Article

transcultural psychiatry

Transcultural Psychiatry
0(0) 1–15

DOI: 10.1177/13634615211000549
journals.sagepub.com/home/tps
SAGE

The hermeneutics of recovery: Facilitating dialogue between African and Western mental health frameworks

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Abstract

The widespread use of faith-based and traditional healing for mental disorders within African contexts is well known. However, normative responses tend to fall within two camps: on one hand, those oriented towards the biomedical model of psychiatry stress the abuses and superstition of such healing, whilst critics adopting a more 'local' perspective have fundamentally challenged the universalist claims of biomedical diagnostic categories and psychiatric treatments. What seemingly emerges is a dichotomy between those who endorse more 'universalist' or 'relativist' approaches as an analytical lens to the challenges of the diverse healing strands within African contexts. In this article, we draw upon the resources of philosophy and existing empirical work to challenge the notion that constructive dialogue cannot be had between seemingly incommensurable healing practices in global mental health. First, we suggest the need for much-needed conceptual clarity to explore the hermeneutics of meaning, practice, and understanding, in order to forge constructive normative pathways of dialogue between seemingly incommensurable values and conceptual schemas around mental disorder and healing. Second, we contextualise the complex motives to emphasise difference amongst health practitioners within a competitive healing economy. Finally, we appeal to the notion of recovery as discovery as a fruitful conceptual framework which incorporates dialogue, comparative evaluation, and cross-cultural enrichment across divergent conceptualisations of mental health.

Keywords

Africa, faith healers, global mental health, hermeneutics, recovery

Introduction

The immense challenge of reconciling different explanatory models of mental health disorder and treatment in African settings is well documented (Patel, 1995; Sohrsdahl et al., 2010). Though indigenous knowledge systems around health are increasingly recognised as important, with calls to foster greater collaboration between practitioners of parallel streams of health care, worries persist that indigenous or local forms of mental health care, particularly faith-based healing, can result in human rights violations and abuse (Mfoafo-M'Carthy, 2017; Ofori-Atta, 2018; Read, 2019; Edwards, 2014). This gulf between practitioners of biomedicine and indigenous faith-based healing is highlighted in two quotations:

> It's very difficult to differentiate between psychiatric conditions and when … you are hearing the voice from God. When the person really has a psychiatric condition—a known psychiatric condition—and says he's hearing [a] voice from God, and he's seeing things in dreams while he's fasting … we [the biomedical staff] believe that he's maybe hallucinating. Maybe he's undergoing the signs and symptoms of [a] psychiatric condition … [The faith healers] will believe

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> anything that the patient says, any form of hallucination. In talking to this person, they will believe it, that actually there is [a] spirit talking to them. (Community psychiatric nurse)

> First is the spiritual, before the physical … The [psychiatric] medicine won't work [and] the physical issue won't resolve itself until the spiritual is addressed first … The healing actually comes spiritually before it manifests itself physically. (Prayer camp pastor, cited in Arias et al., 2016)

At first glance, the divide between these two views appears to illustrate the incommensurable mental health perspectives running parallel within Africa, specifically around the epistemic standing of hallucinations, mental disorder causation, and the status of the spiritual and the physical worlds. These divergent accounts of mental disorder seem to provide a window into fundamentally irreconcilable worldviews.

There are two possible normative responses to this putative incommensurability: one might be to dismiss outright the claims of non-biomedical practices, like faith-based healing, working towards the phasing out of these 'primitive' practices and beliefs to be replaced with a 'universal' standard of care, diagnostic categorisation, and/or normative frameworks (such as human rights). A second response, in contrast, is to adopt a relativist position, suggesting that claims of biomedical psychiatry and faith-based healing might be equally valid depending on the local context, but neither has priority over the other given the absence of any universal criteria. These responses have represented an area of longstanding debate in global mental health between proponents of universalist and cultural relativist approaches (Bemme & D'souza, 2014; Cooper, 2016; Jain & Orr, 2016; White et al., 2017; Whitley, 2015).

However, this article argues for a third, relatively unexplored but much-needed conceptual framework to ground strategies of dialogue, reciprocity, and mutual enrichment, which fundamentally support recent challenges to the false dichotomy that have historically characterised debates around global mental health.[1] Three aspects of this response are crucial: first is the need for *conceptual clarity* and *normative resources* to develop an intellectual framework that fosters interpretive openness, dialogue, and conceptual enrichment. Second is to contextualise the *motivation to emphasise incommensurable difference*, whereby practices and the performance of identity within the economy of healing can help elucidate why practitioners of both biomedicine and faith-based healing in African contexts can emphasise, and potentially exaggerate, their respective distinctiveness. Third is an appeal to a *practical concept* that can function as a potential locus of productive cross-cultural dialogue. This approach applies a combined practical and philosophical analysis to highlight constructive points of contact, integration, and continued cross-pollination between divergent cultural practices of mental health.[2] Philosophical resources have been largely ignored in discussions of global mental health, yet these will be useful in identifying areas of conceptual confusion as well as potential normative frameworks which can ground cross-cultural dialogue and engagement.

We first outline the objectives of a global mental health (GMH) approach and how these have been subject to critiques by more cultural relativist approaches to mental health, particularly around the aspiration to 'scale up' psychiatric interventions in the global context.[3] These critiques, however, have historically tended to perpetuate a false dichotomy between universalist and relativist positions, resting on a conceptual elision between *incommensurability* and *incomparability*. The article then suggests ways in which the normative resources of hermeneutics will be an important mechanism to help foster interpretive engagement, constructive dialogue, and conceptual enrichment between the biomedical model in psychiatry and faith-based healing in the African context and global mental health debates more generally. We also explore how the performance of identity and power dynamics in a competitive healing economy can lead to the emphasis on, or even exaggeration of, difference between practitioners of psychiatry and faith-based healing in African settings. Finally, the concept of *recovery as discovery* is discussed as a potential area of productive convergence: this concept draws upon key claims of the recovery movement, but is further enriched through an examination of how spiritual dimensions of healing might be understood and differentiated. We suggest these as vital strategies which might encourage greater reciprocity and collaboration between the practices and conceptual frameworks of indigenous modes of faith-based healing and psychiatry.

Global mental health approach

The ethical argument for global health equality and social justice grounds a GMH approach (Kirmayer & Pedersen, 2014) which also draws from a human rights perspective to promote human dignity and fairness across countries, cultures, and contexts (Kleinman, 2009). The imperative to redress social inequalities (Venkatapuram, 2010) is based on evidence of the high prevalence, disabling impact, and economic burden of neuropsychiatric disorders, and the vast disparity in mental health care services and resources between high and low–middle-income countries, including vulnerable populations such as the poor,

immigrants, and refugees (Kirmayer & Pedersen, 2014). The GMH approach seeks to develop, implement, and evaluate evidence-based mental health care practices in low- and middle-income countries (LMICs), scaled up through task-shifting from the relatively few psychiatrists and psychologists to mental health care workers, in order to improve access to services and interventions and thereby reduce the treatment gap (Lund et al., 2012; Patel, 2014). Moreover, GMH aims to implement policies which lead to greater parity between physical and mental health care investment.

However the GMH approach has historically come under critique from more localised, socio-cultural perspectives which highlight how Western psychiatry is in itself a cultural product that cannot be assumed *a priori* to have universal application (Kirmayer & Swartz, 2013). With an emphasis on social determinants of mental health, local priorities, and strengthening community resources, socio-cultural approaches argue that GMH may perpetuate Western psychiatric categories, concepts, and interventions that may not be locally relevant (Kirmayer & Pedersen, 2014). The imposition of global categories could divert attention from local social determinants of health and the potential value of indigenous healing strategies that could contribute towards recovery (Kirmayer & Swartz, 2013). Some critics of GMH suggest even further that its normative and practical agenda symbolises the continuation of Western colonialism through its disregard for indigenous culture and implicit promotion of the economic interests of multinational pharmaceutical companies (Mills, 2014; Summerfield, 2012).

As Bemme and Kirmayer (2020) indicate, this longstanding debate between what may be termed universalist approaches within GMH and their more culturally relativist critics has developed some important nuances beyond the caricatures which stipulate that either one must adhere to a general framework of mental disorder causation (drawn from Western psychiatric diagnostic classifications and health determinants), or one is committed to a cultural relativist position, where all local, indigenous approaches stand equal to that of the psychiatric model. Even as discussion has evolved from the false dichotomy between universal and relativist positions, there remain deeper questions around which normative lens can best promote greater health equity between high-income countries and LMICs, and the contextual practices that best address stigma, social integration, and recovery. GMH often draws upon a framework of universal human rights and relativist approaches appeal to more contextualised strategies consistent with decolonisation and the uptake of local practices (Mascayano et al., 2020). Proponents of transcultural psychiatry rightfully caution that unreflective applications of psychiatry in the global context often mean a failure to engage meaningfully with the conceptual schemas and normative practices of different cultures (Whitley, 2015). Some argue that within African thought and practice, for example, mental disorder cannot be reduced to physical causes, but is situated within a holistic framework with metaphysical commitments, where existents in the spiritual domain (i.e., spirits, ancestors, etc.) are believed to exercise agency within the physical world, impacting on the health and well-being of individuals (Kahissay et al., 2017; Kyei et al., 2014; Omonzejele, 2008). Moreover, the maintenance of healthy social relationships is conceived of as an intrinsic part of health and healing. These social and metaphysical commitments sit uneasily with the reductivist, secularist orientation of Western frameworks focused on the biogenetic causation of mental disorder. Consequently, attempts to 'upscale' psychiatric practices tend to represent some form of intellectual and cultural imposition, particularly from an African worldview.

Cultural differences can nonetheless be exaggerated for two reasons: first, the existence of plurality is often conceptually mistaken for relativism, where the descriptive fact of cultural divergence, of incommensurable values, conceptual schemas, and ways of life, is presumed to entail a relativistic acceptance of all values, beliefs, and practices. Yet incommensurability can be understood in two different senses (Chang, 1997): first is a claim about the difficulties of finding a *common measurement* of value, whereby different values or goods cannot be quantified according to a single metric. For example, one may experience a conflict between equally valuable goods, such as religious devotion—which might mean adhering to one's pacifist commitments—and love of country—which might mean going to war. Both goods are not reducible to the same scale, where we attach numerical values to one good and compare it with the numerical values of the other. These goods are therefore incommensurable in a strict sense, as in immeasurable according to a single unit of value.

The second sense of incommensurability refers to the more dubious claim that there is no criterion that could be used to compare, evaluate, and decide between plural values, conceptual schemas, or ways of life. Put differently, the diversity of values, human goods, and conceptual schemas means that these are *incomparable*. This claim has implications for the boundaries of culture and the (im)possibility of finding common ground between different outlooks towards human experience. Indeed, Bemme and d'Souza (2014) point out that the act of asserting a neat distinction between global and local approaches is in itself an act of construction, and may not reflect what happens in practice. Local adaptations and applications of

GMH often require considerable adjustment given local conditions, but these adaptations may not be fully attended to because of the manner in which these adaptations are written up for a GMH audience. Similarly, those with a close interest in the 'local' can defocus from aspects of local practice which easily translate into global terms.

We will have more to say about how different values and conceptual schemas might be compared and evaluated in the next section. The key point here is that, though recent work in GMH has rightly sought more nuanced discussion of longstanding questions about the cultural adaptations and contextualised strategies required to achieve global mental health aims, conceptual presuppositions which confuse incommensurability with incomparability—manifest at times in practical attitudes on the ground—can function as substantive barriers to forging a truly dialogical and collaborative approach (Arias et al., 2016; Kozuki & Kennedy, 2004; Spiro, 1986). Yet acknowledging the absence of a common measurement need not lead to the culturally relativist conclusion that divergent values, conceptual schemas, and practices cannot be compared or evaluated. Nor in challenging such relativism does this lead to a crude universalism that promotes certain frameworks without question, e.g. human rights or Western psychiatry.[4]

Second, as we discuss further below, the exaggeration of differences can reflect complex motives amongst health care practitioners within the African health care context. Claims of incommensurability, particularly around modes of healing, are closely related to the development and performance of distinctive healing identities within a pluralistic, competitive health marketplace.

Incommensurability and the hermeneutics of dialogue

So far, we have suggested that there remains the temptation to frame divergent conceptual schemas around health and healing as a choice between universal ethnocentrism or relativism if we remain unclear about what claims of incommensurability amount to. If we deny the prospect of 'universal,' cross-cultural standards of some kind—or at the very least are alive to the problems associated with unquestioned commitment to such standards—it seems that we are then logically committed to an incommensurable *modus vivendi*. This means that all ways of life are equal to one another given the absence of any Archimedean standpoint or objective rationality by which different values and practices can be evaluated. The prospect of relativism suggests that no external standards can be used to judge particular cultural practices as 'inferior' or 'primitive.' A normative commitment to relativism seems not only to be inevitable, but ethically necessary if due respect is to be shown to African faith-based healers and those who use their services.

But this way of presenting the issue is misleading for two reasons. First, it conflates two separable claims: the fact that there are highly problematic comparisons does not entail the additional claim that *no* evaluative comparison is possible. This is particularly evident in the context of mental health. Different cultures may reference the same phenomena differently: for one context, the phenomena might be called 'depression,' in another it might be referred to as 'thinking too much.' We might rightly consider whether the phenomenon of 'depression' is exactly equivalent to 'thinking too much'—just as we might rightly question the comparative leap involved when a psychiatrist recommends anti-depressants in a context where it is considered 'thinking too much' (i.e., 'this phenomenon is exactly the same and demands the treatment that is recommended in Western psychiatry'). We have to be mindful of constitutive cultural and linguistic meanings implied even at the descriptive level. But none of these claims preclude evaluative comparison writ large: the fact that divergent conceptual schemas and practices can revolve around a common phenomenon or a common concern—even as the linguistic equivalencies are absent—presupposes *something* in common. By implication, the potential for some evaluative comparison is left open. Returning to our example, whether diagnosed as 'depression' or 'thinking too much,' in both cases the common element is that this condition is seen as 'unhealthy.'[5] The differences lie in the interpretive construct which in turn conditions the importance that is attributed to the condition and the therapy that is recommended. The presence of a common element constitutes the foundation for an evaluative comparison and a search for converging, richer interpretations of the phenomenon.

Second, claims of incomparability essentialise the conceptual schemas and practices within culture, characterising these as isolated and self-perpetuating rather than dynamic, interactive, and evolving. When paired with the concerns around GMH, this generates a rather contradictory picture. Post-colonial critiques of GMH emphasise the need to respect indigenous perspectives and practices and recognise the harm of the ethnocentrism implied in GMH initiatives. Indeed, appreciating local culture remains, at root, a core animating principle of transcultural psychiatry. However, such respect is poorly served through a relativist framework: what a protectionist picture of static, insular local mental health practices may emerge which, ironically, would

be equally at home within colonial perspectives of the 'primitive.'

The underlying presumption of incomparability in cultural relativism also has deeper costs. The possibility of comparison and evaluation is necessary to appreciate and recognise cultural difference in a meaningful way; it requires pathways to engaging in dialogue and critical assessment about the respective merits and shortcomings of different cultures—including one's own. However, a relativist framework produces self-validating 'enclaves of mutual incomprehension' (Healy, 2013, p. 268). This is pernicious in a descriptive sense, insofar as it contradicts the historical reality and experience of translation, enculturation, and cultural exchange within Africa, situated within a globalised world. Even as these experiences are intertwined with abuses of colonial power and status, they are also closely bound to the negotiation, navigation, and reappropriation of power relations, agency, and social norms in fostering African identity.

Equally, it is pernicious in a normative sense, insofar as it treats these enclaves of mutual incomprehension as a valuable state of affairs, removing any positive obligation to engage in meaningful dialogue of some form to understand the conceptual schemas and practices of others. At the heart of relativism is a core tension between community and tolerance. Typically, the ethical warrant of relativism is grounded in its potential to cultivate tolerance for another's set of beliefs and conduct. But as Ajei points out, tolerance is in itself an unstable concept: it presupposes a negative normative judgement which denotes difference that is rooted in undesirability, disagreement, disapproval, and a sense of one's own superior or better judgement (Ajei, 2017). Toleration suggests that 'we remain respectful of each other in our silos of conviction and conduct and endure our differences' but 'the negative cast at the onset of our encounter, and conduct to substantiate this judgment, has the effect of obstructing the creation of community' (Ajei, 2017). Erecting barriers which separate us from different others therefore becomes a justifiable form of addressing and living with diversity. By contrast, mutual respect of different cultures necessarily challenges claims of incomprehensibility premised on the exoticisation of certain practices and beliefs; recognising the truth and value of different conceptual schemas stems from aspirations towards building community through identifying potential common points of concern, being open to possibilities of enriched awareness, and learning through cross-cultural contact.

Given these descriptive and normative problems, we can pinpoint the conceptual pitfalls of a dichotomised approach to global mental health, justifying the current imperative of greater collaboration, integration, and interdisciplinarity in global mental health discussions (Bemme & Kirmayer, 2020; Saraceno, 2020). Approaches focused on either 'scaling up' or adopting culturally specific strategies towards mental health care and human rights both share a desire to improve the health and dignity of individuals with mental disorder. But what is often overlooked and particularly insidious about an overly dichotomous approach to global mental health is how both universalist and cultural relativist positions share the same epistemological orientation at a deeper level. On one hand, there is the widespread realisation that some form of cultural modesty around mental health is necessary—if not owing to the imperative to respect cultural difference and local practices, then for basic pragmatic reasons (such as optimising the uptake of certain treatments). But such modesty seems to demand a retreat to relativism premised on the incomparability of cultures and conceptual schemas. On the other hand, our methodological commitments in the human and social sciences hold fast to norms of objective validity, where the ideal of universal repeatability is presumed to guide our descriptions and analysis of human behaviour and experience—including that of mental disorder. Either our commitment to cultural modesty or our model of scientific knowledge has to give way as a result: what we might sacrifice in cultural openness we gain in terms of the putative epistemological soundness of our methodology, or vice versa. Regardless, whether from a relativist who rejects it or an ethnocentric standpoint that embraces it, the shared presumption is that ways of acquiring knowledge of human behaviour and experience demand methodological adherence to an ideal of objective validity. They might lead to different conclusions, but ultimately the epistemological orientations of both share the same misguided starting point.

Unpicking the putative validity of this starting point will be critical to providing firm conceptual grounding for recent imperatives to eschew false dichotomies in global mental health debates and facilitate the genuine cross-cultural engagement needed to establish fruitful points of contact between different explanatory models, conceptual schemas, and practices towards mental health. Here, the framework of Gadamer's (2004) philosophical hermeneutics is central in two ways, each of which we discuss in turn. First, Gadamerian hermeneutics poses the critical question as to whether this model of science—with its epistemological orientation and the methodological trappings that follow—is even appropriate when we are dealing with complex human experience and meanings. Instead, there is the validation of intersubjective forms of knowledge, constituted by complex expressive meanings and divergent but evolving conceptual schemas. Second, this framework provides a dialogical

model that helps foster an interpretive understanding of different ways of life, where alterity or 'otherness' is considered a necessary foil for conceptual enrichment and ethical growth.

Gadamer in *Truth and Method* presents a critical challenge to the predominant model of scientific knowledge within the domain of human affairs. This model presumes that valid knowledge of human behaviours and phenomena comes about through the deployment of a particular methodology, committed to epistemic norms of neutrality which effectively remove the knower from her historical, cultural, and social context. Only through a stance of impartiality are we then capable of grasping an object in a unilateral, fixed sense. What this implies is that the interpretive and linguistic domains lack any epistemological standing in understanding the human sciences: they are relegated to 'subjective' or 'unreliable' descriptions of behaviour or meaning that cannot stand for objective truth.

Crucially, Gadamerian hermeneutics fundamentally questions this epistemological stance, suggesting that the interpretive domain of understanding is in fact the *only* grounding we have to come to grips with the complexity of human meaning and affairs. In other words, when scientific methodology is upheld as the standard by which we understand human meaning, we have effectively adopted the incorrect model of science to understand ourselves and others; rather than achieve an elusive (and impossible) goal of 'objective truth,' we occlude the intellectual orientation that is necessary to enrich understanding. Truth in the domain of the human sciences never achieves the finality or control over the object or phenomenon in a way that mimics the natural sciences, but is ever evolving and open-ended by virtue of the intersubjective, interpretive, and linguistic dimension that is constitutive of human meaning and behaviour. Rather than perceiving the scientific self as a disengaged subject before an object, Gadamer points to how culture and language influence our way of perceiving and interpreting the world. Our understanding of ourselves and the world is an ongoing conversation, where 'the conversation that we are' brings us into contact with realities of the past and the present.

In questioning the neutral descriptions of the human sciences, Gadamer reveals a different framework of understanding that is premised on dialogical engagement rather than epistemological detachment. Our linguistic descriptions of the human sciences necessarily have to appeal to basic features of our understanding of human life—but our appeal to these basic features can also function as a barrier to understanding different ways of life and conceptual schemas. We all have prejudice in this way: prejudice (literally 'pre-judgement') forms the prism through which we interpret ourselves and our engagement with others and the world (Gadamer, 2004). Gadamer removes the pejorative connotations of prejudice to point out how they constitute our way of being, our conceptual schemas, and our language, forming an unavoidable starting point which grounds our initial interpretive understanding.

Dialogical engagement at two levels is required to further shift our prejudices, enrich our understanding, and come to a non-distorted grasp of others or phenomena: first the presence of our prejudices and conceptual schemas that orient our intellectual outlooks needs acknowledgment, so that we can more readily identify where it is difficult to understand the practices or conceptual schemas of another. Second, encounters with 'alterity' or otherness function as a necessary trigger for conceptual enrichment and ethical growth—they bring to the forefront the contingency of that which we assume as true in our prejudices and conceptual schemas. Coming face-to-face with such difference heightens our awareness of the barriers and various distortive views that inhibit genuine understanding of another perspective. Our conceptual schemas necessarily develop and move when we start to question these barriers as a result of engaging in dialogue with what seems alien to us. Gadamer describes this process as a 'fusion of horizons'—where our respective horizons become expanded and more comprehensive through acknowledging the potential truth of other forms of human life (Gadamer, 2004). Through this dialogical process, our construal of others is enriched in ways that mean it becomes truer and less distortive—combining different ways of interpreting the world and what matters to human beings. In other words, such dialogical engagement generates a change in one's own views so that they now include the possibilities imminent in what was initially alien.

This approach to dialogue clearly distinguishes a hermeneutical framework from that of relativism. The latter suggests that the same proposition might have different truth values and implies that respect for difference logically follows. Yet a hermeneutical approach is not committed to such a misguided claim, nor would it suggest that this could properly ground genuine respect for different ways of life. The end game of 'fusing horizons' could not be more different. We acknowledge different vantage points, different questions that we might ask, different features that stand out based on our respective orientations towards the same phenomena, but ultimately, engaging with such difference is for the purpose of developing an account that is richer, and more comprehensive or mutually comprehensible from a broad range of views or horizons (Taylor, 2002). Thus, Gadamer still holds fast to

the idea that different accounts and descriptions *can* be evaluated against one another—some will incorporate less or more distortion, some will be less or more comprehensive, some will have more depth and others more superficial. Learning and understanding are essentially works of mediation where new situations are interpretively integrated—even by rejection—into our existing perceptions to 'broaden our horizons.'

The process of developing undistorted understandings is not easy, however: the transformative potential of dialogue contains its own explanation as to why such dialogue can be so difficult to engage with in the first place or is often engaged with only superficially. As discussed in the next section, we need to be alive to the difficulties inherent to achieving such dialogue in certain contexts.

Performance of identity and power dynamics between spheres of healing

The reality is that genuine dialogue towards a fusion of horizons is highly demanding. Gadamerian hermeneutics is frequently criticised for its overoptimistic depiction of dialogue, where it purportedly misjudges the extent to which we are willing to undertake the demanding task of relinquishing our misleading views of others (Habermas, 1990). Even as Gadamer might be guilty of this charge to some degree, this framework nonetheless sheds important light on the barriers to cross-cultural dialogue—namely our reluctance to face the identity cost incurred through transformative engagement with alternative conceptual schemas and practices. As Taylor writes, 'Really taking in the other will involve an identity shift in us. That is why it is so often resisted and rejected. We have a deep identity investment in the distorted images we cherish of others' (Taylor, 2002, p. 141). Even if this painful shift is viewed subsequently as better and ultimately richer, it still means others may be unwilling to undertake the initial identity cost that comes with genuinely understanding different standpoints.

The deep tensions inherent to mental health practitioners' cultural experiences and perceived identity, particularly within a competitive healing market, illustrate well the identity cost in, and the social barriers to, engaging in the type of transformative dialogue that fosters a 'fusion of horizons.' The motivational barriers to engaging in dialogue are important to acknowledge because they reveal the reality that the identity costs of genuine dialogue are not necessarily distributed evenly or fairly. How practitioners express their distinctive healing identities is grounded on complex motives related to the need to assert one's influence and unique services within a competitive health market, suggesting a potential subjective incentive to emphasise, even exaggerate, difference and incommensurability. This reveals that it is not necessarily the case that these different approaches to mental health are incommensurable or that they commit us to a relativist position, but rather that there are complex reasons to at least let it *appear* as though constructive dialogue remains impossible, not least to protect and regulate the boundaries of one's healing identity.

Numerous studies have shown how mental health care (and health care more generally) operates in a complex, sometimes overcrowded market, where practitioners from different traditions of healing compete to varying degrees to provide services to the public (Kpobi & Swartz, 2018a; Read, 2017). In relation to mental health care, non-medical practitioners can feel the need to distance their own practices from those of biomedicine by making claims that their approaches are more in tune with local understandings and spiritual experiences (Asamoah et al., 2014; Kpobi & Swartz, 2018b; Kpobi et al., 2019). Claims of cultural efficacy seem to constitute a performance of identity within a competitive health care domain but could also be reflective of experiences of the limits of biomedical psychiatric care (Read et al., 2009). By contrast, biomedical practitioners in the mental health field who may, like many people globally, simultaneously hold a range of apparently contradictory beliefs about mental disorder, its origin and treatments (Swartz, 2008), can sometimes feel the need to distance themselves as professionals from views which could be interpreted as animistic or unscientific. Consequently, inadvertent tensions between the practitioners' cultural experiences and perceived identity, and their biomedical training can emerge, particularly for professionals who come from formerly colonised societies, where the wish to be seen as cosmopolitan and sophisticated forms part of a response to racist colonial histories in which local beliefs were viewed as primitive and dangerous. These tensions are experienced not only by practitioners but also by academics and researchers who take on the role of presenting and representing the 'other' to an academic market in the Global North, whilst at the same time presenting themselves as able to traverse boundaries in a thoughtful and sophisticated manner (Swartz, 2018; Swartz & Marchetti-Mercer, 2018).

Within the non-biomedical healing sector, some practitioners may wish to denigrate the views of others in order to accentuate the extent to which they offer distinctively indigenous or appropriate services. In a competitive healing economy, successful business is typically dependent on different levels of identification of practitioners with target users. Moreover, indigenous and faith healing practices include elements of everyday experiences and occurrences. Non-biomedical

healers can be seen as possessing (and indeed emphasising) culturally familiar identities which afford them some level of influence in their communities. This is not to suggest that non-biomedical practitioners work purely for profit, as various studies have shown the commitment to care that many non-medical healers possess (Abbo, 2011; Akol et al., 2018; Musyimi et al., 2018). However, in a context where indigenous and faith practices are construed in dominant thought as primitive, practitioners sometimes find it necessary to highlight the distinctive benefits of their methods over others. Paradoxically, across all sectors (biomedical, indigenous, and faith-based) there may in fact be greater overlap in beliefs and values than at first appear. For example, some people express great faith in biomedicine but also set store by Christian prayer as a means of healing, and some people who identify as indigenous healers can also identify as Christians, as many of the herbalists interviewed by Kpobi, Swartz, and Omenyo (2019), for example, revealed.

The empirical data thus shows the complex intersections of identities and motivations that erect the practical and motivational barriers to engaging in dialogue amongst mental care practitioners. These practical challenges, however, do not invalidate the goal of trying to achieve an enriched understanding of different languages and cultures as a normative ideal. But what they do reveal is the need for a potential conceptual framework which can help foster cross-cultural dialogue and the building of a common healing community in the context of diversity, as we discuss in the next section.

Recovery as discovery

The concept of recovery is a potentially fruitful basis for constructive dialogue and cross-cultural enrichment in divergent conceptualisations of mental health, but it requires some critical distance from overly reductive notions of *individual* recovery. Discourses of recovery have understandably focused on the patient, moving away from a narrow emphasis on clinical outcomes (i.e., observable, measurable outcomes related to symptom remission and a return to previous functioning) to person-centred health and individual well-being related to establishing a meaningful, satisfying life within the experience of disability and illness (Anthony, 1993; Davidson et al., 2005b; Slade et al., 2012). However, the current patient-centred paradigm with its emphasis on empowering the person as an active partner rather than passive recipient of care, involved in treatment planning, decision-making, and leading a productive life (Mezzich et al., 2016), imports neoliberal traits of individualism, self-control, rationality, and subjective choice (Adeponle et al., 2012). This conceptual lens towards the patient as the subject and owner of recovery broadly presupposes a neoliberal vision of the person which tends to assume its putative universality, disregarding its own cultural genealogy.

Though resonant with biopsychosocial approaches,[6] this liberal self does not necessarily carry across different cultures easily (Adeponle et al., 2012; Aldersey et al., 2017; Slade et al., 2014). As frequently noted, many African cultures are committed to a more communitarian self, where the descriptive and normative dimensions of personhood are closely interlinked with one's social belonging.[7] The communitarianism of African personhood does not rest on a trivial claim (i.e., one lives and functions within community) but rather presupposes a deeper relational ontology at three levels: (i) intrapersonal (that which connects the person to one's physical and environmental self); (ii) interpersonal (that which connects the person to social and familial relations); and (iii) transpersonal (that which connects the person to spiritual and ancestral entities) (Gyekye, 1995; Kpanake, 2018; Metz, 2018; Wiredu, 1996). Personhood as embodied in the interconnected agency of physical, social, and spiritual essences means that the treatment and healing from mental disorder will depend on this holistic framework. Like other cultural contexts,[8] the communitarianism of African personhood could therefore be seen to run counter to the individualism implied in the recovery movement, where discourses and disagreement around recovery could inadvertently replicate the conceptual polarisation we have argued against throughout this article. The imperative of dialogical engagement is not necessarily embedded in overly individualist accounts of recovery, whilst the etymology of the term 'recovery' seemingly fosters misleading connotations of regaining certain functionalities or a return to some kind of subjective equilibrium, giving the concept a backward-looking inflection (Davidson et al., 2005a).

Tensions between African and Western notions of personhood must not be overexaggerated, though they do indeed point to some disagreement around the locus of and type of agency that is entailed in recovery. What they do indicate is the need for some conceptual refinement to the recovery framework: the integration of *discovery* can help capture how horizons of healing are hermeneutically expanded at a subjective, intersubjective, and conceptual level. What we call *recovery as discovery* expresses the open-ended, forward-inflection that is required to understand multiple dimensions of illness and healing experiences through intersubjective dialogue. As such, this refinement of the recovery concept expresses explicitly how healing points to finding new equilibriums in our perceptions of health. The dialectical process of discovery is dynamic, and conceptual tensions generate growth that resembles an

upward-moving spiral rather than a linear process, such that the new equilibrium is not a return or recovery to a defined place but a new state, albeit vaguely resonant of previous states.

Recovery as discovery thus supports and critically refines the recovery framework, making it constructive at two levels. At the 'micro' level, this concept focuses on the very real, practical negotiation of the interpretive meanings of social connection, spiritual belonging, and personhood to foster healing at the individual level, and which can model the type of interpersonal engagement that is needed across different healing strands. At a 'macro' level, the concept tracks the more abstract cross-disciplinary, cross-cultural intellectual dialogue that must occur to overcome false dichotomies in the global mental health debate, in order to foster genuine conceptual reciprocity between Western and African frameworks of healing.

At the micro level, recovery as discovery does not foreclose the possible harmony that is both *interior* to the self and *exterior* with regards to how others relate to the self. Different cultural contexts place varying emphasis on what this harmony might entail, but probing deeper one finds a common strand emphasising the importance of family, restoring social connectedness, and normative questions about how to live a flourishing life (Adeponle et al., 2012; Aldersey et al., 2017). Much like the variable terms which cluster around symptoms broadly defined as 'depression,' recovery across different strands of African healing congregates around the process of establishing links at a horizontal level (with family, social relations) and at a vertical level (with one's spiritual beliefs and identity), and the containment of adverse forces and disruption to harmony (Kpaneke, 2018)—thus making the journey towards health and well-being a physiological, psychological, social, and spiritual enterprise. In these contexts, the individual's self-perception is tied to a series of relations that are visible—community, ethnicity, the earth, religious affiliation—and invisible—the world of the transcendent being, spirits, ancestors. The notion of well-being is grounded on the harmonious dovetailing of these relations. This suggests that recovery within the person's environment may include adjustments in attitudes and practices that allow persons who do not fit into the dominant model to live and to thrive, encouraging a wider approach towards healing that considers both the individual and her surrounding context as the subject of healing. It accommodates the possibility of persons undergoing psychiatric care recurring to other health care streams which provide the type of moral or spiritual assistance they feel is absent in mainstream psychiatry (Ae-Ngibise et al., 2010).

The concept of recovery as discovery thus captures possibilities where dialogical engagement could be found and achieved across healing cultures, particularly in how individuals subjectively and intersubjectively negotiate their healing in a nexus of complex relations through comparative evaluations and mutual respect across mental health perspectives. For example, Kpanake (2018) explores a case study in Togo where a patient navigates the seemingly incommensurable tensions between the beliefs of traditional healing and his Christian faith. Rather than treat these as dichotomous modes of recovery, the patient sought a compromise, involving a family member in the traditional healing ceremony whilst he followed rituals in accordance with his spiritual identity. Likewise, Adeponle et al. (2012) use the example of an individual whose combination of traditional rites, ceremonies, and psychiatric treatment led to recovery—not just in terms of the reduction of psychotic symptoms, but 'on both the horizontal plane of family and communal relations and the vertical plane of relations with ancestors' (p. 121). Thus, patients at the crux of different healing processes often model the necessary conceptual and dialogical enrichment that comes through negotiating different facets of the interconnected self. As a model, it is particularly instructive for health practitioners of whatever stripe in terms of how dialogue could be negotiated in ways that, on one hand, acknowledge the depth of one's commitments, yet on the other, aspire towards a fusion of horizons with seemingly divergent discourses around mental health. Notably, in Kpanake (2018) the clinical team explicitly acknowledged and accepted the patient's simultaneous investment in recovery as defined by the traditional healer and other congregation members of his Catholic Church (pp. 210–211). This is not to disregard the reality of the motivational barriers and identity costs which can aggravate polarisation amongst practitioners of different health care strands. But those factors should not orient discussion of the *normative* aims and practices of healing and mental health which can foster some commonality and enhance humane treatments that address the person in a holistic fashion.

At the 'macro' level, recovery as discovery describes the intellectual orientation and dialogue that is needed to deepen current theorisations and concepts of mental health and well-being. Above, we cautioned against the intellectual dogmatism that is implicit in relativist and universalist positions in the global mental health debate. The dynamism underlying recovery as discovery demands an intellectual orientation that is open to dialogical engagement with, and the possibilities imminent within, various conceptual schemas around mental health, aspiring towards a Gadamerian 'fusion of horizons.' Such a dialogue would not only stop at

the level of persons and their individual mental health, but would be extended to questions of how surrounding mental health approaches emerge historically, contextually, and culturally—thereby enriching common descriptive and normative language around such practices. The temptation to treat the human rights approach in Western psychiatry ahistorically ignores how more humane practices are a product of historical circumstance and the ever-developing negotiation of cultural and intellectual traditions. As such, assumptions about the inability of traditional and spiritual healing practices in Africa to undertake and engage in a similar dynamic process, to advance more humane treatment of persons with mental disorders, are unwarrated.[9] In other words, the macro-level global mental health dialogue we are proposing here is an open context of discovery where new ideas and perspectives are discovered and where the context of justification involves a plurality of interpretive models. This demands acknowledging the prejudices that guide one's intellectual orientation—whether these be disciplinary or socio-cultural—and 'testing' them through engaging with frameworks that seem other to one's own.

For example, the increasing biogenetic orientation in mental health is a pre-judgement that forecloses a connection to spiritual forms of transcendence as part of healing the person. Drawing on Philip Rieff's cultural analysis of the therapeutic turn, Taylor (2007) in *A Secular Age* discusses how the transcendent has become off-limits through the therapeutic lens of modern Western secularism, whereby the symptoms of mental illnesses, like depression—melancholy, emptiness, etc.—are conceived as immanent pathologies of the individual rather than what were formally perceived as signs of spiritual misdirection. He writes, 'a crucial feature of a purely immanentist therapy is that the cure of these incapacities is held to involve—or even demand—our repudiation of, or at least distancing from, an aspiration to the transcendent, like religious faith' (Taylor, 2007, p. 622). But so long as this intellectual 'distancing' or 'repudiation' occurs, the important role of spiritual transcendence and the meaning it brings for many living with mental disorder will be disregarded, even within the secular West (Koenig, 2009; Luhrmann, 2013).[10] It is through undertaking the challenge of crossing disciplinary boundaries, of engaging with intellectual frameworks that focus on the deeper history, meanings, and significance of spiritual therapies, both in the African and Western contexts, that the academic lens is better able to understand the transcendent aspirations of patients and human beings more generally. Attending to the spiritual ambitions of patients in their quest to discover a harmonious condition of being is therefore a useful resource, not just in the micro sense discussed above. Indeed, at the macro level, recovery as discovery promotes academic, cross-disciplinary dialogue which fosters an awareness of the historical genealogy and genuine reciprocity in considering ways that African conceptual schemas around personhood, social connectedness, and physical and spiritual belonging could enrich global understandings of healing, health, and well-being.

Conclusion

Too often, the reality of culturally diverse practices and beliefs towards mental health is thought to imply the need to abandon attempts to foster a common purpose and a sense of global community for fear of perpetuating colonial discourse, and a retreat instead to the intellectual confines of relativism. But as we have shown, relativism represents a false comfort: its problematic epistemological assumptions and normative implications perpetuate barriers rather than enhance deeper understanding of the conceptual schemas, practices, and complex motivations of African populations.

This article has explored the type of interpretive orientation that could foster dialogical engagement with seemingly incomparable conceptual schemas in global mental health, whilst not ignoring the very real identity costs involved in such dialogue. The moral import of the hermeneutics of recovery as discovery is in its cultivation of genuine reciprocity and humility towards African conceptual schemas, including appeals to spiritual forms of transcendence. The 'Global' in global mental health, if taken seriously, requires a framework which assumes that there is a 'global' community: in the very etymology of community (*communitas*), *cum munere* underlines witness (*cum*) and reciprocity of giving and receiving (*munere*), whereas the contrary—'im-mune'—denotes isolation and non-exchange. Implicit in any coherent global mental health agenda therefore should be the idea of the pursuit of togetherness that is not monolithic but a communion of diversities, where we make space for the question of: 'What can African thought and practice teach us?' As Appiah (2006) rightly describes, why 'cosmopolitans don't insist that everyone become cosmopolitan' is because '[t]hey know they don't have all the answers. They're humble enough to think that they might learn from strangers; not too humble to think that strangers can't learn from them' (p. 32).

Acknowledgements

Our thanks to two anonymous reviewers and the editors of the journal for their helpful comments and feedback.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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Notes

1. There has been some important progress to reduce this stark dichotomisation in discussions of global mental health: see Bemme & Kirmayer, 2020; Lovell et al., 2019; Patel et al., 2018. Even as these are welcome developments, the temptation to revert back to a dichotomised approach remains; see Cosgrove et al.'s (2020) critique of the Lancet Commission and the charge that the Commission continues to reinforce a biomedical model. Moreover, the growth of psychiatric genomics research is important to highlight as potentially exacerbating divisions between adherents to biomedical and more holistic explanatory models of mental illness (see Kong et al., 2017). Although the Lancet Commission 2018 referred to a dimensional approach to mental disorder, the prioritisation of psychiatric genomics research (both financial and intellectual) has crystallised a reductive, highly physicalist notion of mental disorder, exacerbating the universal vs. relativist framing implicitly. The concept of dimensionality as a diagnostic tool has already been utilised by behavioural psychologists to reiterate the predictive nature of genetics in behavioural traits—see Craddock & Owen (2010); Kong (forthcoming); Krapohl et al. (2018); Plomin (2019). Global projects in psychiatric genomics spearheaded by Western academic consortiums may also have an important impact on the way in which African psychiatrists and other mental health practitioners understand mental illness causality and engage with patients, potentially reinforcing a rigid biomedical model in order to be taken seriously professionally—see Akinyemi et al. (2016); Kamaara et al. (2020); Kong (2018); Mulder et al. (2018).
2. We are not attaching geo-cultural signifiers to biomedical and faith-based approaches to mental health, though our concern revolves around the relationship between African indigenous forms of healing and the biomedical approach in psychiatry that is seen to be part of the corpus of Western scientific knowledge. It is important to acknowledge differences between the divergent conceptual schemas and their substantive commitments in order to facilitate genuine understanding and conceptual engagement (see Kong, 2018).
3. We differentiate between the GMH approach and global mental health in the following way: as outlined in the first section, GMH refers to a particular academic and policy-oriented discussion (sometimes described as the Movement for Global Mental Health) which presupposes the legitimacy of 'scaling up' psychiatric treatments as a response to statistical analyses of the treatment gap between physical and mental health treatments. Global mental health as a scholarly approach, by contrast, does not necessarily start with the GMH presuppositions and we take it to be concerned with the cross-cultural exploration of mental health conceptualisation, treatment, and their justification in different contexts, thereby encompassing the concerns of transcultural psychiatry.
4. As Bemme and Kirmayer (2020) rightly note: "Of course, focusing on culture in mental health care may not ensure effective care, just as universalism and globality do not always lead to the erasure of meaningful difference; both cultural specificity and claims of universality can be mobilized to different ends" (p. 13).
5. Importantly, psychiatric nosology is based on a consensus rather than any formal validation of the features which characterise common mental disorders. A condition like depression is defined by that consensus, supported by evidence generated out of the 'West'—and as such, could be narrowly conceived as a 'Western' construct. Beyond the rather straightforward question of whether putative linguistic equivalents exist in different contexts (i.e., 'thinking too much'), there is the more crucial question of whether those prospective equivalents correspond to the same phenomenon as depression, which then orients discussions about whether and how definitional/practical adaptations are negotiated, rather than the exoticisation of African mental health approaches. Our thanks to an anonymous reviewer for raising this important point.
6. Which increasingly veer towards patient rights and autonomy.
7. This is not to suggest that African cultures are *homogeneous*, and the diversity of African cultures is important to recognise. However, we follow Gyekye (1995) and Kanu (2013) that there are certain patterns in the cosmological beliefs, conceptual schemas, and practices that can warrant some broad generalisation regarding notable common features. And of course, communitarianism does exist within Western conceptual schemas, but not necessarily with the same ontological presumptions surrounding the person.
8. Such as the Maori in New Zealand and the indigenous peoples in Canada: see Kirmayer & Valaskakis (2008); Lavallee & Poole (2010); Mental Health Commission (1999); O'Hagan, et al. (2012).
9. Our thanks to an anonymous reviewer for making this point.

10. See, for example, the legal judgment in England and Wales, *Wye Valley NHS Trust v B* [2015] EWCOP 60.

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