Invasion of the mind-snatchers

Western notions of mental illness are one of the US's most insidious exports – and they are spreading around the world like a contagion, says **Ethan Watters**

IN THIS age of globalisation, you would expect people to value and be sensitive about their local differences and diversity. And few areas could be more critical than different peoples' understanding of the human mind when it comes to mental health and illness.

For example, a Nigerian man might experience a culturally distinct form of depression by describing a "peppery" feeling in his head, while a Chinese farmer might speak only of shoulder or stomach aches. Salvadorean women refugees suffering psychological trauma after a long civil war, on the other hand, often experience something called *calorias*, a feeling of intense body heat.

For a long time, psychiatrists and medical anthropologists studying mental illness in different cultures found that mental illnesses are not evenly distributed globally, and do not take the same form from place to place. Unfortunately, mental health professionals in the US, who dominate the global discussion about how mental illnesses are categorised and treated, have often ignored or dismissed these differences.

Worse, local versions of mental illnesses are now being homogenised into American versions at an extraordinary rate. This is why I wrote *Crazy Like Us,* in which I explore the spread of four illnesses: post-traumatic stress disorder, anorexia, schizophrenia and depression. In this essay, I concentrate on two western forms of mental illness – depression and PTSD – which are spreading around the world with the speed of a contagious disease, bulldozing indigenous forms of mental illness as they go.

Two powerful but different forces are driving this. The diagnosis of PTSD is being spread by roving bands of western trauma counsellors who set up psychological first aid centres after wars and natural disasters. And our western conception of depression is being promoted by multinational drug companies who profit mightily when other cultures adopt the idea and then buy their antidepressants.

Laurence Kirmayer, director of the division of social and transcultural psychiatry at McGill University in Montreal, Canada, had a front-row seat as GlaxoSmithKline launched its antidepressant paroxetine (marketed as Paxil/Seroxat) in Japan in 2000. Kirmayer, an authority on the impact of cultural beliefs on mental illness, had been invited to a GSK-sponsored academic conference in Japan. It was only when he arrived that he realised the true agenda: the company wanted his knowledge to help it understand how cultural beliefs about illness can be changed.

"The clinical presentation of depression and anxiety is a function not only of patients' ethnocultural backgrounds, but of the structure of the healthcare system they find themselves in and the diagnostic categories and concepts they encounter in mass media and in dialogue with family, friends and clinicians," Kirmayer wrote later in *The Journal of Clinical Psychiatry*. In a globalising world, all of these factors are in "constant transaction and transformation across boundaries of race, culture, class, and nation". In other words, cultural beliefs about depression and the self are malleable and responsive to messages exported from one culture to another.

The challenge GSK faced in the Japanese market was formidable. The nation did have a clinical diagnosis of depression – *utsubyo* – but it was nothing like the US version: it described an illness as devastating and as stigmatising as schizophrenia. Worse, at least for the sales prospects of antidepressants in Japan, it was rare. Most other states of melancholy were not considered illnesses in Japan. Indeed, the experience of prolonged, deep sadness was often considered to be a *jibyo*, a personal hardship that builds character. To make paroxetine a hit,

"Globalisation's greatest success story may be the spread of PTSD diagnosis"

PROFILE

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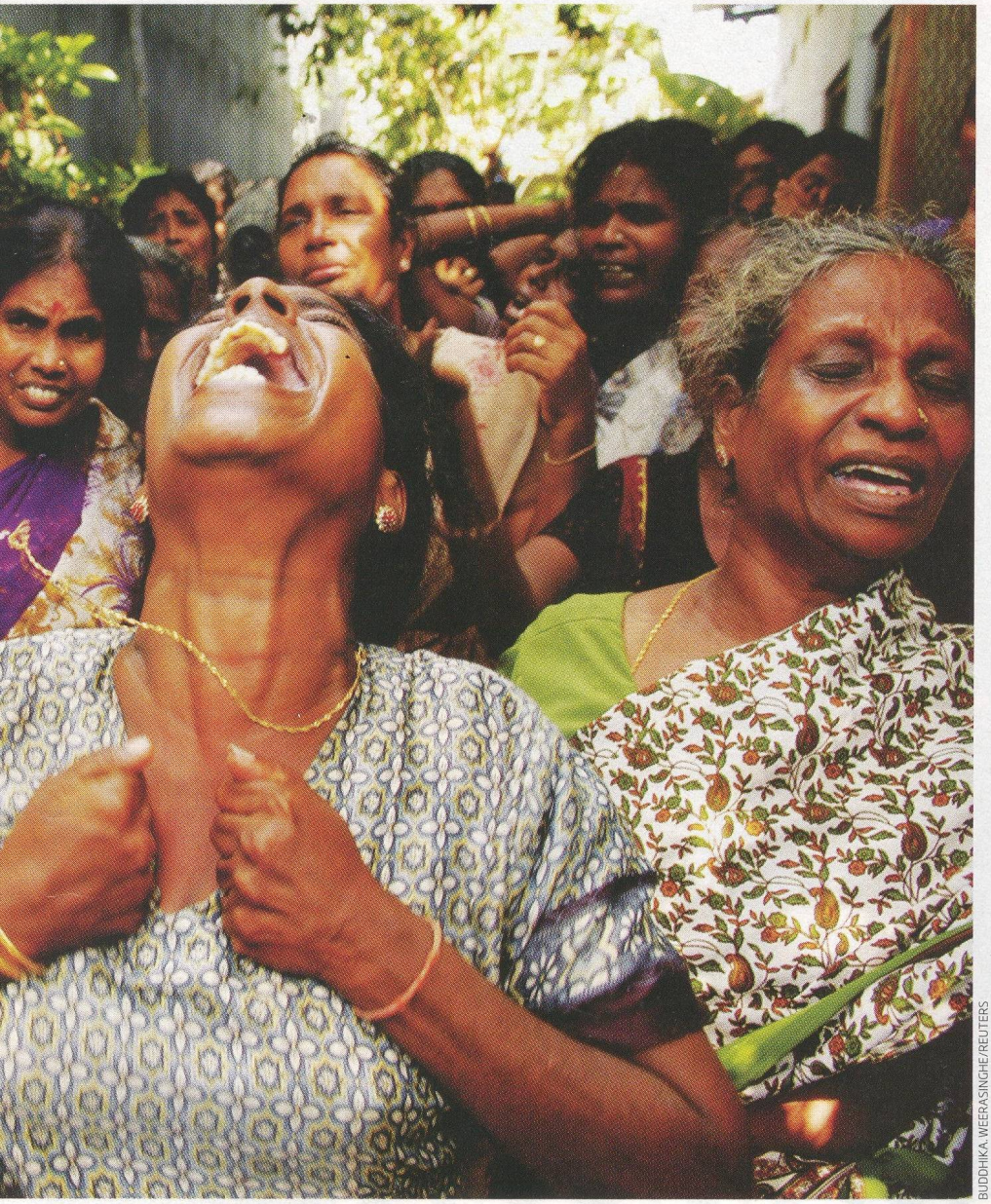

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The Sri Lankan experience of the 2004 tsunami differed significantly from western diagnoses

it would not be enough to corner the small market for people diagnosed with *utsubyo*. As Kirmayer realised, GSK intended to influence the Japanese understanding of sadness and depression at the deepest level.

"What I was witnessing was a multinational pharmaceutical corporation working hard to redefine narratives about mental health," Kirmayer said. "These changes have far-reaching effects, informing the cultural conceptions of personhood and how people conduct their everyday lives. And this is happening on a global scale. These companies are upending long-held cultural beliefs about the meaning of illness and healing."

Which is exactly what GSK appears to have accomplished. Promoting depression as a *kokoro no kaze* – "a cold of the soul" – GSK managed to popularise the diagnosis. In the first year on the market, sales of paroxetine in Japan brought in $100 million. By 2005, they were approaching $350 million and rising quickly.

Giving depression stiff competition is the PTSD diagnosis. It has only been "official" since 1980, when it entered the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, but it has had a meteoric rise. Western counsellors now use it worldwide after natural disasters, wars and genocides. According to Allan Young, a medical anthropologist at McGill, the spread of PTSD as a diagnosis worldwide may be the "greatest success story of globalisation".

In our rush to treat the psychic wounds of traumatised people, we seldom ask if PTSD can be usefully applied everywhere. "The meaning of a horrible event has a tremendous impact on the human psyche, and that meaning differs across the world. The meaning matters as much as the event," says Ken Miller, a psychologist at Pomona College, Claremont, California, who studied in Afghanistan and elsewhere the reactions to war trauma.

He found many psychological reactions that were not on any western PTSD symptom list, and a few with no ready translation into English. In Afghanistan, for example, there was *asabi*, a type of nervous anger, and *fishar-e-bala*, the sensation of agitation or pressure.

Giathra Fernando, a psychologist at California State University, Los Angeles, also found culturally distinct psychological reactions to trauma in post-tsunami Sri Lanka. By and large, Sri Lankans didn't report pathological reactions in line with the internal states making up most of the west's PTSD checklist (hyperarousal, emotional numbing and the like). Rather, they tended to see the negative consequences of tragic events in terms of damage to social relationships. Fernando's research showed the people who continued to suffer were those who had become isolated from their social network or who were not fulfilling their role in kinship groups. Thus Sri Lankans conceived the tsunami damage as occurring not inside their minds but outside, in the social environment.

Many researchers who found culturally distinct expressions of trauma worry whether counsellors can be effective if they don't know the local idioms of distress. Arthur Kleinman, a medical anthropologist at Harvard University, says that although most disasters do not occur in the west, "we come in and pathologise their reactions. We say 'you don't know how to live with this situation'. We take their cultural narratives and impose ours. It's a terrible example of dehumanising people."

Depression and PTSD aren't just symptom lists. Just as hysteria was a quintessential disorder of the Victorian era, so PTSD and depression speak volumes about how the US and the west conceive of the self. They contain assumptions about the events that will damage the human mind and where the line lies between normal psychological states and pathological ones. They go far beyond describing disorders with a symptom cluster: with them, we are exporting a world view. ■