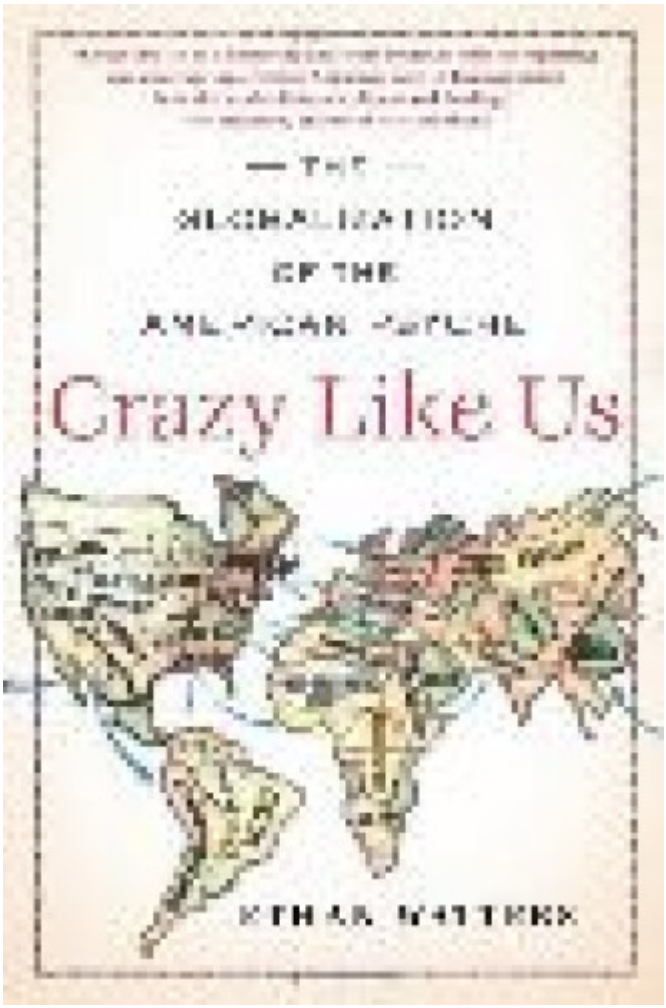
Exporting mental illness

By David Augsburger in the July 13, 2010 issue

In Review



Crazy Like Us

Ethan Watters

An impoverished doctor in an Alpine valley of hearty people, lures a naive country boy into his examining room, shows him frightening anatomical charts of the mysteries within, and awakens fears about hiccups and hair loss, acne and gas

pains. According to this old French fable, the boy leaves clutching a bottle of medicine and carrying alarming stories to pass along. After a few months the fears have spread, the aches and pains of daily labor have become symptoms of serious illness, the clinic is overrun, a hospital is under construction, and medicine has become a necessity.

The power of culture to elicit symptoms, define diagnoses, reify illness patterns, assign self-authenticating names, create new syndromes and identify new diseases, then offer treatments that alert the public and move pharmaceuticals off the shelves, is well known. Each new illness, from irritable bowel syndrome to social anxiety disorder, is met by a matching med and becomes a major boon to the drug industry. What is less understood is how we teach one another to label our inner emotional distress, express it in approved form and seek treatment for an increasing range of approved diagnoses. What for great-grandma was “nerves” is now a spectrum of codes in the DSM-IV—the fourth major revision of the *Diagnostic and Statistical Manual of Mental Disorders*. The specificity can be helpfully perceptive; it can also be unhelpfully prescriptive.

The most significant export the U.S. contributes to the wider world is not McDonald’s or popular TV shows. It is a sweeping set of cultural instructions on how to live, whether sanely or insanely. The cultural flotsam of the U.S. is not the only thing that drives the rest of the world crazy; the U.S. is also literally exporting its mental illnesses. “In teaching the rest of the world to think like us, we have been, for better and worse, homogenizing the way the world goes mad,” writes journalist Ethan Watters. Conditions first widely diagnosed in the U.S., such as anorexia and post-traumatic stress disorder, have been spread abroad “with the speed of contagious diseases.” Big Pharma and the widespread adoption of U.S. health standards have exported the ailing American psyche as the primary diagnostic model for mental health care and treatment.

By 2008, as a case in point, Glaxo SmithKline was annually selling over a billion dollars worth of Paxil in Japan, a society whose members didn’t know they had a widespread problem with depression until drug marketers offered both diagnosis and treatment in a tsunami of commercials and advertisements. Our Western influence over the rest of the world is coming at a great cost: loss of the world’s diversity and complexity, Watters argues. We are flattening the landscape of the human psyche itself. Mental illness—eating disorders, PTSD, Americanized depression—is spreading. The pathogen that leads to these outbreaks is us. This is

not a new proposition, but Watters moves it from critical footnotes in fine print to large font on the front page.

Every culture teaches its members patterns for insanity as well as guidelines for sanity. “If you must go crazy, these are the forms of ideation, emotion and behavior that communicate your distress.” What appears as depression in Washington, D.C., will look very different in Mumbai. The same hormonal changes flow one way when anxiety is blamed on the self (the American way) and another way when anxiety is perceived as an attack from external forces (as in the Sahel region in Africa). Malignant anxiety is treated in a way that contrasts sharply with treatment for vegetative depression.

As final decisions are being made on the next edition of the DSM, one of the diagnoses gaining attention is PTED, post-traumatic embitterment disorder, the name given to a reaction to an exceptionally negative but not life-threatening event such as conflict in the workplace, sudden unemployment, or loss of social status and separation from one’s social group. In addition to embitterment, symptoms include feelings of helplessness and the belief that one has been the victim of injustice. If enough persons sitting on the right DSM-V work group support it, and if a multinational drug company with a drug targeting this condition lobbies for it, then PTED has a chance of being the new PTSD. It could be worth billions. Grief over loss, with its concomitant feelings of resentment and bitterness—once a sign of authentic humanity—would thus become a treatable disease.

But resentment, we pastoral theologians argue, is not a disease; it is a capacity to desire equity and parity. The capacity to feel resentment, like the ability to feel anger, is God’s good gift that leads us to prize justice and seek it for others as well as for ourselves. If we are to support the general transformation of discomfort into a disorder, then may we raise the question of several far more threatening pathological conditions that are socially approved as normal in our culture?

Perhaps we should consider a new diagnosis of lethality: the need to sleep with, carry in the car or conceal on the person a device that enables one to instantly deprive someone else of life at personal whim or in an emotionally grim moment.

We might diagnose infectious greed as compulsive acquisitiveness: the need to acquire a massive fortune, the belief that we have the right to demand a bonus beyond $1,000, the feeling of entitlement to possess multiple residential properties.

Can we diagnose epidermiphobia as a factor in anti-Obama rhetoric? In 1921, Karl Menninger announced racially open hiring practices in the hospitals in Kansas with the words, “Anyone who protests can either resign immediately or submit themselves for treatment since racism is a form of insanity.” Is there a pill for packing heat, piling gold, hating skin tone? Can we take the pill ourselves rather than export it to the world?

Watters has offered us a highly readable investigative tour that explores the emergence of anorexia in Hong Kong, the substitution of Western-style PTSD for culturally appropriate grief work in Sri Lanka, the “shifting of the mask of schizophrenia” in Zanzibar, and the megamarketing of depression in Japan. Watters is a journalist by calling rather than a clinician, and he has done his homework by finding clinicians in each social location to raise the issues and critique the importation of Western solutions. His prose is sometimes tinted with the alarm he feels, but his prognostications on the global uses of Western prognosis are not exaggerated or sensationalistic.

When the world of astonishing diversity is reduced to a common crazy quilt of social and psychiatric labels, problems arise from misidentification of causes, mislabeling of effects, misapplication of treatments and misuse of medical answers. Beneath the marketing of medication are the practices of promising absence of pain, eradication of discomfort, and entitlement to instant solutions. Religion has long been guilty of promising much more than it can deliver to the ailing psyche, the failing relationship, the struggling family and the troubled community—with its offers of miracles, prosperity and, above all, the power to take control when life seems out of control. But move over religion, there are other agents with promises and offers.

“Step into my examining room,” the old fable invites. “Let me tell you about your problems with weight, shyness, grief, loss, troubled feelings, low energy, erectile dysfunction. There is, I promise you, whatever your culture, a rational or pharmacopoeial answer.”