"*Crazy Like Us* is a blistering and truly original work of reporting and analysis, uncovering America's role in homogenizing how the world defines wellness and healing."
—Po Bronson, author of *NurtureShock*

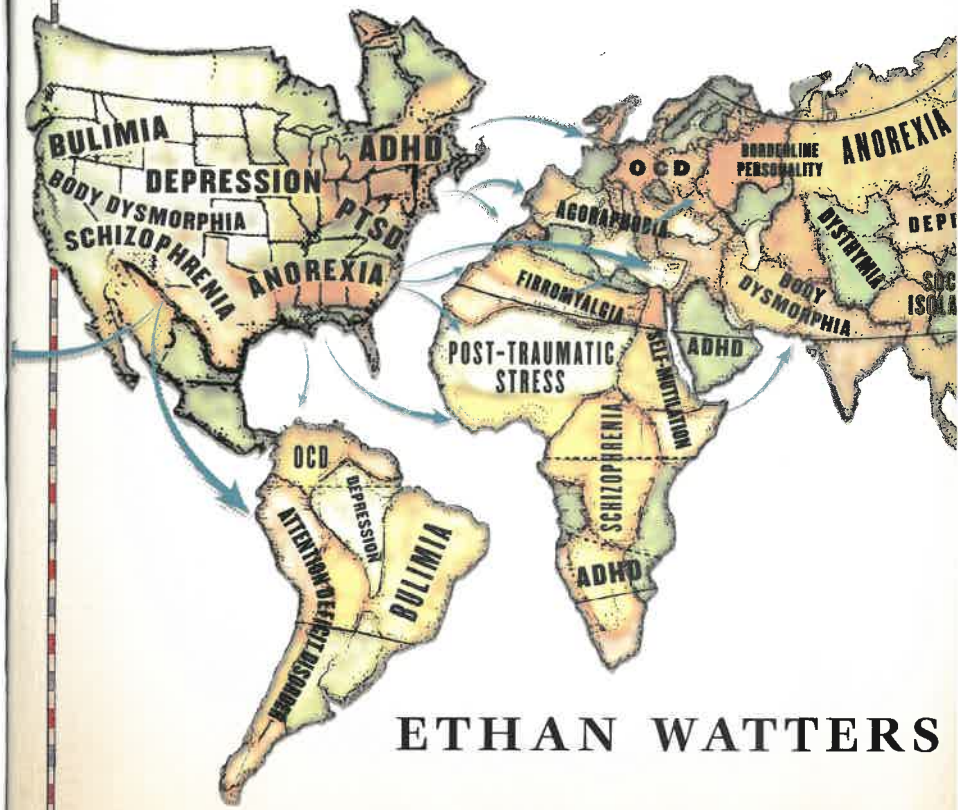
THE

GLOBALIZATION

OF THE

AMERICAN PSYCHE

Crazy Like Us



ETHAN WATTERS

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Crazy Like Us

Introduction

To travel internationally is to become increasingly unnerved by the way American culture pervades the world. We cringe at the new indoor Mlimani shopping mall in Dar es Salaam, Tanzania. We shake our heads at the sight of a McDonald's on Tiananmen Square or a Nike factory in Malaysia. The visual landscape of the world has become depressingly familiar. For Americans the old joke has become bizarrely true: wherever we go, there we are.

We have the uneasy feeling that our influence over the rest of the world is coming at a great cost: loss of the world's diversity and complexity. For all our self-incrimination, however, we have yet to face our most disturbing effect on the rest of the world. Our golden arches do not represent our most troubling impact on other cultures; rather, it is how we are flattening the landscape of the human psyche itself. We are engaged in the grand project of Americanizing the world's understanding of the human mind.

This might seem like an impossible claim to back up, as such a change would be happening inside the conscious and unconscious thoughts of more than six billion people. But there are telltale signs that have recently become unmistakable. Particularly telling are the changing manifestations of mental illnesses around the world. In the past two decades, for instance, eating disorders have risen in Hong Kong and are now spreading to inland China. Post-traumatic

stress disorder (PTSD) has become the common diagnosis, the lingua franca of human suffering, following wars and natural disasters. In addition, a particularly Americanized version of depression is on the rise in countries across the world.

What is the pathogen that has led to these outbreaks and epidemics? On what currents do these illnesses travel?

The premise of this book is that the virus is us.

Over the past thirty years, we Americans have been industriously exporting our ideas about mental illness. Our definitions and treatments have become the international standards. Although this has often been done with the best of intentions, we've failed to foresee the full impact of these efforts. It turns out that how a people in a culture think about mental illnesses—how they categorize and prioritize the symptoms, attempt to heal them, and set expectations for their course and outcome—influences the diseases themselves. 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.

There is now a remarkable body of research that suggests that mental illnesses are not, as sometimes assumed, spread evenly around the globe. They have appeared in different cultures in endlessly complex and unique forms. Indonesian men have been known to experience *amok*, in which a minor social insult launches an extended period of brooding punctuated by an episode of murderous rage. Southeastern Asian males sometimes suffer from *koro*, the debilitating certainty that their genitals are retracting into their body. Across the Fertile Crescent of the Middle East there is *zar*, a mental illness related to spirit possession that brings forth dissociative episodes of crying, laughing, shouting, and singing.

The diversity that can be found across cultures can be seen across time as well. Because the troubled mind has been perceived in terms of diverse religious, scientific, and social beliefs of discrete cultures, the forms of madness from one place and time in history often look

remarkably different from the forms of madness in another. These differing forms of mental illness can sometimes appear and disappear within a generation. In his book *Mad Travelers,* Ian Hacking documents the fleeting appearance in Victorian Europe of a fugue state in which young men would walk in a trance for hundreds of miles. Symptoms of mental illnesses are the lightning in the zeitgeist, the product of culture and belief in specific times and specific places. That thousands of upper-class women in the mid-nineteenth century couldn't get out of bed due to the onset of hysterical leg paralysis gives us a visceral understanding of the restrictions set on women's social roles at the time.

But with the increasing speed of globalization, something has changed. The remarkable diversity once seen among different cultures' conceptions of madness is rapidly disappearing. A few mental illnesses identified and popularized in the United States—depression, post-traumatic stress disorder, and anorexia among them—now appear to be spreading across cultural boundaries and around the world with the speed of contagious diseases. Indigenous forms of mental illness and healing are being bulldozed by disease categories and treatments made in the USA.

There is no doubt that the Western mental health profession has had a remarkable global influence over the meaning and treatment of mental illness. Mental health professionals trained in the West, and in the United States in particular, create the official categories of mental diseases. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, the *DSM* (the "bible" of the profession, as it is sometimes called), has become the worldwide standard. In addition American researchers and organizations run the premier scholarly journals and host top conferences in the fields of psychology and psychiatry. Western universities train the world's most influential clinicians and academics. Western drug companies dole out the funds for research and spend billions marketing medi-

cations for mental illnesses. Western-trained traumatologists rush in wherever war or natural disasters strike to deliver "psychological first aid," bringing with them their assumptions about how the mind becomes broken and how it is best healed.

These ideas and practices represent much more than the symptom lists that describe these conditions. Behind the promotion of Western ideas of mental health and healing lies a variety of cultural assumptions about human nature itself. Westerners share, for instance, 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 are certain that humans are innately fragile and should consider many emotional experiences as illnesses that require professional intervention. We're confident that our biomedical approach to mental illness will reduce stigma for the sufferer and that our drugs are the best that science has to offer. We promise people in other cultures that mental health (and a modern style of self-awareness) can be found by throwing off traditional social roles and engaging in individualistic quests of introspection. 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.

What motivates us in this global effort to convince the world to think like us? There are several answers to this question, but one of them is quite simple: drug company profits. These multibillion-dollar conglomerates have an incentive to promote universal disease categories because they can make fortunes selling the drugs that purport to cure those illnesses.

Other reasons are more complex. Many modern mental health practitioners and researchers believe that the science behind our drugs, our illness categories, and our theories of the mind have put the field beyond the influence of constantly 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 ways and examine DNA sequences for abnormalities. For a generation now we have proudly promoted the biomedical notion of mental illness: the idea that these diseases should be understood clinically and scientifically, like physical illnesses. The assumption is that these remarkable scientific advances have allowed modern-day practitioners to avoid the biases and mistakes of their predecessors.

Indeed modern-day mental health practitioners often look back at previous generations of psychiatrists with a mixture of scorn and pity, wondering how they could have been so swept away by the cultural beliefs of their time. Theories surrounding the epidemic of hysterical women in the Victorian era are now dismissed as cultural artifacts. Even recent iatrogenic contagions, such as the sudden rise of multiple personality disorder just fifteen years ago, are considered ancient history, harmful detours but safely in the past. Similarly, illnesses found only in other cultures are often treated like carnival sideshows. *Koro* and *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." They might as well be labeled "Psychiatric Exotica: Two Bits a Gander."

Western mental health practitioners are prone to believe that, unlike those culturally contrived manifestations of mental illness, 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, the logic goes, if they are unaffected by culture, then these disorders are surely universal to humans everywhere. Their application around the world therefore represents simply the brave march of scientific knowledge.

But the cross-cultural researchers and anthropologists profiled in this book have a different story to tell. They have shown that the experience of mental illness cannot be separated from cul-

ture. We can become psychologically unhinged for many reasons, such as personal trauma, social upheaval, or a chemical imbalance in our brain. Whatever the cause, we invariably rely on cultural beliefs and stories to understand what is happening. Those stories, whether they tell of spirit possession or serotonin depletion, shape the experience of the illness in surprisingly dramatic and often counterintuitive ways. In the end, all mental illnesses, including such seemingly obvious categories such as depression, PTSD, and even schizophrenia, are every bit as shaped and influenced by cultural beliefs and expectations as hysterical leg paralysis, or the vapors, or *zar*, or any other mental illness ever experienced in the history of human madness.

The cultural influence on the mind of a mentally ill person is always a local and intimate phenomenon. So although this book describes a global trend, it is not told from a global perspective. In the hopes of keeping the human-scale impact in sight, I have chosen to tell the stories of four diseases in four different countries. I picked these tales because each illustrates how the globalization of Western beliefs about mental health travel on different currents. From the island of Zanzibar, where beliefs in spirit possession are increasingly giving way to biomedical notions of mental illness, I tell the story of two families struggling with schizophrenia. To document the rise of anorexia in Hong Kong, I retrace the last steps of 14-year-old Charlene Hsu Chi-Ying and show how the publicity surrounding her death introduced the province to a particularly Western form of the disease. I deconstruct the mega-marketing of the antidepressant Paxil in Japan to illustrate how drug companies often sell the very disease for which their drug purports to be a cure. The aftermath of the 2004 tsunami in Sri Lanka provides the opportunity to examine the impact of trauma counselors who rush into disaster zones armed with the diagnosis of posttraumatic stress

and Western certainties about the impact of trauma on the human psyche.

At the end of each of these chapters I turn the focus back to the West, and to the United States in particular. When viewed from a far shore, the cultural assumptions and certainties that shape our own beliefs about mental illness and the human mind often become breathtakingly clear. From this perspective, it is often our own assumptions about madness and the self that begin to appear truly strange.

The cross-cultural psychiatrists and anthropologists featured in this book have convinced me that we are living at a remarkable moment in human history. At the same time they've been working hard to document the different cultural understandings of mental illness and health, those differences have been disappearing before their eyes. I've come to think of them as psychology's version of botanists in the rain forest, desperate to document the diversity while staying only a few steps ahead of the bulldozers.

We should worry about this loss of diversity in the world's differing conceptions and treatments of mental illness in exactly the same way we worry about the loss of biological diversity in nature. Modes of healing and culturally specific beliefs about how to achieve mental health can be lost to humanity with the grim finality of an animal or plant lapsing into extinction. And like those plants and animals, the diversity in the human understanding of the mind can disappear before we've truly comprehended its value. Biologists suggest that within the dense and vital biodiversity of the rain forest are chemical compounds that may someday cure modern plagues. Similarly, within the diversity of different cultural understandings of mental health and illness may exist knowledge that we cannot afford to lose. We erase this diversity at our own peril.

1

The Rise of Anorexia in Hong Kong

> Psychiatric theory cannot deny its participation in the social trajectory of the anorectic discourse, which articulates personal miseries as much as it does public concerns.
>
> SING LEE

On the morning of my visit to Dr. Sing Lee, China's preeminent researcher on eating disorders, I took the subway a few stops north of downtown Hong Kong to the Prince of Wales Hospital in the suburb of Shatin. In the clean and well-lit subway corridors, I passed several large posters featuring outlandishly slender, bikinied young women promoting a variety of health care regimens, cellulite-removing creams, and appetite-suppressant supplements. The advertisements over the handrails in the subway cars repeated the offers. The magazines and newspapers being read by the commuters were filled with similar pitches, often featuring before and after photos, young women becoming little more than skin and bones after the offered treatment. Such products are a huge business in Hong Kong and increasingly in mainland China. Over the past few years the beauty industry in Hong Kong (including dieting, cosmetics, skin care, and fitness) has outspent every other business sector on advertising. In that week's issue of the popular weekly

magazine *Next*, a remarkable 110 of the publication's 150 ads were for slimming or beauty products and services.

The reporting and photojournalism that appeared alongside those ads had a slightly different obsession: telling tales of young women celebrities. That morning's *Standard*, one of Hong Kong's English dailies, prominently reported the recent misadventures of several famous young women, including Britney Spears, who had that week been held against her will at the UCLA Medical Center. She had been "5150ed," which is the code for a California statute that allows doctors to hold a patient involuntarily if she is deemed a danger to herself or others. On the opposing page was an article about the Japanese pop idol Kumi Koda, who lost her job as a spokesmodel for Japan's third largest cosmetics company, Kose Corp., after making pejorative comments about the fertility of older women. The cute and perky 25-year-old had gone on a popular radio show and given her medical opinion that a "mother's amniotic fluid turns rotten once a woman reaches about thirty-five . . . It gets dirty."

The biggest story in *The Standard*, in fact the front-page story in every paper in Hong Kong that morning, was a sex scandal involving a handful of the region's best-known female pop stars and a young actor. Hundreds of very explicit nude photos had been posted on the Internet of singer Gillian Chung and actresses Bobo Chen and Cecilia Cheung Pak-chi, among a dozen others. That same week a humanitarian crisis was erupting along the Gaza-Egyptian border and a severe snowstorm was sweeping across much of eastern China, threatening to strand millions of holiday travelers, yet no other story could compete with this sex scandal. Everyone, from politicians to op-ed writers, felt the need to criticize the behavior of the young women. Even Hong Kong's Catholic bishop John Tong weighed in on the subject of celebrity sin and cyber etiquette, saying that it was important to "keep our minds decent" and "not post or circulate these pictures."

Of course it's not possible to say exactly what these advertisements, images, and stories of celebrity misadventures might have been adding up to in the minds of average adolescent girls in Hong Kong. It didn't take much reading between the lines, however, to perceive a high degree of confusion and ambivalence surrounding the issues of female body image, sexuality, youth, beauty, and aging. Young women in some contexts were worshipped for their attractiveness, while in other situations they were humiliated and publicly vilified with a vitriol that would be hard to overstate. Whatever understanding Hong Kong teenage girls were piecing together about the postadolescent world from these sources, it is safe to say that it was not unconflicted.

Given this environment, it would make sense to most Americans and Europeans that occurrences of anorexia and bulimia have spiked here in the past fifteen years. Nor would it likely be a surprise that Gillian Chung, one of those young celebrities in the sex scandal, had herself battled bulimia. Most well-educated Westerners understand that anorexia is sparked by cultural cues, but they often have a fairly narrow conception of what those cues might be. Most assume that anorexia, with its attendant fear of fatness and body dysmorphic disorder, is born of a peculiar modern fixation with a slender, female body type, and that popular culture transmits this fetish to young women. As we've exported our obsessions with slender models—our Barbie dolls and our Kate Moss fashions—it makes sense to us that eating disorders have followed in their wake.

But although this commonsense cause and effect might be part of the story, Sing Lee's research shows that there have been other, more subtle, cross-cultural forces at work here. The full story of how

anorexia spread from the American suburbs to Hong Kong is more complex and, in many ways, more troubling. It turns out that the West may indeed be culpable for the rise in eating disorders in Asia, but not for the obvious reasons.

After making my way across Shatin, I found Lee's small suite of offices among the labyrinth of midrise buildings that make up the Prince of Wales Hospital. Introduced by his assistant, Dr. Lee was younger than I expected. At 49 years old, he's had a remarkable output as a scholar despite the fact that he has split his time between seeing patients at the public hospital, teaching, and running a mood disorders center. He admits that at times he has been accused of being a workaholic. "I do work long hours, but I've never experienced much work stress," he said to me in what I would come to know as his characteristic humble manner. "I've wanted to be a psychiatrist since high school and I still love the work of meeting patients and writing about ideas." Given the amount of time he spends in his office, he's allowed himself to build a comfortable environment. The place has the feel of a stylish bachelor pad. The bucket seat and gearshift of a sports car sat on the floor next to the couch. Directly across from his desk was one of his prized possessions: an antique vacuum tube stereo connected to two imposingly large speakers. The tuner was made in the early 1960s and at the time cost as much as a VW Beetle and requires vacuum tubes the size of small lightbulbs to operate. For a true classical music audiophile such as Lee, however, there is no substitute for the resonant tones it produces.

Even after two decades of charting the cultural currents that have brought the American version of anorexia to these shores, Lee remains passionately interested in talking about the puzzle. He was the first scholar to document anorexia in Chinese women. The remarkable thing he found was that before the illness was well known in the province, Chinese anorexia was unlike that found in

the West. These atypical anorexics, as he calls them, displayed a different cluster of symptoms than their Western counterparts. Most, for instance, did not display the classic fear of fatness common among Western anorexics, nor did they misperceive the frail state of their body by believing they were overweight. It was while he was trying to puzzle out these differences that he witnessed something remarkable.

Over a short period of time the presentation of anorexia in Hong Kong changed. The symptom cluster that was unique to his Hong Kong patients began to disappear. What was once a rare disorder was replaced by an American version of the disease that became much more widespread. Understanding the forces behind that change may not only explain why anorexia became common in Hong Kong, but it may also lead us to reconsider the momentum behind the disease in the West.

The Death of a Patient

When Sing Lee came back to Hong Kong from his training in England in the mid-1980s, he took a job at the Prince of Wales Hospital and began looking for Chinese anorexics. Having been introduced to the disorder while in England he was, like many young psychiatrists, fascinated by the fundamental conundrum of the disease: Why would healthy young women with plenty of resources starve themselves?

At the time Lee began his search, the long-held belief that eating disorders were confined to American and Western European populations was just beginning to show cracks. Even though prominent eating disorder researchers were making the argument as late as 1985 that anorexia didn't exist outside of the United States, cases were beginning to show up in Russia and Eastern Europe. Although

it was still believed to be rare in Latin American countries, researchers and clinicians also began discovering young women with anorexia in Japan and South Korea.

In China and Hong Kong the disorder remained all but unknown. Searching the two major psychiatric journals published in China, Lee found not a single paper documenting a Chinese woman with anorexia. With little to go on, he got to work searching the databases at the Prince of Wales Hospital. After an exhaustive search, he managed to identify just ten possible cases in the five years from 1983 to 1988. Given the thousands of patients seen at the hospital, he determined that anorexia was an exceedingly rare disorder in Hong Kong. His first paper on the topic, published in 1989 in the *British Journal of Psychiatry,* was titled "Anorexia Nervosa in Hong Kong: Why Not More in Chinese?"

The low rate of anorexia was a mystery that Lee wanted to figure out. Perhaps Chinese cultural beliefs or practices contained protective mechanisms. He knew, for instance, that historically there was little Chinese stigma surrounding larger body shapes. In fact popular Chinese sayings suggested that "being able to eat is to have luck," "gaining weight means good fortune," and "fat people have more luck." He also considered that the later onset of puberty in Chinese girls compared to girls in the West might be a preventive factor. The physical changes that come with puberty might be less psychologically stressful when experienced with an added year or two of emotional maturity.

But even taking these differences into account, Lee couldn't quite understand why the behavior was so uncommon among local adolescents. In many ways Hong Kong seemed primed for the disorder. It was a modern region that, thanks to years of British rule, had incorporated many Western values as well as styles of dress and eating. There were fast-food restaurants and health clubs. Thin Western and Chinese celebrities were idolized. It was a patriarchal

culture, in which parents and teachers put intense pressure on students to compete. The Chinese obsession with food and the layered meanings of sharing meals within a family should have made food refusal a dangerously attractive behavior for an adolescent looking to send a distress signal to those around her.

All the triggers for anorexia that had been identified in Western literature seemed to be present in full force, and yet eating disorders remained rare. Lee suspected that there was something else, some factor that hadn't been fully considered in the Western literature, that remained absent in Hong Kong. What that factor might be he could only guess.

Treating the few cases he could find, Lee discovered another puzzle. He noticed that the women who starved themselves in Hong Kong were different from the anorexics he had studied while training in England. The variations were sometimes so pronounced he wondered if he was seeing the same disease. To illustrate those differences, Lee recounted to me the story of one of the first patients he personally treated, a 31-year-old saleswoman I'll call Jiao.

Lee still clearly remembers the first time he met Jiao in a hospital examination room in 1988. Although he knew from his research how thin anorexic patients could become, he couldn't help but be taken aback at the sight of her. "She was shockingly emaciated—virtually a skeleton," he recalls. "She had sunken eyes, hollow cheeks and pale, cold skin." She was alert but uncommunicative. At 5 feet 3 inches, her ideal body weight should have been in the neighborhood of 110 pounds. Indeed, she had been that weight four years earlier, before she began to waste away. By the time she sought medical treatment she weighed just 48 pounds.

During his physical exam of Jiao, Lee noted that she had dry skin and a subnormal body temperature. More concerning, her blood pressure was low and her heartbeat was a plodding 60 beats per minute. He took X-rays after giving her a drink laced with barium

so he could examine her esophagus. He also used an endoscope to examine her upper gastrointestinal system for blockages or lesions. Convinced the disorder wasn't organic in origin, he began to piece together her personal history.

Jiao was the youngest child of three living children (two of her brothers died soon after birth). She had grown up in a working-class family in a rural village near Hong Kong, where she still lived. Like many in the Hong Kong area, her family was both emotionally enmeshed and yet physically disjointed. To earn a living, her father had lived apart from the family for many years at a time, but when he was present, he demanded the absolute loyalty he felt was his traditional due as head of the household. During his visits home he often berated Jiao and her mother for small infractions, such as interrupting him when he spoke, and he freely expressed his disappointment that Jiao had not performed better in school. Her mother was a traditional housewife who was subservient to her husband and was socially isolated because she spoke only a Chinese dialect called Hakka. Although it was not a happy home, there was no history of mental illness, sexual or physical abuse, or eating disorders.

Jiao's struggles with eating had begun in earnest four years earlier, in 1984, when her boyfriend deserted her by emigrating to England. She was devastated by his departure and began to refuse food and skip meals. Explaining her change in eating patterns to her family, she complained of pain and discomfort in her abdomen. During this time she became increasingly socially withdrawn and lost her job. Over those first years of the illness she saw various doctors. She was encouraged by health professionals as well as her family to eat more. Nevertheless she steadily lost weight year after year.

While relating her personal history to Lee during that first interview, Jiao cried at times but for the most part just looked sad and tired.

"What do you think is your main problem?" Lee finally asked her.

"Abdominal fullness and thinness," she replied.

"What else?"

"A bad mood, it's hard to describe. . . . It is no use talking about it anymore," she said and began to weep.

"Is there a name for your condition?" Lee asked her.

"I don't know," she said. "Can you tell me what kind of disease it is?"

Lee had her draw a picture of herself. This technique is often used to assess whether anorexic patients have a distorted perception of their emaciated condition. The stick figure sketch she handed back to Lee, however, closely matched her skeletal condition.

Jiao's presentation left Lee in a quandary. On the one hand, she was clearly starving herself to the point of death. On the other hand, she didn't fit many of the American diagnostic criteria for anorexia. The *Diagnostic and Statistical Manual of Mental Disorders,* published by the American Psychiatric Association—the third edition released in the late 1980s had quickly become the worldwide standard—stated that someone suffering from anorexia not only rigidly maintains an abnormally low body weight but expresses an "intense fear of becoming obese, even when underweight," and has a disturbed self-image, such as claiming to "feel fat when emaciated."

But Jiao did not express a fear of being overweight. In addition, she didn't have any misperception about the emaciated condition of her body. She described herself pretty much exactly as Lee saw her: as a very sick and dangerously thin young woman.

When he gave her the standard eating disorder questionnaire of the time, it also showed clear differences from what one would expect of an anorexic in the West. For instance, Jiao insisted that she never consciously restricted the amount of food she ate. West-

ern anorexics, he knew, usually admitted to obsessing over food portions and quantities. When asked why she often went for whole days without eating, Jiao would say only that she felt no hunger and, pointing to the left side of her abdomen, describe how her stomach often felt distended.

These deviations from the Western diagnosis weren't unique to Jiao. Most of the Hong Kong anorexics Lee was able to interview or treat around this time similarly denied any fear of being fat or of intending to lose weight to become more attractive. They often spoke of their desire to get back to a normal body weight. When explaining their refusal to eat, they most often ascribed the behavior to physical causes such as bloating, blockages in their throat or digestion, or the feeling of fullness in their stomach and abdomen. Their often repeated claim that they had no appetite also ran counter to conceptions of the disease put forward by Western experts. Psychiatrist Hilde Bruch, who wrote one of the seminal books on anorexia, *The Golden Cage,* asserted that "patients with anorexia nervosa do not suffer from loss of appetite; on the contrary, they are frantically preoccupied with food and eating. In this sense they resemble other starving people."

As a group, these Hong Kong anorexics were different from their American counterparts in other ways as well. These were not the "golden girls" described in Western literature on eating disorders. Anorexia in the West was known to afflict well-to-do, popular, and promising young women who were sometimes perfectionists in other parts of their lives, such as school or sports. But Lee's patients were often from poor families and among the lower achievers in their schools. They also did not give any hint of the moral superiority sometimes observed in Western anorexics.

Most curiously, they were often from outlying villages, not a population that Lee suspected would be most influenced by the globalization of Western pop culture. They had not begun their

self-starvation after reading diet books or engaging in the exercise fads of the day. His atypical anorexics were not among the young women in Hong Kong adopting *Flashdance* fashions or going to Jazzercise classes. If Western pop cultural influences were at the heart of this disorder, there were certainly populations in Hong Kong who should have been harder hit. Hong Kong was, and remains, the most international of cities, and there were plenty of groups of adolescents and young women fully engaging in Western fashion and pop culture. But Lee's patients did not come from these jet-setting subcultures.

While Lee had great respect for the clinical knowledge he had gained during his training in the West, he knew it posed a challenge as well. With the *DSM* becoming the world's diagnostic manual for mental illness, it was easy to gloss over different disease presentations to make them fit the Western standard. But Lee was convinced that the distinctions between the American presentation of anorexia and what he was witnessing in Hong Kong was a meaningful difference that could lead to new insights into the disorder. He knew that if he was going to understand what was happening with his Hong Kong patients, he was going to have to get to the bottom of those differences.

Yin, Yang, and Qi

Despite Lee's uncertainty about the diagnosis of anorexia, Jiao was clearly in need of immediate attention. With Lee's encouragement she checked into the hospital, but she proved to be a difficult patient. She used a shifting series of excuses to refuse the food offered by the dietitian. Lee speculated that her resistance to his ministrations might be bound up in the culture clash between Western and Chinese medicine. Hoping to hit a resonant cultural

3

The Shifting Mask of Schizophrenia in Zanzibar

> What we say about mental illness reveals what we value and what we fear.
>
> JULI MCGRUDER

On my first night in Zanzibar I was awakened by the distant sound of a telephone ringing. I came to consciousness fitfully, puzzling out where I was. I was bone-tired from two days of red-eye plane travel and a rough ferry crossing to the island from mainland Tanzania, disoriented by the ten-hour time change and, possibly, by the side effects of the prophylactic malaria medication I had begun taking a few days before. I checked the bedside clock: 3 a.m. I could hear my hosts, Juli McGruder and her partner, Ahmed Kassim, in the upstairs room of the house as one of them answered the phone. As in most houses in Zanzibar, there was no glass in the windows—better to let the steady trade winds sweep out the stuffy air during the night—and I could hear their voices talking low and intently in Kiswahili. I stood at the window, listening and looking out into the night. It was a full moon and there was a racket of premorning birdsong coming from the thick, low brush beyond the cinderblock wall that surrounded the house. After a few

minutes Kassim came downstairs, walked across the sandy driveway, and drove off in his rattletrap Toyota van. I got back in bed, retucked the mosquito netting, and lay awake wondering what might have occasioned the call. I was new to the local customs, but I suspected that Americans and Zanzibaris shared at least this cultural truism: no good news comes in a phone call at 3 a.m.

I had come to Zanzibar, a sixty-mile long coral island off the Swahili coast of East Africa, to spend some time with McGruder. She had recently retired from her teaching position at the University of Puget Sound in Washington and had opened a guesthouse at the very northern tip of the island with Kassim, a younger local man who was both her romantic and her business partner. She had been a professor of occupational therapy, and late in her career she had received a PhD in anthropology from the University of Washington. Her field research focused on three families struggling with schizophrenia in Zanzibar, where she went to figure out a puzzle that has baffled cross-cultural researchers in mental illness for twenty years: Why did people diagnosed with schizophrenia in developing nations have a better prognosis over time than those living in the most industrialized countries in the world?

In the morning I met McGruder in the kitchen, where she was brewing a pot of strong cowboy coffee, boiling the grounds directly in a pot of water. "I need the real thing this morning," she said by way of greeting. "Instant is not going to do it." She told me the news before I could ask. The early morning phone call had been for Kassim. His 10-year-old daughter, Latifa, a child from an early marriage, had died suddenly in the night. The family had known that the girl had an enlarged heart, but she had recently been healthy and happy. Just that day she had been to Koran school, played with her friends, and eaten well. But that night she woke up vomiting blood. The family had rushed her to the hospital, where she died shortly after being admitted. Kassim had gone south to

assist with the burial, which, according to Muslim custom, would happen that day.

After a moment I asked how Kassim was holding up. McGruder shrugged as she stirred the coffee. "It's hard to say," she said. "Swahili men tend not to show a lot of emotion when things like this happen."

When I saw Kassim late the next day, I shook his hand and told him how sorry I was to hear about his daughter. He smiled weakly and said only, "That is life." Later at dinner he told McGruder and me how the women cried during the day. He described how the crying would reach a crescendo and then die down, only to be started again when a new woman showed up and saw the body.

Kassim's own demeanor remained a mystery to me. At first I assumed that he was just in shock and would be overcome with emotion when he had time to reflect on the event. It would be unfortunate, I also found myself thinking, if some notion of local machismo made him push his true feelings aside. He would certainly pay a steep psychological price for such repressing of his feelings.

Although I had traveled here with the intention of learning about the different ways people in Swahili culture express emotion in the face of mental illness and other difficult life challenges, I couldn't let go of my assumption that the healthy reaction to the loss of a child would be abject displays of grief. I believed the natural—the truly human—reaction to such an event was the way I imagined I would have reacted if the 3 a.m. phone call had carried tragic news about my own daughter back in San Francisco. I was as unable to understand what Kassim was feeling from his outward affect as I was to understand the meaning of his words when he spoke Kiswahili; he was expressing himself in an emotional language that I did not comprehend.

Even anthropologists, who diligently train themselves to be non-

judgmental observers of cultural differences, have trouble when it comes to recognizing and allowing for cultural differences in emotions. Because our emotions come into our consciousness unbidden and often surprise us with their intensity, we often assume that they are not influenced by cultural cues or social scripts. But with careful study, anthropologists have learned that emotions are not like muscle reflexes; rather, they are communications with deep and sometimes obscure meanings. Cultures differ not only in their response to specific events (as we've seen with reactions to trauma) but also in more global ways.

Describing and understanding these differences has in fact been central to McGruder's research on Zanzibari families who struggle with schizophrenia. During her research she began to suspect that the emotional tenor of families dealing with mental illness in Zanzibar was qualitatively different from that of families in the industrialized world. Subtle differences in this emotional temperature of households, she theorized, might go a long way to explaining why a schizophrenic patient in Zanzibar will often do better than someone diagnosed with the disease in the United States.

From the Clouds to the Equatorial Sun

McGruder is of a type common among the faculty of West Coast colleges. Her politics are liberal and she is prone to antiestablishment and contrarian thinking. She is short with spiked blond hair and a friendly but no-nonsense demeanor. As a child she was smart and rebellious, a difficult combination for a Catholic schoolgirl growing up in northern Indiana in the 1950s. When she was a teenager she dated African American men despite her parents' strenuous objections. One of her first encounters with the mental health profession was when her parents forced her to see

a psychologist to cure her of her "pathological" romantic behavior. At one point she was even threatened with incarceration in a mental hospital.

Despite her parents' efforts, she got married at age 18 to an African American man. This was just one year after the Supreme Court's 1967 ruling *Loving v. Virginia*, which effectively ended race-based restrictions on marriage in the United States. McGruder's first job after college was in the mid-1970s at the Hudson River Psychiatric Center in Poughkeepsie, where she witnessed what passed for mental health treatment at the time. As she remembers, the doctors relied heavily on sedating antipsychotics such as Thorazine, Stelazine, and Haldol and some early tricyclic antidepressants. She couldn't help but notice the way some of the drugs knocked the patients for a loop. "These drugs worked like big hammers," she told me. "They just snowed people. They would make the patients shake and drool and feel miserable."

After that she went back to school for a degree in science education and became a teacher, eventually finding a post teaching occupational therapy at the University of Puget Sound. On the side she worked as a private therapist and guardian with elderly and institutionalized schizophrenic clients. After a decade of teaching and making her way up the university's academic ladder, she got bored with the routine and found herself reading feminist philosophical tracts on science and gender. With a sabbatical coming up, she sent out dozens of letters to international aid agencies offering her services. For months she heard nothing. Then came a lone reply from a Danish international development organization that had an office in Dar es Salaam, Tanzania. They offered her a year-long post at the Kidongo Chekundu Mental Hospital on the island of Zanzibar with a salary of forty-two dollars a month. She jumped at the chance and immersed herself in learning Kiswahili. Once she got to Zanzibar, she helped establish an occupational center at the

hospital where patients could learn carpentry skills and practice art therapy.

The Western-trained doctors she met at the hospital in Zanzibar had access to the basic arsenal of Western antipsychotic drugs. However, the idea that diseases such as schizophrenia spring from chemical imbalances or brain abnormalities had not yet been accepted by most of the population of Zanzibar. Much more salient were beliefs in spirit possession and the permeability of the human consciousness by magical forces.

McGruder became fascinated by the ways these beliefs in spirits shaped the experience of mental illness both for the families and the patients themselves. She was also interested in how these local ideas were beginning to intermingle and sometimes compete with the imported Western idea that mental illnesses were caused by biological brain malfunctions. At the end of her sabbatical, she decided to pursue a doctoral degree in anthropology so she could dive further into these questions. After finishing her course work in anthropology at the University of Washington, she couldn't wait to escape the dreary Pacific Northwest and get back to the island.

Zanzibar lies at the midpoint of the Swahili Coast, a 1,800-mile stretch of coastline straddling the Equator from Kenya to Mozambique. For millennia it was to this coastline that all of Central Africa brought its goods in order to trade them with the world. The predictable monsoon trade winds were key to its culture. From November to March those winds blew steadily down the coast, bringing merchants and traders from India and the Persian Gulf. From July to September they shifted northward, sending the traders home. On the northbound winds small lateen-sailed boats called dhows traveled up the coast with sturdy mangrove wood, aromatic tree resins, gold, ivory, clove, and the fine, multipurpose fibers of the raffia palm. On the southbound winds they brought

back manufactured goods from Arabia, India, and China in the form of carpets, incense, glassware, and cloth. The months between the shifts in the trade winds gave merchants from the Middle East time to sell their goods and buy their new cargo. It also gave them time to share their ideas and religious beliefs and to infuse Swahili with Arabic words. The months in foreign harbors also allowed for merchants and sailors to take wives and otherwise leave their genetic mark on the population.

The resulting cultural texture of Zanzibar was endlessly interesting to McGruder. She enjoyed the smell and the sound of the place, the way the echoing calls to prayer broke up the day, and the constant commotion of children at play. She even liked the way the names of things felt on her tongue. The place-names Kisimkazi, Manzi Moja, and Kakunduchi felt good to say. She particularly liked saying the name of the local public transport along one of the main roads: the *Bububu daladala.*

Not that life there was a tropical paradise. Although her memory of that first year has sweetened, her field notes attest to the frustrations of living in a developing country. There were outbreaks of cholera, and the dust whipped up by the constant trade winds during the dry season often contained enough bacteria to cause epidemics of conjunctivitis. Raw sewage sometimes fouled the white beaches and the baby-blueness of the ocean. Fishermen had recently taken to using sticks of dynamite to fish the reefs, and the joy of speaking the words *Bububu daladala* was offset by the sheer terror she felt while actually riding these speeding minibuses.

In the end, however, her desire to return and study mental illness in Zanzibar came not simply out of an abstract pursuit of knowledge or the social good that might come of her findings, but because she felt a deep affinity for the people and the place.

Incidental Content versus Essential Form

McGruder was well aware that the cutting-edge research on schizophrenia was not coming out of the field of anthropology. More than any other mental illness in the Western world, this one belonged to the "hard scientists" who looked for the causes in bad genes, biochemistry, and the structure of the brain. The advent of brain scans—allowing a researcher to see into the head of live patients—brought with it a seemingly endless series of theories about the root cause of the illness. Abnormalities supposedly key to schizophrenia have been reported in the frontal cortex, the prefrontal cortex, the basal ganglia, the hippocampus, the thalamus, the cerebellum—and pretty much every other corner of the brain as well. No firm consensus had emerged about the location or cause, but there was wide agreement that the exciting advances in understanding the disease were coming from the laboratories of brain researchers.

Although far from the limelight, there were scholars and researchers looking at the disease from other perspectives as well. McGruder found perplexing data and fascinating theories in cross-cultural studies of the disease. Although something approximating schizophrenia could be found in populations at every corner of the globe, there were enough variations to suggest that the disease was shaped by something besides the purely genetic or biological.

The most obvious differences between cultures were in the delusions and hallucinations experienced by those with schizophrenia. These harrowing visions and disembodied voices were often distorted reflections of the phobias and fascinations of specific cultures. No one, after all, endures the psychotic delusion that the CIA is beaming microwave signals into his or her fillings unless that person is culturally acquainted with the CIA, modern dentistry, and

the disquieting idea that our bodies are constantly permeated by unseen electromagnetic waves.

Those who have studied these differences have noted, among other things, that delusional guilt is most often associated with Judeo-Christian cultures, as are religious hallucinations such as hearing the voice of God. Such hallucinations are rarer in Islamic, Hindu, and Buddhist populations. Schizophrenic patients from Pakistan are more likely to have visual hallucinations of ghosts and spirits than are British schizophrenics, who are more prone to hearing persecuting voices. In traditional Southeast Asian villages, where it is often frowned upon to strive willfully for personal status, delusions of grandeur are rare. In the United States, where celebrity, wealth, and power are popular fetishes, people with schizophrenia commonly believe that they are famous or all-powerful.

It is also clear that delusional content in any particular culture can change over time. In Austria, to take one example, cases of delusions of grandeur, hearing the voice of God, and feeling persecuted have been steadily increasing over the past fifty years, while delusional guilt and psychotic hypochondria are on the decline.

Researchers who focused on the biomedical or genetic linchpins of the disorder often dismissed these differences. The fact that the "delusions of schizophrenics in industrialized societies will concern television sets and x-rays rather than ghosts and spirits . . . [is] often considered to be of secondary importance," writes Rutgers professor of psychology Louis Sass. "They are presumed to have little to do with the illness's genesis or essential form."

Does it really matter that a person with schizophrenia in one culture talks with a dead relative, while someone in another culture believes he is receiving communications from an extraterrestrial? The distinction that often gets made in this debate is between *pathoplastic* aspects of the disease, which vary from person to person, and the *pathogenic* cause, which is assumed to be the root cause of the

disorder. Pathoplastic symptoms are often dismissed for describing only the coloring and content of an illness but not its fundamental nature. The true prize—the quest of the brain researchers—was to get past the cultural noise and discover the pathogenic factors that are the universal cause of the illness. They wanted to weed out the "incidental content" and get to the "essential form."

But McGruder kept coming across research suggesting that culture and social setting play a more complicated role in the disease than simply influencing the content of the delusions. Studies showed, for instance, that prevalence rates vary from place to place. Those living in urban settings in the United States and Europe appear to suffer more often from the disease than those living in the country or the suburbs. These curious spikes in the disorder remain even when researchers took migration, drug use, and poverty out of the equation. Men living in the most densely populated areas of Sweden, for instance, are at a 68 percent higher risk of being admitted for psychosis—often the first sign of schizophrenia—than those who live in the countryside. For women the risk is 77 percent higher. Something about city living seems to spark the harrowing delusions, hallucinations, and disorganized thinking characteristic of a schizophrenic break. Stranger still, some neighborhoods in cities produce more schizophrenics, to such a degree that scientists have wondered about the environmental pathogens that might exist in one place and not another.

The more McGruder read of the cross-cultural research on the disorder, the more it appeared to shape-shift from place to place, and no one seemed to have a clear explanation for this. Janis Hunter Jenkins and Robert John Barrett, two of the premier researchers in the field, describe the general state of affairs.

> In sum, what we know about culture and schizophrenia is . . . [that] culture is critical in nearly every aspect of schizophrenic illness experience: the identification, definition and meaning of the illness during the primordial, acute, and residual phases; the timing and type of onset; symptom formation in terms of content, form, and constellation; clinical diagnosis; gender and ethnic differences; the personal experience of schizophrenic illness; social response, support, and stigma; and perhaps most important, the course and outcome with respect to symptomatology, work, and social functioning.

By "course and outcome," Jenkins and Barrett are referring to that most perplexing finding in the epidemiology on the disease: people with schizophrenia in developing countries appear to do better over time than those living in industrialized nations.

McGruder read with fascination the startling results of two huge international studies carried out by the World Health Organization over the course of twenty-five years starting in the late 1960s. These two studies, which had follow-up periods of two and five years, took place in a dozen sites around the world, taking into account ten countries and following more than a thousand patients from both rural and urban settings. What they found was that those diagnosed with schizophrenia living in India, Nigeria, and Columbia often experienced a less severe form of the disease (had longer periods of remission and higher levels of social functioning) than those living in the United States, Denmark, or Taiwan. Whereas over 40 percent of schizophrenics in industrialized nations were judged over time to be "severely impaired," only 24 percent of patients in the poorer countries ended up similarly disabled.

That result, which is perhaps the most famous finding in the field of cross-cultural psychiatry, was widely discussed and debated in part because of its obvious irony: the regions of the world with the most resources to devote to the illness—the best technology,