeking to completely integrate one ontological system into another can help draw attention to those categories that do not fit neatly into accepted scientific ontologies. A similar strategy can be pursued for concepts of mental disorder and corresponding approaches, as I have previously argued with regard to normative notions of mental disorder (Popa 2020). Further claims about cognitive diversity, such as those holding that mental disorders are caused by distinct cognitive mechanisms operating in different cultures (Washington 2016), can also be spelled out this way: some of these mechanisms may be broadly compatible across various psychiatric classifications and approaches, while others may be radically different. With regard to concerns of how different concepts relate, this framework helps counter the prioritization of overlapping aspects and highlights cases when local concerns are in conflict with mainstream concepts and approaches. It is also interesting to briefly compare this to Kukla's view on the concept of disease as 'irreducibly and hopelessly messy': given the different

goals concepts of disease are supposed to meet, there is no unified underlying notion (2022: 131). The partially overlapping ontologies view adds at least one order of magnitude to this, showing how goals and ways of meeting them also vary across cultures and some may be irreconcilably different.

Secondly, adopting an overarching concept of health as metaphysically social can help further spell out the model of partial overlaps with regard to medicine as well as adequately answer question (d) above. Valles's definition of health as metaphysically social spells it out as 'a state of positive holistic well-being, inseparable from societal contexts' (Valles 2018: 45). Perhaps the most controversial part of Valles' definition is that health is not defined in connection to the lack of dysfunctions, but through overall well-being, inspired by a definition by the World Health Organization (1946). On this view, it is not only healthcare interventions that improve health in this sense, but also broader social interventions addressing upstream causes of illness such as poverty, living conditions, experiences of oppression, or access to education. There are objections against this view in relation to mental health specifically, notably that it may lead to the medicalization of social problems with downstream effects of mental health and that using well-being in the definition is too demanding given that it is tied to preferences and choices that are personal as opposed to holding for an entire population (Wren-Lewis & Alexandrova 2021). Valles's defence of a social concept of health answers the concern pertaining to the first critique, pointing out that the focus on a positive as opposed to negative (i.e., lack of disease) definition that this does not entail that (mainstream) medicine should take over the areas that have a positive impact on health. These issues should rather be addressed through approaches such as 'Health in all Policies', which highlights the health effects of policies in different areas, thus allowing for singling out and acting upon social determinants without expanding the scope of the medical perspective. On a global level, this would help find ways of addressing social or economic causes of mental health problems in addition to the provision of mental health support. At the same time, the objection regarding well-being still stands and it is especially important given that people's views of what a good life amounts to can vary significantly across cultures and assuming a single notion can bring about issues analogous to those regarding exporting psychiatry. I believe that the issue can be addressed by dropping well-being from Valles's definition and replacing it with *the capacity to reach positive, holistic well-being, inseparable from social context*. This draws from the definition brought forward by Wren-Lewis and Alexandrova, which refers to 'psychological capacities that, if developed and maintained, enable individuals to pursue any conception of the good life or well-being, whatever conception of it they adopt' (2021: 694). The main difference is that in defining mental health as metaphysically social these capacities are explicitly linked to social factors. This helps explain why certain things may count as mental disorders in some cultures where certain conceptions of the good life are prevalent, but not in others. It also helps explain variation within the same culture, where one particular ability or treatment may be more important for some individuals but not for others (see Halliburton 2009 for examples). It also aligns with the capabilities approaches to health justice, mentioned above.

The definition of health as metaphysically social can be linked to the overlapping ontology perspective above: as health is inseparable from context, different manifestations can obtain under different

social and cultural conditions. Some of these patterns can be common across cultures, while others may be widely different. Again, it should be noted that while this focuses on the social, it is not limited to social properties of health. Work on 'local biologies' such as that on different experiences and physiological manifestations of menopause across cultures linked to differences in lifestyle and nutrition is illustrative of this (Lock & Kaufert 2001). Linking this encompassing definition of (mental) health to concepts of mental disorder, multiple concepts of mental disorder can be linked to multiple social determinants which can be more or less relevant within particular cultures. Again, the point here is not to focus only on the ones that hold across most contexts (e.g., experiencing trauma because of military conflict), but also those (seemingly) incompatible with mainstream understandings of mental health (e.g., being denied the ability to participate in practices that have a local cultural or religious significance). The social framing allows for a more encompassing formulation of individuals or populations having needs met even if some of these needs may fall outside the scope of mainstream psychiatry (or science more broadly). This broadly social perspective is also present in anthropological studies that look at religious interventions (Raguram et al. 2002; Halliburton 2009). Thus, this view also avoids collapsing into wholesale relativism – determinants of mental health and effective interventions in cases of disorder can be framed socially even in cases where some dimensions of health or local needs do not align neatly with mainstream approaches.

5. Conclusions

In this paper I have sketched out a set of justice requirements for a pluralist stance on concepts of mental disorder to be used in global context. Drawing from research on epistemic injustice, I have singled out the requirement of participatory justice with regard to local concepts. Using insights from health justice, I have also pointed out that approaches comprising multiple concepts of mental disorder should lead to distributive and procedural justice involving those concerned, as well as connect to social determinants of health. I have investigated these requirements along two dimensions of pluralism: what concepts to include and how they relate. I have further singled out two main challenges arising here: from the prioritization of concepts similar to those in the Global North that integration gives rise to and from avoiding the medicalization of social determinants of illness. I have argued that an ontology of partial overlaps connected to a concept of health as metaphysically social can help address these challenges.

Placing the argument here in broader context, issues regarding participation and incorporating local concerns still remain and research on issues such as how to constitute pluralistic expert panels is relevant here (e.g., Bschir & Lohse 2023). Nevertheless, this contribution will help provide philosophical background for underlying questions about how to deal with the complexity of multiple concepts of mental disorder, how they relate to particular contexts, and what kinds of interventions they entail. It also helps answer a common concern raised about pluralistic views: on what basis to decide what to include and what is appropriate? My approach above has supplied a framework for just pluralism articulated for scientific and particularly health-related uses. Future research can use this framework to look at specific local concepts and cases, and their

historical interactions with mainstream psychiatry, as well as envision more just ways of using the said concepts or new ones.

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