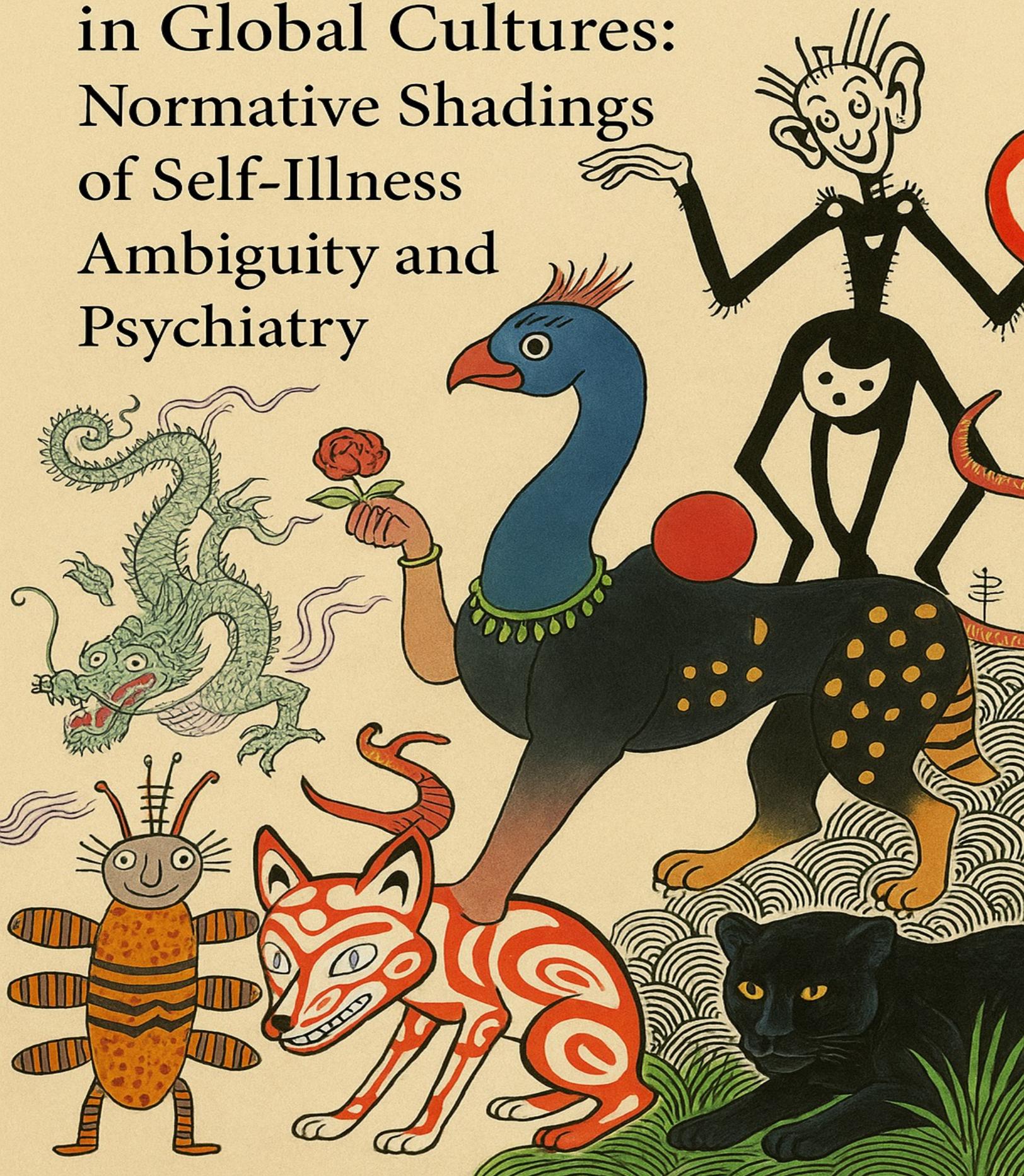


Selective Permeability in Global Cultures: Normative Shadings of Self-Illness Ambiguity and Psychiatry





Selective Permeability in Global Cultures: Normative Shadings of Self-Illness Ambiguity and Psychiatry

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Abstract

This article exposes some culturally contingent foundations of self-illness ambiguity, wherein psychiatric patients struggle to distinguish their authentic selves from their diagnosed conditions and to determine which is in control. In cultures where the self is experienced as fairly fluid and situational, with its causal force downplayed, “losing control” or “not knowing who one is” may carry less significance. Clinicians, however, may accentuate self-illness ambiguity by uncritically subsuming Western ideals of selfhood, such as aspirations toward independent individualism—perhaps contributing to the pathologization of culturally unfamiliar temperaments. Cultural environments, in turn, may range from supportive to hostile depending on how specific self-construals are valued within them, selectively exacerbating distress, and psychiatric frameworks may misinterpret such outcomes as internal disorders. The article finishes by urging a reevaluation of mental illness models to better account for cultural variability in self-understandings.

Keywords Cultural psychology · *DSM* · Mental illness · Neurodiversity · Global Indigenous philosophies · Medical categorization · Normativity · Philosophy of psychiatry · Psychiatric diagnosis · Self-illness ambiguity

1 Introduction

Self-illness ambiguity is the blurring of boundaries between the self and psycho-medical conditions, wherein patients question whether their thoughts, desires and actions are their own or instead outcomes of their disorders—potentially intensifying uncertainty about agency that sometimes already accompanies mental illness (Dings & Glas, 2020; Tekin, 2022). This article shifts the discussion by looking at how both parts of the self-illness compound can be artifacts of Western values.

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To a point, self-illness ambiguity scholars agree, critically interrogating concepts of self and mental illness (e.g., Dings & Glas, 2020; Tekin, 2020). Sadler (2007, p. 113)—who coined the term self-illness ambiguity—notes that “the personal self is a Western commonsense concept,” also urging cultural bridging (Sadler, 2003, pp. 1823–1814; 2005, pp. 253–254). But recognizing the problem is not the same as addressing it—and the literature largely overlooks Sadler’s cues. This omission matters. Though non-Western ideas have long been explored by psychologists (e.g., Fromm & Suzuki, 1970), research still overwhelmingly focuses on WEIRD (Western, Educated, Industrialized, Rich and Democratic) populations (Henrich et al., 2010). WEIRD scholars widely treat mental illnesses as disorders of the self (e.g., Fuchs & Röhrich, 2017; Gallagher, 2003; Parnas et al., 2002; Sousa et al., 2019; Tekin, 2019). When coupled with the Western value of “knowing who one is” and the tendency to seek underlying causes for thoughts, desires and actions (Timimi & Maitra, 2009), the likelihood of confusion between self and illness increases.

Regarding “mental illness,” the mainstream medical community may deem abnormal what some non-Westerners see as normal (Benedict, 1934; Eisenberg et al., 2008; Horwitz & Wakefield, 2007, Ch. 10; Timimi & Leo, 2009a). Relatedly, research to be discussed suggests that conditions like depression and AD(H)D can be epistemically adaptive—though this does not mean they always are and that the disorder label never applies. In challenging the normative assumptions behind some diagnoses, I review evidence suggesting that given disorders can be specific to the cultures and historical periods that produced them. This segues into the idea that cultures can be selectively hostile: someone considered normal in one setting may struggle in another. As a result, “being oneself” can amount to illness after cultural relocation.

As for the “self,” many definitions exist. Self-illness ambiguity scholars regularly cite the impracticality of evaluating them all, instead stipulating a preferred concept or else just talking about patients “not being themselves” (see Dings & Glas, 2020; Dings & de Bruin, 2022; Tekin, 2020). Yet experiences of self vary across historical periods, cultures and individuals—much like concepts of “justice” or “love”—rendering broad ontologies elusive (Crippen, 2025a). Rather than assume universality, we might trace how cultures generate divergent models of selfhood. For instance, Buddhists speak of no-self; Indigenous American worldviews often extend the self into the land; and certain Asian, African and Latin American cultures emphasize we-self in some contexts (Ed. Andía, 2018; Crippen, 2021, 2023, 2025b, c); Ho, 1995; Kitayama & Salvador, 2024; Raj et al., 2018; Salvador et al., 2025; Wang et al., 2012; Whitt et al., 2001).¹ It gets more complex still, since factors like rapid transportation, the internet, colonization, international trade and other changing material conditions lead to shifting ideas about self. As also recognized for decades, people can be primed to adopt alternative self-construals depending on temporary influences (e.g., Hong et al., 1997; Roland, 1988; Wang et al., 2025).

While not reducing cultures to one another, recent psychological research nonetheless highlights that non-Western experiences of the self tend to be contextually interdependent, though bases for this vary (de Oliveira & Nisbett, 2017a, b; Kitayama & Salvador,

¹ For a dissenting opinion on Latin Americans, see Kryszewski et al. (2022).

2024; Vignoles et al., 2016). Because contexts shift, certain non-Westerners report “a less continuous inner self” (Tafarodi et al., 2004, p. 115), feeling like different people throughout the day (Spencer-Rodgers et al., 2009). Accordingly, “not knowing who one is” may arise less frequently as a problem. Without arguing it is always the case, one can therefore speculate that distressing self-illness ambiguity is more likely for Westerners, who often see the self as fairly “bounded, unitary, stable,” not to mention “internal,” “private” and “separate” (Markus & Kitayama, 1991, p. 230; also see Ge, 2025). For Westerners, moreover, differentiating oneself from others and doing what one wants are celebrated in the ideal of individualistic independence (Lu et al., 2021). Self as cause is a corollary. Thus, uncertainty about agency—typifying self-illness ambiguity—becomes problematized.

An amplifying factor is that heightened individualistic self-focus predicts depression and reduced well-being (Boehme et al., 2015; Das et al., 2023; Elmer & Stadtfeld, 2020; Gibbons et al., 1985; Hankey & Shetkar, 2016; Humphrey & Bliuc, 2022; Ingram & Smith, 1984; McCullough, 2000, 2003; Mor & Winquist, 2002; Park et al., 2017). Some may counter that self-concept clarity reduces anxiety (Kaczurkin et al., 2022), but several caveats apply. First, anxiety is not equivalent to mental illness. Second, clarity can take problematic forms—a Nazi may feel quite self-assured. Third, anxiety can be beneficial, as it sometimes correlates with creative intelligence (Moutafi et al., 2006; Perkins et al., 2015; Schouwenburg & Lay, 1995). More crucially, the above objection presumes a culturally narrow individualistic notion of self.

For example, have clarity proponents weighed their approach against Buddhist no-self meditation? Have they considered that patients could clarify their we-self? In fact, priming Chinese participants toward individualism has been found to increase sensitivity to negative social evaluations, physical pain and its neural correlates (Wang et al., 2014; Zhang et al., 2017), while also heightening feelings of marginalization across a wide range of bicultural subjects (Ferenczi et al., 2015). Simultaneously, however, preexisting (unprimed) interdependent orientations made negative social interactions more distressing to a multiethnic cohort at a Texas university (Umeda & Park, 2024). The last point is unsurprising since the self-construal in question almost definitionally implies attunement to others.

Together, these mixed findings support a broader point: that the uncritical acceptance of independent individualism as inherently good and universally beneficial warrants scrutiny—not because the self-construal is necessarily harmful, but because it may not conduce to wellbeing in all cultural contexts. Moreover, psychiatric categories, largely grounded in WEIRD research, often reflect Western norms that can pathologize non-Western temperamental styles. The upshot is that both the concept and lived experience of self-illness ambiguity are shaped by culturally specific models of self and mental health.

2 Self, Illness and Ambiguity

Major illnesses can reshape self-understanding in diverse ways. As Sadler (2007, p. 115) observes, people may equate cancer to an external assault, saying they were “struck” by it, “hit ... like a ton of bricks. This can impact identity without elevating self-illness ambiguity, as with Terry Fox, who lost his leg to cancer and tried to run across Canada to raise awareness and funds. The affliction may also bring about self-illness ambiguity and

agential uncertainty. Even so, Fox saw little ambiguity here: though his identity changed, he did not think the cancer was taking over his self any more than the Indigenous warriors at Little Bighorn mistook themselves for their enemies (Crippen, 2025a).

In contrast, Sadler (2007) notes that psychological disorders are often framed not as external threats but as intimate takeovers from within. While terms like “anxiety attack” suggest exceptions, he observes that psychiatric illness often “comes over” and “envelops the person and may even penetrate her inner being, her personal self” (p. 115). Here the boundary between self and illness phenomenologically blurs, making one worry whether mania, alcoholism or AD(H)D—rather than the self—drove a hookup, a binge or an urge to sleep, generating uncertainty about agency (Tekin, 2022). In this context, Sadler points to the *DSM-IV-TR*'s (APA, 2000, p. xxxi) recommendation to describe someone as “an individual with Alcohol Dependence,” not “an alcoholic,” which he suggests may help disambiguate self from illness. The goal was also to reduce stigma by avoiding reductive labels—an approach that will later be shown to carry clinical implications for self-illness ambiguity.

The above descriptions of disorder experiences are fairly clear-cut. But this section will show that self-illness ambiguity has ambiguous implications, while highlighting how it can sometimes be avoided, starting with an example from older *DSM* editions, followed by some from the latest revision.

To start, consider the *DSM*'s classification of homosexuality as “sociopathic” and “deviant” in its 1952 and 1968 editions—language excised in 1973. A 1974 APA (American Psychiatric Association) referendum showed 42% disagreeing with the change, and the *DSM* kept distress about sexual orientation as a disorder until its fifth edition in 2013. Critics questioned whether distress about height should also be counted (Drescher, 2015). And what about race or gender? Gender dysphoria remains Listed as a disorder as of the 2022 *DSM-5-TR*, which Drescher (2018), who was a contributor, ascribes to a wish to ensure access to medically assisted gender reassignment and insurance. Several points arise. First, some psychiatric labels are negotiated (via votes, insurance considerations, etc.). Second, wellness judgments reflect prevailing values from specific times and places. Third, by current *DSM* and Western legal standards, pathologizing homosexuality—central to many people's senses of self—was both factually and morally wrong. This raises a question: if homosexuality was once an illness, would disambiguating self from illness have meant defining oneself by what one is not—possibly leading to self-self ambiguity?

Led by Robert Spitzer, the *DSM-III* was meant to make psychiatry scientifically respectable, with subsequent editions modelled after it (Horwitz, 2021). Later, however, Spitzer lamented cataloguing disorders without “looking at the context in which those conditions developed” and “considering that ... conditions might be normal reactions, which are not really disorders.”² Now, the *DSM-III* (APA, 1980) does not totally ignore context. Of ego-dystonic homosexuality (roughly, a distressful wish not to be homosexual), it says that amelioration “is apparently facilitated by ... a supportive homosexual subculture” (p. 281). But this undercuts the idea of a general disorder by suggesting it is relative to levels of social non-acceptance. Non-acceptance is too vague to qualify as a medical category.

² Remarks from Adam Curtis's 2007 *BBC* documentary, *The trap* (part 2).

Having reflected on an older example, we now turn to the *DSM-5-TR* (APA, 2022), beginning with premenstrual dysphoric disorder (PMDD). East Asians report PMDD less frequently (Schatz et al., 2012), often emphasizing physical symptoms like bloating, fatigue, pain and cold sensitivity rather than the mood changes that the *DSM* highlights (Ussher, 2013). Some Asian cultures also reject assumptions that women's bodies must function identically to men's (Hård, 2023). Whether sexist or not, this raises a question: must premenstrual mood shifts be pathologized? Or, as Ussher (2013) suggests, could the outcome result from employers and partners being unsupportive when women feel unwell, compounded by stereotypes linking menstruation to irrationality? Though places like South Korea legally permit monthly menstrual leave, this does not guarantee a sympathetic social milieu. For example, one woman interviewed as part of a larger (ethically approved) project associated with this article recounted her Korean husband demanding she clean cat Litter at 11:30 PM despite severe menstrual cramps—later diagnosed as fibroids and advanced endometriosis requiring major surgery. A Western professor also threatened grade penalties for missing class the day after her hospital discharge. Like the earlier-mentioned Indigenous alliance at Little Bighorn, she viewed actors around her—not her condition—as the source of her distress, despite living in a culture known for situationally inflected self-construals. Neither self-illness ambiguity nor self-situation ambiguity were at issue.

Might AD(H)D similarly be grasped as a product of selectively hostile environments? Industrialized societies emphasize sustained, focus-intensive work—expectations that give the diagnosis much of its significance. AD(H)D co-occurs with autism in 50–70% of cases (Hours et al., 2022), and both may involve cognitive strengths—AD(H)D with creativity and flexibility; autism with systematizing, attention to detail and reduced bias (Timimi & Leo, 2009a; Armstrong, 2010; Uddin, 2022). This is not to downplay real challenges, such as language impairments in some autism cases, or to dismiss the value of supports—especially since reshaping educational and work tasks can ease the burden (Crippen & Lindemann, 2024). Although methylphenidate is a common AD(H)D treatment, a recent review rated its effectiveness as having “very low certainty” and noted underreported side effects (Pereira et al., 2021, p. 434). Like PMDD, AD(H)D rates vary across regions (Hart & Benassaya, 2009; Smith, 2017), reflecting differences in diet, socialization and pharmaceutical advocacy or disability incentives (Timimi, 2009; Timimi & Leo, 2009b). But these variations may signal more. Poor focus can amount to a restless drive to move on, and Eisenberg et al. (2008) report that among Ariaal nomads (in Kenya), those who measure higher in this tendency and other AD(H)D markers enjoy certain benefits, e.g., they are better fed. Would this mean that a nomad develops a disorder by relocating to an industrialized setting, only to be cured upon returning home? An alternative is to recognize the extent to which obstacles are externally imposed—and to internalize them less—which would help obviate self-illness ambiguity.

Simultaneously, avoiding overgeneralizations means allowing that some disorders are called such because they are harmful across most contexts, and self-illness ambiguity is not always bad. For instance, regular excessive drinking is problematic and may define who one is. With recovery, however, the self-that-was-an-alcoholic becomes the illness. And remission may be beneficially extended by a distressing internal debate about whether one simply misses wine with cheese or whether the disorder is fueling temptation (Drożdżowicz, 2023).

Sacks (1970/1998, p. 102–104) offers another case that might be regarded as benign self-illness ambiguity: an 89-year-old with late-onset neurosyphilis, which left her “livelier, friskier” and “a flirt.” She wanted the condition to remain “just as it is” without progressing—a feasible wish since the damage was irreversible, though penicillin could end the infection. Here, the woman may wonder whether it is she or the neurosyphilis that leads her to make a romantic advance, though she is not distressed.

We have seen that psychiatric designations are negotiated, and the APA invited the public to propose new disorders for the *DSM-5* (Watters, 2010, pp. 251–252). We have also reviewed how prevailing moralities have shaped the *DSM*. This remains so, for exhibitionistic and voyeuristic disorders would not be in the *DSM-5-TR* (APA, 2022, pp. 780–784) if morally praiseworthy. This is implicit in the diagnostic criteria, requiring (1) persistent paraphilic ideation or behavior and (2) distress or social impairment, with ethical norms about privacy usually ensuring the latter. Now, moralities will continue to evolve, for example, with some activists wanting a meatless future to lessen animal cruelty and planetary destruction. If eating animals comes to be condemned and outlawed, a future *DSM* (which already includes eating disorders) could list consuming or fixating on meat under a heading like “carnorexia” (from Latin and Greek for “flesh” and “appetite”). Clinicians might cite extant studies showing that heavy meat eating is comorbid with psychopathy, narcissism and authoritarianism (Allen et al., 2000; Sariyska et al., 2019). Our hypothetical future could have a subgroup, convinced they can distinguish real meat from facsimiles that top chefs praise as perfect replicas but with a moral status comparable to simulated pornographic violence. Our future could additionally have pharmaceuticals that induce allergic reactions to meats, mimicking alpha-gal syndrome.

In fact, some strongly identify with eating meat, equating privation to losing a part of who they are (Allen & Hung Ng, 2003), mirroring descriptions of self-illness ambiguity as “not being who one is.” In our future society, carnorexics might experience other doubts characteristic of self-illness ambiguity, questioning whether meat hankerings—even for lab-grown—are authentic or just disorder flare-ups. Echoing current rhetoric, future generations could claim carnorexia was always widespread but overlooked due to flawed cultural values. In this case, self-illness ambiguity would stem from a newly introduced disorder—one most today would not recognize.

The takeaway is that self-illness ambiguity is itself ambiguous. Confusing oneself with a disorder can have good or bad effects. The unclarity may be unsettling or not, even if distress is part of bonafide self-illness ambiguity. The phenomenon may arise when once-normal behaviors become pathologized. It may also disappear as disorder labels get dropped. Weinstock and Nair (1984, p. 557) add that in old case studies, “dislike of the patients or negative moral judgments about their actions frequently were involved in making a diagnosis of antisocial personality.” And, in fact, the main criteria for antisocial personality disorder in the *DSM-5-TR* (APA, 2022, p. 748) are such that an impulsive, itinerant, drug-using hippie would tick enough boxes if they were an adult, engaged in this Lifestyle since age 15 and not schizophrenic or bipolar. Though the manual goes on to add more nuance, and one imagines clinicians exercising restraint, conventional morals clearly shape some diagnostic criteria.

3 Normativity and Mental Illness

We have seen how value judgments underpin diagnostic categories, influencing their emergence, persistence or abandonment, affecting possibilities of self-illness ambiguity. This section offers a more fine-grained account, focusing on normative assumptions in Western medical models that lead many to view designated disorders as maladaptive and epistemically distorting. This will later build into the case that psychiatric conditions often reflect external obstacles imposed unequally, rather than inherent flaws in the self, chipping at both parts of the self-illness compound, a process continued later when I examine mental health in the context of global societies.

To start, consider PTSD. It entered the *DSM* in 1980, following petitioning from Vietnam veterans and media exposés (Lembcke, 1998; Summerfield, 2001). Many affected soldiers had not seen combat, linking their distress to government betrayal and public backlash. Still, advocates downplayed these Vietnam-specific grievances to get PTSD recognized—seeking medical benefits, disability support and occasionally justifications for misconduct (Huffman, 1972; Lembcke, 1998; McNally, 2003; Summerfield, 2001). This underscores that PTSD’s definition is negotiated *without denying* psychological injuries occur.

PTSD symptoms from past or ongoing trauma include hypervigilance, anxiety, insomnia, emotional numbness, detachment, difficulty concentrating, impulsivity and avoidance (Krüger-Gottschalk et al., 2022). Trauma cues may trigger flashbacks—intense memories, not hallucinations unless schizophrenia is involved (Steel, 2015). Though distressing and physiologically harmful, traits like hypervigilance may be adaptive when danger persists, despite adverse side effects. By way of analogy, escaping a charging buffalo might cause a muscle tear, yet it is the resultant injury—not the adaptive fleeing—that warrants treatment (Crippen, 2025d). Similarly, while prolonged stress hormone elevation can cause glucocorticoid toxicity and hippocampal shrinkage (Lau et al., 2016), these effects stem from adrenaline-driven responses that adaptively boost alertness and fight-or-flight readiness (Sherin & Nemeroff, 2011). For a soldier facing peril, the injuries are a cost of responding adaptively. They may warrant treatment, as may the response if maladaptively continued in civilian life, but we would not necessarily want to suppress the latter—akin to the fleeing—in cases of ongoing threat.

Additionally, while reduced neural suppression for successive sounds counts as a PTSD-related deficit (Villarreal & Hunter, 2016), detecting redundant clicks (normally merged into one) can save a soldier’s life. Likewise, domestic abuse may heighten sensitivity to subtle body language—or to the smell of tobacco, even on people who have showered and brushed their teeth, if the scent signals an abuser is home.³ PTSD also associates with decreased activity in the anterior cingulate and prefrontal cortices, which govern complex cognitive weighing (Shin et al., 2001). But in unpredictable and high-risk situations, overthinking can be unreasonable. Indeed, it is ludicrous to pause in a warzone to ponder whether explosions are fireworks or an attack (Crippen, 2025d).

As repeatedly stated, none of this denies trauma can lead to maladaptive outcomes. A soldier returning home with PTSD may struggle with a disorder—phenomenologically

³ From interviews.

marked by disruptions to her world and relations. Among sexual assault survivors, about two-thirds report revictimization (Sorenson et al., 1991), and PTSD may involve re-exposure—such as attachment to abusive partners (e.g., Fereidooni et al., 2023). In these cases, diagnosis and treatment may be warranted.

However, some sexual abuse survivors may counter that re-exposure is inevitable, noting that men pose the greatest danger in most environments, especially for women (Crippen, 2025e). Although this does not mean a given man is likely to attack, the cumulative risk is real. Thus, a woman unable to endure another assault may justifiably take low-probability threats seriously to avoid harm over time. In Merleau-Ponty's (1945/1962) parlance, her world becomes threat-suffused, prompting a recalibration of her horizon of expectations and perceptual readiness. This does not reflect delusion but a pragmatic attunement to risk—an affective style aimed at avoiding misplaced trust in safety. More plainly, increasing the number of false alarms can adaptively reduce jeopardy if the cost of occasionally missing a threat is high. Even if less anxious behavior would not materialize danger, one cannot know this until after the fact, and traumatized individuals may reasonably find certain risk levels intolerable. Hence, researchers introduce sweeping value judgments when characterizing PTSD sufferers as having “perception of threats where none exist” (Barrett et al., 2016, p. 9) and praising medications for reducing “avoidance of trauma-related activity by week 10” (Davidson, 2006, p. 35). The claim that PTSD involves assigning “more negative and threatening interpretations than [events] warrant” (Wilkinson et al., 2017, p. 7) ignores the subjective weight and impact of objective risk. And asserting that PTSD is absent if the alarms are not false is unconvincing, as it would exclude those living in active warzones or abusive contexts from the diagnosis.

Like PTSD, depression often comes with heightened anxiety (Strunk et al., 2006). When healthy individuals expect negative events, their brain activity mirrors the baseline of those with depression—suggesting a persistent readiness for adversity (Abler et al., 2007). From this, some might conclude that depression is *necessarily* epistemically distorting, but arguments weigh against the generalization. For now, the focus is on depression linked to life events, with temperamentally depressed individuals discussed in the next section.

To start, depression can resemble a dehydration headache that encourages corrective action (Andrews et al., 2020; Rao et al., 2016). Useful analogies come from non-human animal studies. One experiment compared squid with and without local anesthetic after a tentacle amputation; untreated squid attuned to their injury and suffered less predation because they hid (Crook et al., 2014). Likewise, feeling down may reflect shifted attunement to the world, where diminished capacities make everyday demands feel heavier. The situation has been found to aesthetically draw burdened individuals to enclosed spaces (Mealey & Theis, 1995), in other words, areas affording protection or restoration.

A second experiment (Andrews et al., 2020) examined rodents and found that an analogue of depression, when caused by gastrointestinal illness, curbed libido and appetite while increasing sleepiness and motor retardation—adaptively precipitating cautious rest. Starvation-induced depression also dampened sex drive but heightened food obsession, motor activity and expectant searching, together conducting to getting nourishment. Though caution is warranted since we cannot ascertain

the allegedly “depressed” affective moods of rodents, the findings parallel human experiences. We might, for instance, wander frantically in a city looking for restaurants—and not sex—when depressingly food-deprived.

Another example is relatable to academics: that months of unproductive scholarly effort can lead to procrastination and depressed exhaustion. Like pain, these symptoms may be remedial if they shift us toward more rewarding pursuits (Rottenberg, 2014, Ch. 7; Wittman, 2014). But for an alternative framing, consider Oshima Ichiro’s suicide. Over 17 months, he worked 87-h weeks, and lawyers later debated whether depression caused his death (Herskovitz, 2000; Watters, 2010, Ch. 4). Yet do we need a mental health diagnosis to explain his suicide—or was his absurd exploitation explanation enough? I will return to this question later.

Repeating James (1879) and Heidegger (1927/1962), psychologists observe that elevated thinking often accompanies trouble (e.g., Andrews & Thomson, 2009), be it failed relationships, broken tools or difficult exam questions. Trauma-induced depression also follows from problems and likewise fosters solitary rumination and behaviors facilitating it, like social withdrawal (Bartoskova et al., 2018; De Fruyt et al., 2020; Elmer & Stadtfeld, 2020). Deflation itself seems to conduce to thinking, at least during intelligence tests where it associates with higher scores. Along related lines, depression has been linked to enhanced analytic processing, possibly aided by motor slowing (Azorin et al., 1995; Caligiuri & Ellwanger, 2000; Ratcliffe, 2015, Ch. 3; Karpinski et al., 2018). The upshot is that depressed rumination may aid reassessment and recalibration—helping one escape a bad situation or avoid its recurrence, suggesting the condition is *sometimes* epistemically adaptive.

Now, like a calf torn while fleeing a charging buffalo, depression is almost definitionally unpleasant, and stabilizing processes may add discomfort: swelling and hence muscle immobilization in one case, cautious recalibration in the other, even if either response overshoot the ideal. Depression associates with inflammatory slowdown and elevated glucocorticoids, which can have harmful effects (e.g., Lau et al., 2016; Miller & Raison, 2016). Depressive rumination also involves localized brain hyperactivity, potentially leading to neuron breakdown (McEwen, 2005). These effects are unfavorable in themselves, and intervention may be warranted. Still, as with PTSD, labeling depressive responses as inherently maladaptive may conflate an adaptive reaction with the injury that follows—even if the latter as well as the former eventually require treatment.

The next section will look at global societies to argue that culturally imposed normative constraints can pathologize what might otherwise be seen as alternative ways of being. This supports my broader aim of challenging both the “illness” and, later, the “self” sides of self-illness ambiguity. As mentioned at the outset, this will expose shortcomings in psychiatry. However, it is worth reiterating that logically consistent skepticism about illness essentialism obviates a universal rejection of psychiatric disorders.

4 Selective Permeability, Psychiatry and Cultures

An unaddressed issue remains: depression unrelated to trauma or matters like gastrointestinal illness. What I am terming “temperamental depression” may nonetheless parallel gastrointestinal illness in that it can link to energy dysregulation, i.e.,

physiological problems (Rao et al., 2016). But the main point here is that cultures set norms for temperament, shaping how “maladaptive” dispositions are defined.

Let me start by stating that if my views are constructivist, this is not in the sense of projecting conceptual schemes. Rather, we concretely build cultural arrangements that exist beyond the mind—arrangements that ease coping for some while making it harder for others, who are more likely to be labeled “disordered.” This can be grasped through the affordance-based concept of selective permeability, first applied to urban geography and later extended to multiculturalism, education, gender and digital spaces (e.g., Crippen, 2022, 2024, 2025b, d, e); Crippen & Klement, 2020; Crippen & Lindemann, 2024).

To review, affordances are action possibilities that simultaneously constrain: stairs enable climbing by blocking level movement. Gibson (1966, 1979) defines an affordance as “positive” if it beneficially permits more actions, “negative” if it harmfully restricts them—like a cat for a mouse or a cliff for a human. Selective permeability emphasizes that people can encounter different affordances in the same space. In a subway, women may face more negative affordances than men due to harassment. Likewise, a participatory circular desk arrangement may amplify negative affordances for a student who mitigates anxiety by sitting up front to avoid visual crowding. And, as seen, an Ariaal nomad may thrive in rural Kenya but appear to have AD(H)D in industrialized settings. Rottenberg (2014, Ch. 5) offers the analogy of bold fish effectively exploiting novel food sources—unless it is bait, in which case hesitant fish survive longer. In humans, tentativeness links to neuroticism, which correlates with depression, creativity and high intelligence, especially in the anxious (Moutafi et al., 2006; Perkins et al., 2015; Schouwenburg & Lay, 1995). These individuals may excel at complex tasks yet struggle comically with simple ones, showing how situations selectively accommodate different temperamental styles.

Ess (2014) warns that speaking of “culture” overgeneralizes, as groups contain internal diversity and evolving traditions. In cultural psychology, statistical averages obscure outliers, and how data are parsed—by nationality vs. ethnicity, for instance—can mask differences. Class, religion, politics, health and rural–urban background also shape outcomes differently across cultures (Crippen, 2025e). Still, regional patterns emerge, sometimes echoing the hesitant–bold spectrum. For example, Japanese business contracts may be seen as somewhat tentative (Hattori, 2018; Nisbett, 2003, Ch. 8) Japanese respondents tend to endorse opposing views more than Westerners (Spencer-Rodgers et al., 2009). They may admire indecisive politicians as thoughtful, unlike Americans, wont to label them “flip-floppers,” or Chinese, who frequently favor decisiveness (Yates et al., 2010). Similarly, while “compromise” in English can imply weakness—e.g., “she was compromised”—in China, Japan and Korea, it is often valued as a path to harmony (Spencer-Rodgers et al., 2009).

Thus, the psychiatrist Laurence Kirmayer (2004, p. 172) writes that “one society’s enhancement of personality can be another’s provocation,” adding that “something like this may occur with Prozac, where the extroversion, gregariousness, and pushiness that typify the life of a salesman in the United States may be associated with inappropriately brash and insensitive social behavior in Japan.” He concludes

that ideal personality traits—and the point at which they are seen as problematic—vary across cultures.

This raises a possibility: that somebody—named Yumi, say—may have pronounced but still normal tendencies in East Asia but be regarded as abnormal after relocating to the US. There, she might be labeled depressed or placed on the autism spectrum, reported at elevated subclinical and clinical rates in Japan, often with camouflaged symptoms in women (Atherton et al., 2023; Ratto et al., 2018). Medical essentialists might claim Yumi had a latent disorder, merely unrecognized in Japan, China or Korea, where she traces her mixed ancestry, pointing to Japan's lower depression diagnoses but higher suicide rates as evidence of underdiagnosis (De Vaus et al., 2018). I will soon argue that Yumi's East Asian temperament, similar to the Ariaal nomads, may be misread as pathology in the West—raising challenges for self-illness theorists and psychiatry—before mounting a critique of essentialism.

For now, I want to expand on selective permeability in relation to psychological struggles, starting with schizophrenia, which labels a cluster of symptoms tracing to different physiological issues and disjoint genotypic networks (e.g., Arnedo et al., 2015a, b; Insel, 2010). In other words, while the *DSM* basically classifies it under a single rubric with subvariations, “schizophrenia” names multiple distinct diseases if one wants to use medicalized terminology (and again, opposing essentialism carries an obligation not to reject the possibility that disease designations are sometimes warranted). Now, persistence in the gene pool does not automatically imply adaptive value. Nonetheless, researchers speculate that genes increasing susceptibility to schizophrenia may linger due to associated intellectual gifts—not necessarily in afflicted individuals but linked to genes correlated with the condition (Cariaga-Martinez et al., 2018). Notably, highly creative and top-performing non-schizophrenics have a higher than average number of first-degree relatives who have the condition (Karlsson, 2004).

While schizophrenia is heritable, monozygotic twins are only about 50% comorbid, meaning other factors contribute (Kahn et al., 2015).⁴ Though debated due to inconsistent metrics and healthcare access, prognosis appears better than average in parts of Ghana, Nigeria and India (Luhmann et al., 2024; Padma, 2014). Mitigators may include strong informal community support and “the less rigid nature of rural life” (Padma, 2014, p. S15). Additionally, stigma appears less pronounced in parts of the Global South, where schizophrenics can occupy valued roles as shamans (Armstrong, 2010, Ch. 8). Luhmann et al. (2024) compare this to how cultural acceptance can erase the distress of same-sex feelings. Their results also underscore therapeutic aspects of shamanic training that teaches individuals to ignore bad spiritual voices while engaging with good ones, reducing detrimental effects of toxic identification with psychosis. Altogether, this suggests that social milieus can have varying degrees of hostility, shaping the extent to which schizophrenia is experienced as a mental illness.

⁴ 50% alignment may be more an indicator of non-genetic influences than an affirmation of genetic factors because, as compared to dizygotic twin, “MZ twins spend more time together, more often have the same friends, are treated more similarly by parents and others” (Joseph, 2009, p. 60).

If a setting can support coping for a given temperament, what about the reverse? To close this section, consider Yumi's move to the US. There, her quiet, deliberate style—valued in Japan as thoughtful and respectful—clashes with workplace norms favoring quick decisions and enthusiastic assertiveness. Her pauses are seen as passivity, her collaborative mindset as lack of ambition. Though athletic, Yumi sometimes experiences vertigo, aches and an inconsistent appetite, and while none of this especially concerned her in the past, her American friends notice. At Friday outings, she tries to fit in but finds the loud music, flashing lights and crowds overwhelming—more so because they worsen her sleep problems, deepening her fatigue.

While unproblematic in Japan, Yumi's tendencies take on different meanings in her new environment. Her emotional reserve, shaped by East Asian norms discouraging overt displays of feeling (Kraus et al., 2024; Murata et al., 2013), gets interpreted as flat affect. Her habit of checking her reflection on her phone, taught as a discreet way to manage appearance, seems mildly neurotic. Her self-blame and polite deflection of praise, once read as humility, now look like worthless self-assessments. Even her indirect communication—formerly considered respectful and nuanced—manifests as evasive.

Without assuming Yumi would be diagnosed with depression, recent *DSM* editions note that non-Western individuals may express it through somatic symptoms—like aches or imbalance—rather than emotional complaints. Besides this, Yumi fits several other *DSM-5-TR* (APA, 2022, p. 183) criteria for depression: abnormal appetite, fatigue, sleep issues, indecisiveness, motor peculiarities and worthlessness. A diagnosis requires four symptoms plus either depressed mood or anhedonia, which need not be self-reported; observed behaviors like inexpressiveness may suffice. Some might argue clinicians would not diagnose on that basis—but if so, why does the *DSM* allow it? Wakefield (2015, p. 192) criticizes the *DSM*'s depressive category as “bloated beyond plausibility,” citing low diagnostic thresholds and high false positive rates, shown by some researchers to outnumber true positives in primary care, where the bulk of treatment is handled (e.g., Mitchell & Vaze, 2009; Shaughnessy, 2022). Conversely, though, stigma in non-Western cultures may indeed lead patients to report physical rather than emotional symptoms (Lauber & Rössler, 2007), with the *DSM* warning about low help-seeking. While the manual encourages evaluation within cultural norms, it nonetheless frames depression as a universal disorder. All this together raises concerns about bias toward positive diagnoses, especially given that many *DSM* contributors have financial ties to pharmaceutical firms (Cosgrove & Krinsky, 2012; Davis et al., 2024).

To make the case more compelling, imagine Yumi experiences moderate sadness and anhedonia stemming from her inability to achieve the East Asian value of social harmony while in the US. However, this is unclear to her and her primary care provider. Combined with other temperamentally normal East Asian traits, might this tip the scale toward a positive diagnosis, paralleling the Aarial nomad case? Conversely, suppose the clinician recognizes her as culturally typical, not diagnosing her. If Yumi had spent her high school and college years in the US and feels American, might those same traits, though unchanged, be viewed as pathological? And in reverse, if an American with identical symptoms moved to Japan and adapted over time, would he no longer be seen as depressed?

Research suggests white clinicians are more likely to diagnose East Asian clients with psychological disorders (Li-Repac, 1980). So, for argument's sake, suppose this happens to Yumi. If the diagnosis recalibrates her self-perception—leading her to internalize her way of being as pathological—does she, in adopting a more inward, isolated and atomistic focus, become more characteristically Western? Do the blurred lines between temperament and pathology render her formerly normal East Asian self the illness? In such a case, does self-illness ambiguity collapse into self-self ambiguity—or even illness-illness ambiguity?

5 Self, Sickness and Society

Without suggesting that non-Westerners lack individual senses of achievement, competitiveness, disappointment or identity, a glance around the world suggests that the value that many Westerners place on independence is less than universal. This has ramifications for psychiatric disorders and self-illness ambiguity.

To start, consider Kim's (2021, p. 62) recollections about living in Madagascar. She recounts learning from friends there that, unlike English, Malagasy lacks a clear subject-object distinction—that anything discussed is already part of the self and vice versa. This controversial claim is difficult to articulate in languages depending on subject-object distinctions. In her public talks, Kim has related how a Western colleague simply responded that Malagasy speakers must have, and be unaware of, their own subject-object distinctions. The retort reflects the challenge in thinking beyond familiar cultural-linguistic norms, in this case about the self. Though not the main point here, resistance to viewing depression and other conditions as sometimes adaptive may similarly follow from “disorders” and “mental illnesses” being definitionally bad.

A comprehensive review of global experiences of self being unfeasible, this section offers snapshots. Mbiti's (1970, p. 152) African formulation states: “I am because we are, and since we are, therefore I am.” Here, “we-ness” is foundational. Importantly human capacities—e.g., language, religion and cooking—emerge communally, with sub-Saharan ubuntu traditions sometimes treating privacy as more between groups than individuals (Crippen, 2021). Some Indigenous Americans stress the “collective embodiment of clanship experiences” (Jojola, 2003, p. 92), viewing self, community and land as interdependent, akin to parent-child bonds (Whitt et al., 2001). Rumi's Islamic Sufism frames enlightenment as oceanic unity between self and God (Trans. Mafi, 2018), and the Bhagavad Gita describes a merger with the divine cosmos (Trans. Miller, 1986). The Confucian Analects (Trans. Slingerland, 2003) tie humility and the harmonious fulfillment of social roles to humaneness (仁), a term combining person (人) and two (二), implying relational self. While less prescriptive about social roles, Buddhism and Daoism value humility and stress interdependence (Trans. Lau, 1972; Trans. Cleary, 1993, Ch. 39). Neuroscience offers complementary insights: for Chinese participants, thinking about either their mothers or their selves activates brain regions tied to self-processing—specifically, the medial prefrontal cortex (MPFC) and the anterior cingulate cortex (ACC). In contrast, Americans show

heightened MPFC activity only when reflecting on themselves (Wang et al., 2012; Zhu et al., 2007).

Possibly due to atypical MPFC and ACC functioning, schizophrenic voice hallucinations involve individuals generating dialogue without recognizing it as self-produced (Cui et al., 2015). Here, culturally inflected selfhood appears to moderate the condition. Luhrmann et al. (2015) found that Americans often perceive schizophrenic voices as intrusive, whereas Ghanaians and Indians more frequently report them as friendly or playful. The American experience may partly reflect individualistic dispositions, especially valued in the US, which can make voices feel violating—what one woman described as “a hostile takeover of my mind” (Luhrmann et al., 2024, p. 451). The characterization recalls Sadler’s (2007, p. 115) phenomenology of self-illness ambiguity as an “ego-alien” takeover that “envelops the person” to “penetrate her inner being, her personal self,” with invasiveness typical of the schizophrenic distress encountered by Americans. African women, for instance, also value autonomy, yet often pursue it through peer involvement that supports interrelational experiences of self (Ferrari, 2022). In such cases—and in ubuntu contexts, where privacy is viewed more between groups than individuals—an interdependent sense of self may make voices less invasive. In other words, intermingled subjectivity brings self-as-other closer to the norm, dissipating problematic alienation, so that Sadler’s “coming over” becomes more akin to a mood change that ensues upon a friend’s arrival. Put in slightly paradoxical terms, the “other” ceases to be unequivocally other, making voices less frightening.

As noted earlier, contextually interdependent and fluid experiences of self and world are pronounced in Eastern contexts, notwithstanding local variation. After first reviewing these patterns, we will explore their implications for self-illness ambiguity and psychiatric conditions.

Let us begin with findings suggesting that people in parts of East Asia tend to experience the self and world as mutable. More than Americans, East Asians self-evaluations avoid citing fixed traits like inherent aptitude, genes or race, instead leaning toward changeable factors such as effort, motivation, attitude, skill and strategy (Ge, 2025). Eye-tracking experiments identify a developmental point at which American infants focus more on objects (e.g., a dog), Chinese on actions (e.g., a hand petting the dog) (Šašínková et al., 2023). Chinese (and Korean) children also learn verbs much faster than their English- and French-speaking peers (Yee, 2020). Among adults, Westerners tend to be more object-oriented than Taiwanese participants, who register more information from overall scenes (Waxman et al., 2016).

This result has been well-replicated across East Asian cohorts—and, interestingly, increased gray matter in brain regions involved in scene processing predicts interdependent self-construals (Yu et al., 2021). Interdependent self-construals likely overlap with heightened awareness of situationally shifting dispositions—for example: “At work with colleagues, I’m responsible and honest, but not on Friday nights when pursuing hookups” (for review, see Spencer-Rodgers et al., 2009). Other work reports greater frequency of interdependent self-construals in China’s historically rice-farming regions, compared to wheat-producing ones (Talhelm et al., 2014). This is possibly due to the greater social coordination that rice cultivation demands (Talhelm et al., 2014), indicating socio-physical scaffolding.

In-group variation is elevated further by evolving socio-physical scaffolding, leading to intergenerational shifts and increasingly complicated experiences of self. Younger East Asians raised in private bedrooms and exposed to Western media may develop stronger senses of independence (Ess, 2014). Matters may be more complex still. Wang and colleagues (2025) report that Chinese students primed with images of the US Capitol or the Great Wall respectively shifted between dispositional and situational explanations of others' behavior (Wang et al., 2025). While this effect has long been observed in Hong Kong (and was replicated by Wang et al. on that population), it is statistically absent among Mainland Chinese born before 1978, who consistently favored situational attributions. Still, even among younger cohorts, the results align with longstanding trends: East Asians show greater variability in self-relevant emotions, thoughts and behaviors; they tend to admire personal change more than Westerners; and they often experience a dialectical self—aware of inner contradictions, unbothered by them and frequently feeling like different people throughout the day (Joo et al., 2021; Spencer-Rodgers et al., 2009).

These patterns may help inoculate East Asians against distressing self-illness ambiguity—at least compared to Westerners. A Korean nurse who attributes his thoughts and actions to situational factors is already accustomed to not seeing himself as fully in control. If a Chinese student regards poor test results as reflecting changeable traits, the idea of “not being who she is (was)” carries less weight. Wang et al. (2025) found that dialectical self-construals increase further when Hongkongers are primed with Western cues—likely due to heightened awareness of colonial biculturalism. So, for a Hong Kong professor teaching Westerners, tolerating self-contradictions and feeling like different people in the same day should weaken the urgency of asking “who am I?” To the extent this question decreases in frequency—and uncertainty about agency causes less distress—the outcome might resemble asymbolia: pain sensations without suffering. Here, it becomes unclear whether the result still counts as pain, and in the just given circumstances, certain phenomenological features of self-illness ambiguity, along with its conceptual underpinnings, begin to dissipate.

As with schizophrenia, self-construals also have mental health implications here. One study found that interdependence predicts anxiety—but not depression specifically—among Chinese students (Tan et al., 2022). Still, interdependent tendencies may heighten sensitivity to East Asia's complex social hierarchies (Crippen, 2025b), and failure to navigate them can lead to bullying and, eventually, depression (Kiing et al., 2025). Social media may worsen this by encouraging upward comparisons, which harm mental health (Crippen, 2024). Even so, overall rates of depression remain lower in East Asia than in the West.⁵ Yet the foregoing narrative nonetheless raises a familiar question: How much does an intervening mental health condition like depression add to our understanding of stigma-induced despair? And if sufferers view their distress situationally, that is, as externally caused by maltreatment, how likely are they to experience the internal “takeover” that Sadler (2007) associates with self-illness ambiguity?

⁵ Based on Oxford University's “Our World in Data,” <https://ourworldindata.org/grapher/depressive-disorders-prevalence-ihme?time=2021>.

6 Culturally Manufactured Distress

At this point, it should be clear that self is a normative value: one community may esteem independent individualism, while another emphasizes interdependence, with a third stressing both—since neither necessarily excludes the other (Crippen, 2025b). We have also explored how culturally inflected experiences of self and mental health intersect, degrading the generalizability of psychiatry at least somewhat. The issue also runs in reverse: by promoting standardized categories and therapies across cultures, psychiatry may construct illnesses that would otherwise be absent—potentially generating self-illness ambiguity where none would have otherwise emerged.

To begin, one obstacle to standardized models of mental illness like depression is that the biology of what the *DSM* captures under that label may differ across cultures. Though depression rates are higher in the West, some researchers—controversially—suggest greater genetic vulnerability in East Asia (Chiao & Blizinsky, 2010; Giannakopoulou et al., 2021). The unexpectedly lower East Asian rates could relate to dietary and cultural factors such as self-construal, which, alongside genetic factors, have also been offered as explanations for why East Asians respond differently to antidepressants (Chen et al., 2009; Takahashi et al., 2021; Marazziti et al., 2021). Another cultural variation is that negative emotions elevate interleukin-6—a depression marker—more in Americans than in Japanese (Miyamoto et al., 2013; Ting et al., 2020). Additionally, while BMI (body mass index) correlates positively with depression in the West, the relationship often reverses in East Asia—challenging the universality of energy dysregulation models (Giannakopoulou et al., 2021; O’Loughlin et al., 2023).

As should now be clear, biological differences are rarely independent of culture and material conditions. For instance, inverse BMI-depression correlations are stronger for rural than urban Chinese, null for East Asians in the West and may be positive for Chinese women influenced by thin ideals (O’Loughlin et al., 2023). Intra-cultural variation matters too. Chinese individuals sometimes integrate their mothers into their self-concepts (e.g., Wang et al., 2012), and filial piety negatively correlates with depression for them (Ng & Bhugra, 2008; also see Sun & Ryder, 2016). While some cite stigma-related underreporting, we have seen that unmet obligations (e.g., to family) can heighten stigma and depression in East Asia. So, one could also argue that even with some underreporting, rates are lower than would otherwise be expected.

Here, it is worth remembering that priming Chinese participants towards individualism exacerbates their physical and psychological pain (Wang et al., 2014; Zhang et al., 2017). Among Westerners, too, and possibly Easterners as well, there is evidence depression can increase self-focused attention (distinct from self-awareness, i.e., sensitivity to one’s impact on others), which predicts chronic negative emotion and correlates with first-person singular pronoun use (Brockmeyer et al., 2015; Duval & Wicklund, 1972; Ingram, 1990; McCullough, 2000, 2003; Mor & Winquist, 2002; Sun & Ryder, 2016). A contrast is Csikszentmihalyi’s (1975) flow psychology, defined as the “merging of action and awareness” (p. 45) that arises through skillful activity, such as playing music or sports. Though individuals retain feelings of control, they undergo “ego-less” experiences paralleling certain Buddhist

mindfulness practices (p. 50), the overall result being enhanced well-being, according to Csikszentmihalyi.

However, the argument is not that depression or individualism is absent outside the West. Nor is it that individualism causes depression. Rather, depression may be more culturally specific—and thus nominalist—than the *DSM* suggests, not only having differing biomarkers but also ranging self-construal-dependent phenomenologies. In Tanaka-Matsumi and Marsella's (1976) study, 43.2% of white Americans associated depression with “sad,” indicating inward focus, while *yuutsu*—a Japanese depression analogue—frequently evoked “rain” (35.3%), an atmospheric term. Americans favored isolation-related words such as “lonely” (21.2%) and “alone” (4.1%), whereas “solitude” appeared less frequently among Japanese (8%), suggesting atomistic self-awareness is more central to American experiences. Japanese also used more somatic descriptors—“disease” (5.3%), “tiredness” (4.7%), “headache” (4.7%), and “fatigue” (4%)—compared to only one somatic term from Americans (“tired,” 4.7%).

Cross-cultural research similarly shows that allegedly depressed Koreans note epigastric burning, while Chinese complain of body aches, digestive issues, menstrual cramps, painful intercourse, pounding hearts and short breath, with equatorial Africans reporting peppery head sensations (Kirmayer, 2001; Li et al., 2023). The *DSM-IV* (APA, 1994, p. 324) notes that “complaints of ‘nerves’ and headaches (in Latino and Mediterranean cultures)” or “‘imbalance’ (in Chinese and Asian cultures)” may manifest instead of sadness. But are such variations culturally inflected presentations of a single disorder? A Zimbabwean's letter to the editors of the *British Journal of Psychiatry* expresses a contrary opinion: that depression may sometimes have “no exact equivalent in non-Western cultures, not least because these do not share a Western ethnopsychology that defines ‘emotion’ as internal, often biological, unintentioned, distinct from cognition, and a feature of individuals rather than situations” (Xenitidis & Campbell, 2017, p. 52).

Despite claims that its categories are heuristics, the *DSM*'s language contributes to the idea of genuine but hidden psychiatric conditions, reinforcing an essentialized (natural kinds) view of mental illness (Hyman, 2010). The mindset helps explain how medical essentialists might dismiss Japan's comparatively low depression rates—arguing the condition is simply underdiagnosed, given Japan's high suicide rates, which declined after antidepressants were introduced in the late 1990s. A perspective like this is part and parcel to self-illness ambiguity, where sufferers believe hidden, underlying mechanisms, invisible even to themselves, control their actions.

What weighs against assuming depression is hidden and underdiagnosed in Japan? For one, antidepressants entered the market concurrently with government launched anti-suicide campaigns, plus pharmaceutical advertising boosted awareness (Nakao et al., 2008; Ihara, 2012). Yet how much these drugs reduced suicides remains unclear. Industry-funded ghostwriters have skewed trial results (Hengartner, 2021, Ch. 4), prompting a 2008 US congressional investigation. Kirsch (2014) adds that trials often count symptom relief—like improved sleep—as a success, even if mood or coping remains unchanged; that half of trials show no benefits but go unpublished; that participants often guess whether they are receiving real or placebo treatments; and that just two positive trials suffice for FDA approval, regardless

of how many failed. When unpublished data is included, he argues, antidepressants barely outperform placebos. It is also inconsistent to accept drug-trial depression scales as valid in the West yet dismiss them when they show inconveniently low Japanese rates—especially in a country that leads in life expectancy. Meanwhile, US antidepressant use has surged since 2000 (Luo et al., 2020), even as suicide rates rose nearly twice as much as they declined in Japan between 2000 and 2019 (Ilic & Ilic, 2022). Suicides in the two nations essentially converged in 2024 (Weaver et al., 2025), but with Japanese depression rates almost unchanged over the decades.⁶

Depression—or a similar condition—may contribute to some suicides in Japan, but other factors are involved. Dewey (1920/1929), who spent several years in East Asia, observed that dense populations and limited privacy scaffolded a public sense of self, still fostered today by practices like awarding high shoeboxes to top students (Crippen, 2025b). In such contexts, where individual failures are highly visible and sometimes dishonoring to families and communities, social missteps can feel like public nudity—fueling “shame culture.” The common individualist–collectivist binary blurs here. At rates higher than Westerners, one study found that East Asian students value class discussions and prefer group work not just for collective experiences but to engage diverse perspectives. This is even while speaking less—driven by a fear of error and a humble concern for others’ time (Crippen, 2025b). In Korea, relational identity runs deep—people say “our husband” instead of “my husband” (Kim, 2021). One interviewee recalled struggling to date a Jewish vegan because she craved a sense of “we” while eating to the point she normally consumes disliked things when with others; yet she also described solitary, competitive study—where failure is personal yet publicly conspicuous, triggering shame. She added that, with so much about oneself made public in her country, people want to keep things hidden. As an example, she pointed to the ubiquitous use of tinted car windows—a tendency that runs parallel to the earlier-cited finding that East Asians are more likely than Westerners to keep their emotions out of sight.⁷

This raises a familiar question: How much does a condition like depression add to our understanding of suicide amid intense social pressures? Shame can certainly lead to despair and suicide, yet the *DSM-5-TR depression* criteria do not mention shame or humiliation. Suicide may also occur without despondency—as a duty—especially in Japan, where some forms have historically carried moral or aesthetic meaning (Targum & Kitanaka, 2012). Shame, melancholic or not, is socially and epistemically grounded—embedded in the world, much like East Asian self-construals and the Japanese analogue to depression, *yuutsu*. Here, self-illness ambiguity may be less common, as distress often stems more from community expectations than a sense of internal pathology. While psychotherapeutic treatment can help, few would dispute that addressing the social context is also advisable.

This uncontroversial point has broad implications: depression and suicide are more common among lower socioeconomic groups and those who feel disadvantaged next to their peers (Jespersen et al., 2025). In such cases—and others like the

⁶ *Ibid.*

⁷ As stated, interviews were part of a larger ongoing ethically approved project.

overworked Japanese man who died by suicide—it is worth asking whether a medical diagnosis is needed to explain despair. One might even argue, perhaps cynically, that labeling such distress as illness shifts blame to the individual and serves to justify a harmful economic system, with productivity as a tacit goal of treatment advocacy.

The earlier mentioned Zimbabwean critic, who wrote the editors of the *British Journal of Psychiatry* (Xenitidis & Campbell, 2017, p. 52), faults the discipline for conflating depression with situational distress, such as that linked to poverty in parts of the Global South. The author also objects to the treatment of “Western mentality and ways of being a person as definitive anywhere.” Yumi’s case suggests a deeper issue: that diagnoses can generate illness. If she internalizes others’ views, her confidence may erode, with mistakes and stigma multiplying. Eventually, she may believe she has a disorder as hidden within, shaping her actions—fomenting self-illness ambiguity. As self-concepts and illness categories blend across cultures, we risk being left with a monolithic mental health model that erases meaningful psychological variation.

7 Conclusion

This article challenged assumptions about both components of “self-illness ambiguity” while exposing conceptual and empirical gaps in psychiatry. Scholars often overlook non-Western views of the self and neglect evidence linking self-focus and individualism to conditions like depression. Central to my position was the selective permeability model, which suggests that environments pose uneven challenges. For example, while AD(H)D may confer cognitive strengths, prevailing norms can turn them into liabilities.

These arguments raise questions: To what extent does a disorder reside within the person, and to what degree does it reflect an environment that selectively burdens certain individuals? My view does not deny the existence of mental illness or the usefulness of *DSM* categories and treatments. But it cautions against automatically concluding that divergent behavior is mostly a product of internal dysfunction, proposing that reframing such assumptions may help reduce confusion between the person and their diagnosis.

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Declarations

Institutional Review Board Statement Data collection for this study was ethically approved by the Institutional Review Board at Pusan National University and followed the principles outlined in the Declaration of Helsinki (1964, revised in 2024).

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