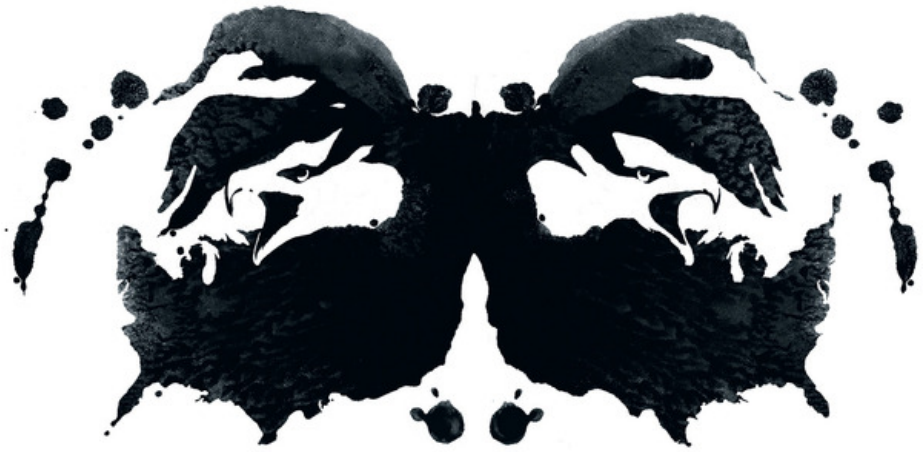
The Americanization of Mental Illness



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By ETHAN WATTERS
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AMERICANS, particularly if they are of a certain leftward-leaning, college-educated type, worry about our country's blunders into other cultures. In some circles, it is easy to make friends with a rousing rant about the McDonald's near Tiananmen Square, the Nike factory in Malaysia or the latest blowback from our political or military interventions abroad. For all our self-recrimination, however, we may have yet to face one of the most remarkable effects of American-led globalization. We have for many years been busily engaged in a grand project of Americanizing the world's understanding of mental health and illness. We may indeed be far along in homogenizing the way the world goes mad.

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This unnerving possibility springs from recent research by a loose group of anthropologists and cross-cultural psychiatrists. Swimming against the biomedical currents of the time, they have argued that mental illnesses are not discrete entities like the polio virus with their own natural histories. These researchers have amassed an impressive body of evidence suggesting that mental illnesses have never been the same the world over (either in prevalence or in form) but are inevitably sparked and shaped by the ethos of particular times and places. In some Southeast Asian cultures, men have been known to experience what is called amok, an episode of murderous rage followed by amnesia; men in the region also suffer from *koro*, which is characterized by the debilitating certainty that their genitals are retracting into their bodies. Across the fertile crescent of the Middle East there is *zar*, a condition related to spirit-possession beliefs that brings forth dissociative episodes of laughing, shouting and singing.

The diversity that can be found across cultures can be seen across time as well. In his book "Mad Travelers," the philosopher Ian

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Hacking documents the fleeting appearance in the 1890s of a fugue state in which European men would walk in a trance for hundreds of miles with no knowledge of their identities. The hysterical-leg paralysis that afflicted thousands of middle-class women in the late 19th century not only gives us a visceral understanding of the restrictions set on women's social roles at the time but can also be seen from this distance as a social role itself — the troubled unconscious minds of a certain class of women speaking the idiom of distress of their time.

"We might think of the culture as possessing a 'symptom repertoire' — a range of physical symptoms available to the unconscious mind for the physical expression of psychological conflict," Edward Shorter, a medical historian at the University of Toronto, wrote in his book "Paralysis: The Rise and Fall of a 'Hysterical' Symptom." "In some epochs, convulsions, the sudden inability to speak or terrible leg pain may loom prominently in the repertoire. In other epochs patients may draw chiefly upon such symptoms as abdominal pain, false estimates of body weight and enervating weakness as metaphors for conveying psychic stress."

In any given era, those who minister to the mentally ill — doctors or shamans or priests — inadvertently help to select which symptoms will be recognized as legitimate. Because the troubled mind has been influenced by healers of diverse religious and scientific persuasions, the forms of madness from one place and time often look remarkably different from the forms of madness in another.

That is until recently.

For more than a generation now, we in the West have aggressively spread our modern knowledge of mental illness around the world. We have done this in the name of science, believing that our approaches reveal the biological basis of psychic suffering and dispel prescientific myths and harmful stigma. There is now good evidence to suggest that in the process of teaching the rest of the world to think like us, we've been exporting our Western "symptom repertoire" as well. That is, we've been changing not only the treatments but also the expression of mental illness in other cultures. Indeed, a handful of mental-health disorders — depression, post-traumatic stress disorder and anorexia among them — now appear to be spreading across cultures with the speed of contagious diseases. These symptom clusters are becoming the lingua franca of human suffering, replacing indigenous forms of mental illness.

DR. SING LEE, a psychiatrist and researcher at the Chinese University of Hong Kong, watched the Westernization of a mental illness firsthand. In the late 1980s and early 1990s, he was busy documenting a rare and culturally specific form of anorexia nervosa in Hong Kong. Unlike American anorexics, most of his patients did not intentionally diet nor did they express a fear of becoming fat. The complaints of Lee's patients were typically somatic — they complained most frequently of having bloated stomachs. Lee was trying to understand this indigenous form of anorexia and, at the same time, figure out why the disease remained so rare.

As he was in the midst of publishing his finding that food refusal had a particular expression and meaning in Hong Kong, the public's understanding of anorexia suddenly shifted. On Nov. 24, 1994, a teenage anorexic girl named Charlene Hsu Chi-Ying collapsed and died on a busy downtown street in Hong Kong. The death caught the attention of the media and was featured prominently in local papers. "Anorexia Made Her All Skin and Bones: Schoolgirl Falls on Ground Dead," read one headline in a Chinese-language newspaper. "Thinner Than a Yellow Flower, Weight-Loss Book Found in School Bag, Schoolgirl Falls Dead on Street," reported another Chinese-language paper.

In trying to explain what happened to Charlene, local reporters often simply copied out of American diagnostic manuals. The mental-health experts quoted in the Hong Kong papers and magazines confidently reported that anorexia in Hong Kong was the same disorder that appeared in the United States and Europe. In the wake of Charlene's death, the transfer of knowledge about the nature of anorexia (including how and why it was manifested and who was at risk) went only one way: from West to East.

Western ideas did not simply obscure the understanding of anorexia in Hong Kong; they also may have changed the expression of the illness itself. As the general public and the region's mental-health professionals came to understand the American diagnosis of anorexia, the presentation of the illness in Lee's patient population appeared to transform into the more virulent American standard. Lee once saw two or three anorexic patients a year; by the end of the 1990s he was seeing that many new cases each month. That increase sparked another series of media reports. "Children as Young as 10 Starving Themselves as Eating Ailments Rise," announced a headline in one daily newspaper. By the late 1990s, Lee's studies reported that between 3 and 10 percent of young women in Hong Kong showed disordered eating behavior. In contrast to Lee's earlier patients, these women most often cited fat phobia as the single most important reason for their self-starvation. By 2007 about 90 percent of the anorexics Lee treated reported fat phobia. New patients appeared to be increasingly conforming their

experience of anorexia to the Western version of the disease.

What is being missed, Lee and others have suggested, is a deep understanding of how the expectations and beliefs of the sufferer shape their suffering. “Culture shapes the way general psychopathology is going to be translated partially or completely into specific psychopathology,” Lee says. “When there is a cultural atmosphere in which professionals, the media, schools, doctors, psychologists all recognize and endorse and talk about and publicize eating disorders, then people can be triggered to consciously or unconsciously pick eating-disorder pathology as a way to express that conflict.”

The problem becomes especially worrisome in a time of globalization, when symptom repertoires can cross borders with ease. Having been trained in England and the United States, Lee knows better than most the locomotive force behind Western ideas about mental health and illness. Mental-health professionals in the West, and in the United States in particular, create official categories of mental diseases and promote them in a diagnostic manual that has become the worldwide standard. American researchers and institutions run most of the premier scholarly journals and host top conferences in the fields of psychology and psychiatry. Western drug companies dole out large sums for research and spend billions marketing medications for mental illnesses. In addition, Western-trained traumatologists often rush in where war or natural disasters strike to deliver “psychological first aid,” bringing with them their assumptions about how the mind becomes broken by horrible events and how it is best healed. Taken together this is a juggernaut that Lee sees little chance of stopping.

“As Western categories for diseases have gained dominance, micro-cultures that shape the illness experiences of individual patients are being discarded,” Lee says. “The current has become too strong.”

Would anorexia have so quickly become part of Hong Kong’s symptom repertoire without the importation of the Western template for the disease? It seems unlikely. Beginning with scattered European cases in the early 19th century, it took more than 50 years for Western mental-health professionals to name, codify and popularize anorexia as a manifestation of hysteria. By contrast, after Charlene fell onto the sidewalk on Wan Chai Road on that late November day in 1994, it was just a matter of hours before the Hong Kong population learned the name of the disease, who was at risk and what it meant.

THE IDEA THAT our Western conception of mental health and illness might be shaping the expression of illnesses in other cultures is rarely discussed in the professional literature. Many modern mental-health practitioners and researchers believe that the scientific standing of our drugs, our illness categories and our theories of the mind have put the field beyond the influence of endlessly shifting cultural trends and beliefs. After all, we now have machines that can literally watch the mind at work. We can change the chemistry of the brain in a variety of interesting ways and we can examine DNA sequences for abnormalities. The assumption is that these remarkable scientific advances have allowed modern-day practitioners to avoid the blind spots and cultural biases of their predecessors.

Modern-day mental-health practitioners often look back at previous generations of psychiatrists and psychologists with a thinly veiled pity, wondering how they could have been so swept away by the cultural currents of their time. The confident pronouncements of Victorian-era doctors regarding the epidemic of hysterical women are now dismissed as cultural artifacts. Similarly, illnesses found only in other cultures are often treated like carnival sideshows. *Koro*, amok and the like can be found far back in the American diagnostic manual (DSM-IV, Pages 845-849) under the heading “culture-bound syndromes.” Given the attention they get, they might as well be labeled “Psychiatric Exotica: Two Bits a Gander.”

Western mental-health practitioners often prefer to believe that the 844 pages of the DSM-IV prior to the inclusion of culture-bound syndromes describe real disorders of the mind, illnesses with symptomatology and outcomes relatively unaffected by shifting cultural beliefs. And, it logically follows, if these disorders are unaffected by culture, then they are surely universal to humans everywhere. In this view, the DSM is a field guide to the world’s psyche, and applying it around the world represents simply the brave march of scientific knowledge.

Of course, we can become psychologically unhinged for many reasons that are common to all, like personal traumas, social upheavals or biochemical imbalances in our brains. Modern science has begun to reveal these causes. Whatever the trigger, however, the ill individual and those around him invariably rely on cultural beliefs and stories to understand what is happening. Those stories, whether they tell of spirit possession, semen loss or serotonin depletion, predict and shape the course of the illness in dramatic and often counterintuitive ways. In the end, what cross-cultural psychiatrists and anthropologists have to tell us is that all mental illnesses, including depression, P.T.S.D. and even schizophrenia, can be every bit as influenced by cultural beliefs and expectations today as hysterical-leg paralysis or the vapors or *zar* or any other mental illness ever experienced in the history of human madness. This does not mean that these illnesses and the pain associated with them are not real, or that sufferers deliberately shape their symptoms to fit a certain cultural niche. It means that a mental illness is an illness of the mind and cannot be understood without understanding the ideas, habits and

predispositions — the idiosyncratic cultural trappings — of the mind that is its host.

EVEN WHEN THE underlying science is sound and the intentions altruistic, the export of Western biomedical ideas can have frustrating and unexpected consequences. For the last 50-odd years, Western mental-health professionals have been pushing what they call "mental-health literacy" on the rest of the world. Cultures became more "literate" as they adopted Western biomedical conceptions of diseases like depression and schizophrenia. One study published in The International Journal of Mental Health, for instance, portrayed those who endorsed the statement that "mental illness is an illness like any other" as having a "knowledgeable, benevolent, supportive orientation toward the mentally ill."

Mental illnesses, it was suggested, should be treated like "brain diseases" over which the patient has little choice or responsibility. This was promoted both as a scientific fact and as a social narrative that would reap great benefits. The logic seemed unassailable: Once people believed that the onset of mental illnesses did not spring from supernatural forces, character flaws, semen loss or some other prescientific notion, the sufferer would be protected from blame and stigma. This idea has been promoted by mental-health providers, drug companies and patient-advocacy groups like the National Alliance for the Mentally Ill in the United States and SANE in Britain. In a sometimes fractious field, everyone seemed to agree that this modern way of thinking about mental illness would reduce the social isolation and stigma often experienced by those with mental illness. Trampling on indigenous prescientific superstitions about the cause of mental illness seemed a small price to pay to relieve some of the social suffering of the mentally ill.

But does the "brain disease" belief actually reduce stigma?

In 1997, Prof. Sheila Mehta from Auburn University Montgomery in Alabama decided to find out if the "brain disease" narrative had the intended effect. She suspected that the biomedical explanation for mental illness might be influencing our attitudes toward the mentally ill in ways we weren't conscious of, so she thought up a clever experiment.

In her study, test subjects were led to believe that they were participating in a simple learning task with a partner who was, unbeknownst to them, a confederate in the study. Before the experiment started, the partners exchanged some biographical data, and the confederate informed the test subject that he suffered from a mental illness.

The confederate then stated either that the illness occurred because of "the kind of things that happened to me when I was a kid" or that he had "a disease just like any other, which affected my biochemistry." (These were termed the "psychosocial" explanation and the "disease" explanation respectively.) The experiment then called for the test subject to teach the confederate a pattern of button presses. When the confederate pushed the wrong button, the only feedback the test subject could give was a "barely discernible" to "somewhat painful" electrical shock.

Analyzing the data, Mehta found a difference between the group of subjects given the psychosocial explanation for their partner's mental-illness history and those given the brain-disease explanation. Those who believed that their partner suffered a biochemical "disease like any other" increased the severity of the shocks at a faster rate than those who believed they were paired with someone who had a mental disorder caused by an event in the past.

"The results of the current study suggest that we may actually treat people more harshly when their problem is described in disease terms," Mehta wrote. "We say we are being kind, but our actions suggest otherwise." The problem, it appears, is that the biomedical narrative about an illness like schizophrenia carries with it the subtle assumption that a brain made ill through biomedical or genetic abnormalities is more thoroughly broken and permanently abnormal than one made ill though life events. "Viewing those with mental disorders as diseased sets them apart and may lead to our perceiving them as physically distinct. Biochemical aberrations make them almost a different species."

In other words, the belief that was assumed to decrease stigma actually increased it. Was the same true outside the lab in the real world?

The question is important because the Western push for "mental-health literacy" has gained ground. Studies show that much of the world has steadily adopted this medical model of mental illness. Although these changes are most extensive in the United States and Europe, similar shifts have been documented elsewhere. When asked to name the sources of mental illness, people from a variety of cultures are increasingly likely to mention "chemical imbalance" or "brain disease" or "genetic/inherited" factors.

Unfortunately, at the same time that Western mental-health professionals have been convincing the world to think and talk about mental illnesses in biomedical terms, we have been simultaneously losing the war against stigma at home and abroad. Studies of attitudes in the United States from 1950 to 1996 have shown that the perception of dangerousness surrounding people with schizophrenia has steadily increased over this time. Similarly, a study in Germany found that the public's desire to maintain

distance from those with a diagnosis of schizophrenia increased from 1990 to 2001.

Researchers hoping to learn what was causing this rise in stigma found the same surprising connection that Mehta discovered in her lab. It turns out that those who adopted biomedical/genetic beliefs about mental disorders were the same people who wanted less contact with the mentally ill and thought of them as more dangerous and unpredictable. This unfortunate relationship has popped up in numerous studies around the world. In a study conducted in Turkey, for example, those who labeled schizophrenic behavior as *akil hastaligi* (illness of the brain or reasoning abilities) were more inclined to assert that schizophrenics were aggressive and should not live freely in the community than those who saw the disorder as *ruhsal hastagi* (a disorder of the spiritual or inner self). Another study, which looked at populations in Germany, Russia and Mongolia, found that "irrespective of place . . . endorsing biological factors as the cause of schizophrenia was associated with a greater desire for social distance."

Even as we have congratulated ourselves for becoming more "benevolent and supportive" of the mentally ill, we have steadily backed away from the sufferers themselves. It appears, in short, that the impact of our worldwide antistigma campaign may have been the exact opposite of what we intended.

NOWHERE ARE THE limitations of Western ideas and treatments more evident than in the case of schizophrenia. Researchers have long sought to understand what may be the most perplexing finding in the cross-cultural study of mental illness: people with schizophrenia in developing countries appear to fare better over time than those living in industrialized nations.

This was the startling result of three large international studies carried out by the World Health Organization over the course of 30 years, starting in the early 1970s. The research showed that patients outside the United States and Europe had significantly lower relapse rates — as much as two-thirds lower in one follow-up study. These findings have been widely discussed and debated in part because of their obvious incongruity: the regions of the world with the most resources to devote to the illness — the best technology, the cutting-edge medicines and the best-financed academic and private-research institutions — had the most troubled and socially marginalized patients.

Trying to unravel this mystery, the anthropologist Juli McGruder from the University of Puget Sound spent years in Zanzibar studying families of schizophrenics. Though the population is predominantly Muslim, Swahili spirit-possession beliefs are still prevalent in the archipelago and commonly evoked to explain the actions of anyone violating social norms — from a sister lashing out at her brother to someone beset by psychotic delusions.

McGruder found that far from being stigmatizing, these beliefs served certain useful functions. The beliefs prescribed a variety of socially accepted interventions and ministrations that kept the ill person bound to the family and kinship group. "Muslim and Swahili spirits are not exorcised in the Christian sense of casting out demons," McGruder determined. "Rather they are coaxed with food and goods, feted with song and dance. They are placated, settled, reduced in malfeasance." McGruder saw this approach in many small acts of kindness. She watched family members use saffron paste to write phrases from the Koran on the rims of drinking bowls so the ill person could literally imbibe the holy words. The spirit-possession beliefs had other unexpected benefits. Critically, the story allowed the person with schizophrenia a cleaner bill of health when the illness went into remission. An ill individual enjoying a time of relative mental health could, at least temporarily, retake his or her responsibilities in the kinship group. Since the illness was seen as the work of outside forces, it was understood as an affliction for the sufferer but not as an identity.

For McGruder, the point was not that these practices or beliefs were effective in curing schizophrenia. Rather, she said she believed that they indirectly helped control the course of the illness. Besides keeping the sick individual in the social group, the religious beliefs in Zanzibar also allowed for a type of calmness and acquiescence in the face of the illness that she had rarely witnessed in the West.

The course of a metastasizing cancer is unlikely to be changed by how we talk about it. With schizophrenia, however, symptoms are inevitably entangled in a person's complex interactions with those around him or her. In fact, researchers have long documented how certain emotional reactions from family members correlate with higher relapse rates for people who have a diagnosis of schizophrenia. Collectively referred to as "high expressed emotion," these reactions include criticism, hostility and emotional overinvolvement (like overprotectiveness or constant intrusiveness in the patient's life). In one study, 67 percent of white American families with a schizophrenic family member were rated as "high EE." (Among British families, 48 percent were high EE; among Mexican families the figure was 41 percent and for Indian families 23 percent.)

Does this high level of "expressed emotion" in the United States mean that we lack sympathy or the desire to care for our mentally ill? Quite the opposite. Relatives who were "high EE" were simply expressing a particularly American view of the self. They tended to believe that individuals are the captains of their own destiny and should be able to overcome their problems by force of personal will. Their critical comments to the mentally ill person didn't mean that these family members were cruel or uncaring; they were simply applying the same assumptions about human nature that they applied to

themselves. They were reflecting an "approach to the world that is active, resourceful and that emphasizes personal accountability," Prof. Jill M. Hooley of Harvard University concluded. "Far from high criticism reflecting something negative about the family members of patients with schizophrenia, high criticism (and hence high EE) was associated with a characteristic that is widely regarded as positive."

Widely regarded as positive, that is, in the United States. Many traditional cultures regard the self in different terms — as inseparable from your role in your kinship group, intertwined with the story of your ancestry and permeable to the spirit world. What McGruder found in Zanzibar was that families often drew strength from this more connected and less isolating idea of human nature. Their ability to maintain a low level of expressed emotion relied on these beliefs. And that level of expressed emotion in turn may be key to improving the fortunes of the schizophrenia sufferer.

Of course, to the extent that our modern psychopharmacological drugs can relieve suffering, they should not be denied to the rest of the world. The problem is that our biomedical advances are hard to separate from our particular cultural beliefs. It is difficult to distinguish, for example, the biomedical conception of schizophrenia — the idea that the disease exists within the biochemistry of the brain — from the more inchoate Western assumption that the self resides there as well. "Mental illness is feared and has such a stigma because it represents a reversal of what Western humans . . . have come to value as the essence of human nature," McGruder concludes. "Because our culture so highly values . . . an illusion of self-control and control of circumstance, we become abject when contemplating mentation that seems more changeable, less restrained and less controllable, more open to outside influence, than we imagine our own to be."

CROSS-CULTURAL psychiatrists have pointed out that the mental-health ideas we export to the world are rarely unadulterated scientific facts and never culturally neutral. "Western mental-health discourse introduces core components of Western culture, including a theory of human nature, a definition of personhood, a sense of time and memory and a source of moral authority. None of this is universal," Derek Summerfield of the Institute of Psychiatry in London observes. He has also written: "The problem is the overall thrust that comes from being at the heart of the one globalizing culture. It is as if one version of human nature is being presented as definitive, and one set of ideas about pain and suffering. . . . There is no one definitive psychology."

Behind the promotion of Western ideas of mental health and healing lie a variety of cultural assumptions about human nature. Westerners share, for instance, evolving beliefs about what type of life event is likely to make one psychologically traumatized, and we agree that venting emotions by talking is more healthy than stoic silence. We've come to agree that the human mind is rather fragile and that it is best to consider many emotional experiences and mental states as illnesses that require professional intervention. (The National Institute of Mental Health reports that a quarter of Americans have diagnosable mental illnesses each year.) The ideas we export often have at their heart a particularly American brand of hyperintrospection — a penchant for "psychologizing" daily existence. These ideas remain deeply influenced by the Cartesian split between the mind and the body, the Freudian duality between the conscious and unconscious, as well as the many self-help philosophies and schools of therapy that have encouraged Americans to separate the health of the individual from the health of the group. These Western ideas of the mind are proving as seductive to the rest of the world as fast food and rap music, and we are spreading them with speed and vigor.

No one would suggest that we withhold our medical advances from other countries, but it's perhaps past time to admit that even our most remarkable scientific leaps in understanding the brain haven't yet created the sorts of cultural stories from which humans take comfort and meaning. When these scientific advances are translated into popular belief and cultural stories, they are often stripped of the complexity of the science and become comically insubstantial narratives. Take for instance this Web site text advertising the antidepressant Paxil: "Just as a cake recipe requires you to use flour, sugar and baking powder in the right amounts, your brain needs a fine chemical balance in order to perform at its best." The Western mind, endlessly analyzed by generations of theorists and researchers, has now been reduced to a batter of chemicals we carry around in the mixing bowl of our skulls.

All cultures struggle with intractable mental illnesses with varying degrees of compassion and cruelty, equanimity and fear. Looking at ourselves through the eyes of those living in places where madness and psychological trauma are still embedded in complex religious and cultural narratives, however, we get a glimpse of ourselves as an increasingly insecure and fearful people. Some philosophers and psychiatrists have suggested that we are investing our great wealth in researching and treating mental illness — medicalizing ever larger swaths of human experience — because we have rather suddenly lost older belief systems that once gave meaning and context to mental suffering.

If our rising need for mental-health services does indeed spring from a breakdown of meaning, our insistence that the rest of the world think like us may be all the more problematic. Offering the latest Western mental-health theories, treatments and categories in an attempt to ameliorate the psychological stress sparked by modernization and globalization is not a solution; it may be part of the

problem. When we undermine local conceptions of the self and modes of healing, we may be speeding along the disorienting changes that are at the very heart of much of the world's mental distress.

Ethan Watters lives in San Francisco. This essay is adapted from his book "Crazy Like Us: The Globalization of the American Psyche," which will be published later this month by Free Press.

An earlier version of this article misstated the publisher of Ethan Watters's book.

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