The Impact of Globalization on the Third World and on People with Psychiatric Disabilities

Globalization is the process of the formation of a global capitalist world system. Globalization is seen primarily as economic, but it is also social, cultural and political. With the spreading of capitalism everywhere with a economy being shared. world market being set up, it follows that technology is shared. There is also a knowledge

Globalization has had both positive and negative consequences for the developing countries. I intend to discuss both consequences, with a special emphasis on how globalization has impacted people with psychiatric disabilities worldwide.

In “Globalization and the Postmodern Turn”, Axtmann is quoted as saying that global citizenship and the effects of globalization might promote acceptance of diversity, heterogeneity and otherness rather than homogeneity and sameness. Others talk about globalization being the hegemony of the western world, thus promoting sameness. As globalization evolves and capitalism develops worldwide, globalization is cited by Kellner as a “replacement for imperialism”. In the days of colonialism, the hegemonic powers would colonize developing countries and use their resources as England did in India. Now it is considered a rewarding political move to go into a country, deplete it of its natural resources, and then move on to new markets. This idea of globalization amounts to the expansion of capitalist markets around the world.

Adam Smith saw the discovery of the Americas by the Europeans as significant. He saw the establishment of a world market system as something that would benefit the entire world. Both Smith and Marx saw globalization as creating similar relations of production of commodities and culture throughout the world.

Globalization has meant the spread of a market economy to developing countries. This has lead to increased poverty for these countries as they try to operate in a world economy. Except for India and China, who refused to follow the dictates of the World Bank and IMF, developing countries allowed their currencies to be devalued. For example, in 1994 in Senegal after the devaluation of the West African Franc, the value of domestic products was immediately cut in half. Consequently, the price of a sack of rice doubled. In order to meet their countries' demands for goods like food, these countries had to borrow money from the West and have been further impoverished by having to sell off their natural resources to pay their debts. In Africa, governments pay northern creditors four times the amount of money they spend on the health and education of their people. This disparity in wealth between the developing and developed nations drastically increased during the twentieth century. In 1820, the gap between the richest and poorest countries was 3:1. By 1992 the gap was 72:1.

There is also a gap in the world's health systems. Eighty percent of the people with disabilities live in the developing countries. These countries also carry 90% of the disease burden of the world, yet they only have access to 10% of the world's health resources. Western ideas of health and society have also negatively impacted developing countries.

For example, the World Bank in its 1993 World Development Report, "Investing in Health" refers to 'disease burdens' and 'the cost effectiveness of different interventions'. They define individuals by lost productivity and not by medical need. This means that those deemed least useful in certain societies, like women, children, the elderly and those with disabilities, will have little or no entitlement to public health services.

Though much disability is congenital or caused by accidents, there is also a sizeable amount of disability caused because people do not have adequate healthcare available to them because the funding policies of the World Bank and IMF have put developing countries into such debt, that in order to repay this debt, they must curtail essential services like healthcare.

Globalization is also directly affecting the support of persons with disabilities as the large extended households that once took care of these individuals are breaking up into smaller western-style family units that no longer have the capacity to support these individuals. In "Globalization Versus Internationalization:Some Implications, Bhagwati states that these negative consequences of globalization are because the IMF is acting as if there is one world economy and the needs of its individual member nations are subsumed under it instead of acting as a league of nations where the well-being of all of the individual nations is taken into consideration. Instead the developing nations are dominated by the hegemonic powers like the U.S. Bhagwati proposes that there should be a redistributive mechanism for compensation to countries that lose to those who gain.

Globalization has also had some positive effects. It has meant that people in developing countries can be treated more for mental illness than previously. Usually in developing countries there is less than one psychiatrist for every 100,000 people. In fact, according to statistics of 2005, Rwanda has only one psychiatrist for the entire country.

A global study published in the Journal of the American Medical Association in 2004 found that 1-5% of the world's population has a mental illness. In poor countries 80% of serious cases of mental illness went untreated. Global figures of mental illness are not thought to be accurate. In the same study, 26% of Americans were judged to have a mental illness, while only 4% of the residents of Shanghai and 5% of the residents of Nigeria were reported to have a mental illness. The difference is thought, at least in part, to reflect the difference of acceptance of and identification of mental illness in the culture. As the knowledge economy spreads, more people in developing countries will be identified as having a mental illness. Now, for example, there is no word in Chinese to differentiate between "sadness" and "depression".

A study of schizophrenia in Colombia, Nigeria, India, Russia, Czechoslovakia, Britain, Ireland and the U.S. in 1998 found that persons with schizophrenia in developing countries responded better to treatment than those in technologically advanced countries probably because of cultural factors like stronger extended families. As previously stated, one of the reasons why the levels of mental illness are reported to be lower in developing countries is because acknowledging mental illness is not as acceptable. For example, the WHO says that the reason the Japanese report a 3% level of depression is because of the

stoicism of the culture. The same can be said for the fact that the U.S. has a 9.6% rate of mood disorders while China's rate is only 2.5%. However, as the culture of mental illness becomes more acceptable in China, that figure should rise.

Globalization brings psychiatric treatment to developing countries. When the tsunami hit Sri Lanka and Indonesia, counselors from many countries went there to help the people. Some psychiatrists, like Sally Satel of the American Heritage Institute, felt that bringing counseling in was an unwelcome intrusion since the governments of those countries did not ask for counseling but for help for the countries' existing supports. However, I attended the World Congress for Mental Health in Cairo the year after the tsunami(2005) and found that the people of Sri Lanka and Indonesia found some Western therapy besides talk therapy helpful. One example was the usefulness of art therapy with children which helped them to express their feelings about the disaster.

The knowledge economy has been increased by American and other psychiatrists going to help with such disorders as post-traumatic stress disorder(PTSD). Like China, Sri Lanka did not have a word for depression. The Sri Lankans were found to have PTSD, though it was not in the form of nightmares and flashbacks that people in the Western world experience. Instead it manifested itself as people losing their place in their group. PTSD was also found in Serbia, Croatia and Bosnia. It was found to exist but took different forms than there were English words for. The Serbian, Bosnian and Croatian mental health professionals received some help from Chilean psychiatrists who had

treated political victims of torture. This demonstrates that even though PTSD is expressed differently in different cultures, it is still a specific psychiatric diagnosis.

Besides the West spreading its technology to developing countries, the Western world can learn a lot about the outcomes of mental illness from the Third World. Psychosis, primarily schizophrenia, is seen in every culture, though the severity of it differs from culture to culture. The course of schizophrenia is more severe in Western societies than in the developing world. Warner (2004) states that a poorer course and prognosis for schizophrenia exists in Western society because of industrialization. He cites many studies that have shown a link between the economy, unemployment and hospitalization for mental illness in the West. He lists some facts that support there being a link between these factors:

a. Rehabilitation of psychiatric patients has been most successful during periods of war and of labor shortage.
b. Discharge and recovery rates were high in the early nineteenth century when there was a labor shortage.
c. Recovery rates declined as there were more unemployed and poor people.
d. Recovery rates from schizophrenia were worse during the Depression because lack of work affected those most vulnerable for schizophrenia.

Another reason for the course of schizophrenia to be worse in the West is cultural. In the West there are higher expectations for the person with psychosis in terms of achievement and ability to take care of themselves. In the Third World, mentally ill persons live as part

of an extended family, so there is always a place for them and something for them to do. This is important because work is important to the development of self-esteem and is therefore crucial to one's mental stability. Whereas someplace is maintained for the mentally ill person in the extended families of developing countries, in industrial societies mentally ill persons are maintained on subsistence allotments and are often segregated from the rest of the population.

In addition, in Western societies, much stigma is still attached to mental illness, alienating the person from society which contributes to their development of symptoms. In the Third World, mentally ill persons generally do not face stigma, at least for those who seek their country's traditional treatment. A minority who seek Western treatment might be stigmatized. Warner (2004) recounts the example of a young Guatemalan Indian woman named Maria who alienated her relatives before becoming fully psychotic. She hallucinated that spirits of dead relatives were trying to take her away to the dead. A shaman said her problem was caused by supernatural forces beyond her control and her family must participate in a healing ceremony to help her. She must also move back to her father's house. She does this and the psychosis clears up in a week. It is notable that she was never stigmatized or blamed for her condition. Besides not being blamed for their illness, in many Third World countries there is a certain status associated with psychosis. Some with psychosis can advance to become shamans. Acquiring status with psychosis does not occur in the western world.

There are numerous reports that psychosis is briefer in the Third World. Some Third World cases of psychosis can be organic because of the prevalence of parasitic, nutritional and infectious diseases. However, a study by the WHO found that the superior outcomes for the psychoses in the Third World are not because organic psychoses have been included. In addition, many studies done in Third World countries show their superior outcome from psychoses. Some examples from Warner (2004) follow:

1. Two Indian studies found that
    a. of people who were ill for less than a year and had a first contact with the hospital, 60% completely recovered and ¾ showed no social impairment.
    b. a group who received no treatment was studied and 30% were found to have recovered within a year.
2. Mauritius

    A study of African and Indian people showed that their incidence rate for schizophrenia was close to that of the British. However, when these people were treated in the hospital without drugs, 64% had a symptom-free, complete recovery and 70% could function independently. This is a higher cure rate than the British had even with medication.

3. Bali

    A comparative study of a five-year outcome for patients with schizophrenia in Bali and Tokyo was done. The psychopathology was similar for the two groups. The Bali hospital stay was ¼ of that of the patients in Tokyo. Readmission rates

were lower in Bali. At the follow-up time, 25% of the patients in Bali were on medication as compared with 85% of the patients in Tokyo.

4. Sichuan, China

   Five hundred and ten people were identified with schizophrenia. Only 6% would accept antipsychotic medication. However, 38% had a partial or full remission and ¾ were able to work.

Besides stigma and unemployment, there have been other reasons attributed to why industrialized countries have higher rates of psychosis than developing countries. Another reason is because there are many stressors in urban life, for example overcrowding creates problems, job insecurity and the pressure to be productive.

Warner (2004) states that just as there are differences between developing and developed countries, there have also historically been differences between people of the rich and poor classes. In developing countries, the upper class has traditionally experienced more schizophrenia than the lower classes. This was because the jobs that the upper class had in developing countries were more affected by changes in the overall economy than the jobs of the poor. However, as these developing countries became more industrialized and their work patterns became more like those of the West, the poor became more negatively affected.

Warner (2004) points out that in the post-industrial West, schizophrenia is more common with the poor, though it has not always been this way. Before the 20th century,

schizophrenia was more common in the upper class of the West because upper class babies were more likely to survive birth traumas because of better care, including those traumas that Warner feels could cause schizophrenia, like head trauma. Babies from poorer classes had a higher death rate when injured. However, he suggests that as innovations like caesarian sections became available – first to the rich – there was less likely a problem of head trauma, the incidence of schizophrenia in the upper class fell. As these innovations spread to the poor and the death rate among poor infants fell the protection and hence the incidence of schizophrenia rose in poor populations. Today, except for in developing countries, the poor have a higher rate of schizophrenia. Warner further postulates that this lower prevalence of psychosis in Third World countries is due to the fact that people suffering from it either recover or die early.

Globalization has also had negative effects on the mental health of people in developing countries. For example, female suicide is at epidemic proportions in China. It is at five times the average rate elsewhere in the world. Five hundred female suicides occur each day in rural China. One explanation for this is a shift to a market economy. The economic and social changes in China during the last twenty years have had large numbers of men leaving their rural families to find work in urban society. These changes may further burden the wife, contributing to her feelings of hopelessness.

In general, mental illness is found to be rising in developing countries and this is due to some extent to the economic restructuring that has been taking place. In many countries rapid social and economic progress is creating special stress which is affecting the

elderly. By 2025 it is projected that three-fourths of the world's cases of dementia will be in the developing world. In India, like in most Third World countries, 95% of all mentally ill people are treated by faith healers and priests. In fact, in the early 1990s there was only one psychiatrist for every million people in India.

Finally, because of globalization, the Third World is also negatively impacting the psychiatry of the Western world. China, for example, does not completely regulate its chemical industries. There are important regulatory gaps. For example, certain intermediary chemicals are not inspected, so it is possible for Chinese chemical companies to make counterfeit drugs for schizophrenia, for example. They export these drugs to developing countries and sometimes they end up on the internet where Americans who are seeking cheaper alternatives to this country's expensive pharmaceuticals buy them.

Globalization has been, at best, a mixed blessing for those suffering from mental illness in developing countries. However, as the pressure mounts for globalization to be a more equitable process, developing countries should come to reap many of the benefits that the West, especially in medicine, has to offer and the countries of the North will be better able to receive and use the knowledge about what makes for good outcomes from mental illness that developing countries have to offer.

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