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Pharmaceutical imperialism and the global trade in psychotherapeutics

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The pain in our shoulder comes
You say, from the damp; and this is also the reason
For the stain on the wall of our flat.
So tell us:
Where does the damp come from?

— Bertolt Brecht, *A Worker's Speech to a Doctor* (1938)

In 1965, a young woman from a drought-wracked village in northeast Brazil was indicted on two counts of murder: she had smothered her infant son and hacked her one year-old daughter to pieces with a machete. Incarcerated in the city of Bom Jesus da Mata in a cell with a single street-facing window, the woman became, for a brief time, something of a sideshow attraction for passersby who delighted in assailing her with invective. When queried about her motives one afternoon by anthropologist Nancy Scheper-Hughes, the woman could say only that it was "to stop them [her children] from crying for milk." Scheper-Hughes later recounted the conversation to a Brazilian friend, who shook her head sadly and attributed the double homicide to *delírio de fome*—hunger-madness—a psychopathological condition that arose from prolonged starvation. *Delírio de fome*, Scheper-Hughes soon discovered, was rife throughout the region. Hunger, no longer understood as a result of nutritional deprivation, had been normalized to such an extent that local medical authorities would acknowledge only its final, maddening stages as a cause for concern. Manageable with the aid of tranquilizers, painkillers, and sleeping pills imported from the United States, Germany, and Switzerland, *delírio de fome* would become, in the ensuing years, a national codeword for mental instability rather than a symptom of socioeconomic inequality.

Around the world, images of health and happiness are increasingly correlated with access to pharmaceuticals. In 2003, global pharmaceutical spending approached half a trillion dollars, and the top ten drug companies savoured a profit of 14.3 percent of their annual sales (as against a 4.6 percent median for other industries). While infectious diseases such as HIV/AIDS that disproportionately afflict impoverished societies remain undertreated, global markets for psychotherapeutic drugs have rapidly ballooned: international sales of antidepressants rose by 5 percent in 2002, while sales of antipsychotics grew a breathtaking 19 percent. Over the past decade, moreover, worldwide antidepressant sales have risen dramatically among low-income groups, who have been relentlessly urged by a multibillion-dollar public relations industry to conceptualize mental health as a purchasable commodity and, thus, a problem of consumer choice.

Behind these figures lies a tangle of uneasy questions concerning the traditional flow of resources and labour from the South to the North, and the role of corporate science in propagandizing captive populations. While the myth of universalism in biological psychiatry—which insists that the feelings of stress, anxiety, depression, vulnerability, resentment, and fatigue that suffuse neoliberalized societies are best understood as congenital defects—has been a boon to multinational pharmaceutical firms and private insurance companies the world over, blinkered conceptions of psychic suffering acquire especially ironic undertones in regions subject to the depredations of the IMF and World Bank. What does it say about the global culture of capitalism—not to mention the Hippocratic ethos of Western biomedicine—when doctors in rural Brazil can only send hungry sugarcane-cutters home with bottles of anxiolytics and anticonvulsants to subdue the quivering of their malnourished limbs? Or when dilapidated Argentinean hospitals have to begin arbitrarily assigning diagnoses of bipolar disorder to patients in exchange for direly needed grants from foreign biotechnology companies?

In August 2001, as Argentina entered its fourth year of recession, a public education campaign sponsored by a domestic manufacturer of the antianxiety agent Tranquinil (alprazolam, available as Xanax in the United States) was launched in Buenos Aires. "Anxiety Disorders Week," it was called. Newspaper pages were peppered with prominent advertisements grimly advising readers that one in every four Argentines suffers from phobias marked by feelings of insecurity about the future. The campaign, as the University of California's Andrew Lakoff details in his recent book *Pharmaceutical Reason: Knowledge and Value in Global Psychiatry*, was successful beyond its sponsors' wildest dreams: hospitals were deluged with patients complaining of panic attacks and symptoms of stress. Anxiolytic prescriptions predictably spiked, marking the tail end of a period of hyper-recession wherein national unemployment rates grew to 20 percent and net income from antidepressant sales leapt 16.5 percent within just twelve months.

This episode throws into sharp relief the relations of institutionalized collusion between multinational drug firms, public health officials, and third-party insurance providers that typify the global trade in psychotherapeutics. As Lakoff points out, "the model of rational consumer choice assumed by the strategy of deregulation is clearly an inappropriate one for the pharmaceutical market, which is inherently 'imperfect': the one who chooses the drug is not the one who consumes it, and the one who consumes is not (or often is not) the one who pays for it." Within the first five years of the IMF's ravaging of the Argentinean economy in the early 1990s, total pharmaceutical revenues rose an awesome 70 percent: the privatization of healthcare and deregulation of drug prices meant that stressed and suicidal Argentines without private insurance were denied therapeutic alternatives to increasingly expensive antidepressants and antianxiety agents. At the same time, spooked by the proliferation of unlicensed copies of their patented compounds, multinationals like GlaxoSmithKline and Pfizer ramped up their efforts to encourage Argentinean psychiatrists to prescribe Paxil and Zoloft by sending them on free trips to prestigious North American and European scientific congresses (otherwise unaffordable for most researchers in the global South) and supplying them with free samples of brand-name product (cherished commodities in underfunded state hospitals).

At the height of the Argentinean debt crisis, the French biotechnology company Genset initiated a collaboration with an underfunded Buenos Aires hospital: medical residents would gather blood samples from patients diagnosed with bipolar disorder (*DSM-IV-TR* 296.0-296.4) and dispatch them on ice to France, and, in exchange, the hospital would receive $100,000. Hoping to identify and patent the genes linked to bipolar disorder on a shoestring budget, Genset had decided to outsource the untidy business of blood collection to Argentina due to the country's relaxed regulations on genetic research and intellectual property. The Argentinean clinicians' own participation in the scheme was no less cynical, however. Most were quite candid in their discussions with Lakoff that they saw the vaunted *Diagnostic and Statistical Manual of Mental Disorders* as little more than "a catalogue for marketing pharmaceuticals." And, although they diligently made the required diagnoses in order to procure the coveted blood samples, they acknowledged they did so chiefly to clinch the $100,000 lifeline, and to thereby secure enough cash to maintain the hospital's existing stock of psychotherapeutics.

The pattern delineated above is not unique to Argentina. When social supports are dismantled, drugs must take up the slack; the bureaucratic imperative to stay within budget and maintain high patient turnover rates is a prime mover of psychotropic over-prescription all around the world. For doctors in desperately understaffed public clinics throughout the global South, the temptation to prescribe new, increasingly potent chemicals to stem the spreading mass misery can be almost irresistible in the absence of easy alternatives. Indeed, when Scheper-Hughes returned to northeast Brazil in the 1990s, she discovered that the long-acting antipsychotic injection Prolixin (fluphenazine) had become the latest tonic for famished labourers, who continued to blame dizziness and shortness of breath on their own bodies and brains. In India, where over a decade of structural adjustment has led to both the widespread collapse of agricultural markets and soaring suicide rates, antidepressant sales are so reliable that marketing managers for best-selling brands no longer bother to advertise them: a 2005 study sponsored by the World Health Organization (WHO) found that generic Prozac (fluoxetine) is sold in 77 percent of Indian medicine shops, making it more widely available throughout the country than the household painkiller ibuprofen; it even comes in a liquid form for easier absorption. In Mexico, where widespread privatization in the early 1990s shrivelled wages and lengthened the average workday, imports of methylphenidate increased from 0 to 4.7 million S-DDD ("defined daily doses for statistical purposes") between 1990 and 2002. Notorious in North America as the psychostimulant

Ritalin, methylphenidate is better-known to many Mexican workers as a treatment for daytime drowsiness and lethargy.

As the IMF and World Bank traipse across the globe, denuding people of their livelihoods and dignity, it is child's play for pharmaceutical representatives to flit into impoverished clinics with their neurochemical palliatives, churning public trauma into private profit under the guise of humanitarian concern. It is difficult to overestimate the profits to be made from the globalization of *DSM* psychopharmacology. Since 1994, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS, administered through the WTO) has afforded worldwide patent protection to multinational pharmaceutical firms: TRIPS illegalised the reverse-engineering of patented molecules, thus depriving small biotechnology companies of a vital source of revenue and effectively allowing multinational heavyweights a monopoly over burgeoning Southern markets. For firms like Eli Lilly and Pfizer, the prospect of accessing a vast, relatively untapped pool of anxious and immiserated consumers in developing countries has been nothing less than a coup, enabling the rapid recovery of profits lost following a long-anticipated wave of patent expirations around the turn of the millennium.

In its 2001 World Health Report, the WHO announced that psychiatric disorders—led by depression, alcoholism, and self-injurious rituals—had come to account for fully 12.3 percent of the global "disease burden," a measure of the social impact of illness based on projected mortality and morbidity rates, losses in financial productivity, and other factors linked to premature death. Of the total number of years lived with disability, mental disorders accounted for fully 31 percent, with depression as the leading cause. Yet, as University of Edinburgh researchers Stefan Ecks and Soumita Basu point out in a recent *Transcultural Psychiatry* paper, "it seems odd that rates of depression should have multiplied by a factor of 1,000 since antidepressants were marketed." It is odder still that billowing rates of psychiatric illness and concomitant increases in worldwide psychotherapeutic sales are more often attributed to the onward, upward march of biomedical science—that is, the "discovery" of more and more instances of undiagnosed maladjustment in developing regions—than to the intensifying structural violence to which most of the world's population is subject. It is, of course, true that pain and anguish are spreading, along with the sundry coping mechanisms toward which the pained and anguished turn. But it is also true that to *pathologize* pain is to evacuate it of political meaning—a move that is serviceable not only to the profiteering of pharmaceutical firms, but to the interests of those who would gleefully take any excuse to dismiss their victims' grievances as irrational.

The question that now confronts us is whether the transnational epidemiology patterns described above bear out the drug industries' argument that their business practices, however venal, are ultimately defensible because they help benighted people recognize their mental suffering as medically remediable. Is it true, in other words, that the increasingly angry, anxious, and anguished multitudes of the global South in fact benefit from the diligent diagnostic and prophylactic efforts of *DSM*-trained psychiatrists and public health authorities?

The answer to this question may be surprising to those of us enculturated into cherished Western chauvinisms identifying mental health as the exclusive privilege of the scientifically enlightened. Anthropological studies regularly reveal that the imposition of psychiatric diagnoses upon people is itself pathogenic, serving to normalize violence while stigmatizing injury, and resulting in the internalization of clinical expectations. That is, when an unemployed Argentinean worker is sent home from the doctor's office with a bottle of anxiolytic capsules, having been told that she has a neurochemical syndrome known as Generalized Anxiety Disorder (*DSM-IV-TR* 300.02), she is likely to begin experiencing *more* panic attacks and is less likely to appreciate the legitimacy of her dread at escalating food prices. Psychiatry is unique among the medical specialties in that its diagnostic classifications intrinsically deny the rationality of the diagnosed, thus encouraging self-contempt; as philosopher of science Ian Hacking has written, such labels, "when known by people or by those around them, and put to work in institutions, change the ways in which individuals experience themselves—and may even lead people to evolve their feelings and behaviour in part because they are so classified."

Kim Hopper, a researcher at the Nathan S. Kline Institute for Psychiatric Research, has additionally revealed that the WHO's studies of severe mental disorders such as schizophrenia, functional psychoses, and major depressive disorders consistently find *better* outcomes for afflicted individuals in developing regions, where family supports are more widely available and employment opportunities are flexible, than in the developed world, where treatment is

more likely to be narrowly pharmaceutical. In a similar vein, as Harvard anthropologist Byron Good notes, "Where such illness is considered inevitably chronic, an essential part of the self that cannot be altered… the illness is more likely to *be* chronic." By contrast, as a prodigious amount of ethnographic literature has shown, mental illness is far less functionally debilitating in societies where it is understood as ephemeral rather than congenital, and invested with philosophical meaning through rich cultural idioms like spirit possession and trance.

Such findings throw into serious doubt the Hippocratic alibis of the drug barons and their proxies. It is not my intent to either romanticize the world's have-nots or impugn the philanthropic impulse of doctors who, forced to make therapeutic decisions in severely constrained circumstances, may have no choice but to salve their patients' psychic wounds with chemical prostheses and make diagnoses that they themselves find suspect. It is, however, incumbent upon us to ask *whose interests are served* when unruly citizenries are chemically pacified, particularly in a global polity marked by such ruthless asymmetries of wealth and health. Like any other industry, the psychopharmaceutical sector is profit-based and cannot be expected to promote views of illness that are unfavourable to their economic interests; indeed, they are obliged to actively discredit such views. Meeting Wall Street growth expectations has become an increasingly daunting task as pharmaceuticals companies' patents on their blockbuster molecules sequentially expire, opening the international market to a flood of generics. In order to keep pace with investors' hopes, the multinationals must either usher three to five new compounds into domestic markets per year, or, as we have seen, compensate for fiscal shortfalls by growing markets abroad. If an unintended outcome of this strategy is the gradual excision of historical depth and geographic breadth from local understandings of oppression, that is just a happy coincidence for ruling elites. ■

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