

PART TWO

Clinical Manifestations of Anxiety

The Medicalization of Worry

People in Ho Chi Minh City occasionally joke that they live at 766 Võ Văn Kiệt Street in District 5, the address of the Ho Chi Minh City Psychiatric Hospital (*Bệnh viện Tâm thần Thành phố Hồ Chí Minh*). During my early fieldwork, all roads leading there were covered in a thick layer of dust from the repaving of the surrounding neighborhoods. An environmental safety project funded by the Japanese government had partially dredged the Tàu Hủ Channel that runs in front of the hospital grounds, so winds often brought in the scent of the polluted Saigon River. The unruliness of the hospital's exterior, however, is no match for its interior. Hailing from across southern Vietnam, patients and their family members line up hours before the doors open to secure an appointment and then scramble to find space in waiting rooms, hallways, and staircases while they wait as doctors, nurses, administrators, and security guards expertly weave their way past them.¹ Although it still manages to seem like an out-of-the-way place, as the joke about its address attests, the Ho Chi Minh City Psychiatric Hospital looms large in the public imagination. Indeed, the specter of madness itself is also not far from people's minds. Comments and jokes about others or oneself being crazy (*điên*) are routine in everyday conversation, yet admission of one's own mental health struggles is exceedingly rare.

Perhaps it should not have come as a surprise when Vietnam's National Psychiatric Association made headlines in 2017 by announcing that Vietnam faced a mental health crisis hiding in plain sight. According to their estimates, 16 percent of the population could potentially be diagnosed with some form of mental disorder,² and roughly forty thousand individuals die by suicide every year (Dương Liễu 2017; Liên Châu 2017).³ With steadily rising numbers of patients treated at the main psychiatric hospital, Ho Chi Minh City has the highest rates of mental illness in Vietnam. For example, the prevalence of all anxiety disorders in the city is 6.1 percent, compared with 2.27 percent for the rest of the country. Many psychiatrists told me that large swaths of the population are undiagnosed

and unwell, requiring treatment to reach their full potential. Instead, they either squandered their opportunities or wasted their money on doctors who were treating essentially psychosomatic symptoms. Reflecting the increased economization of mental health, psychiatrists warned that not treating undiagnosed conditions would be more costly than addressing their needs and positioned themselves as critical to the progress of national development. Increased attention to mental health concerns, however, is not limited to health and development experts. One of the biggest changes I have noticed over the course of my research is the growing awareness and even open discussion of mental health, especially among the younger members of Ho Chi Minh City's middle class.

Most people attribute the surge of mental illness in Vietnam to the destabilizing force of rapid economic growth. This linkage of sweeping social transformations and mental health issues is perhaps the most extreme version of the age of anxiety. The master narratives of modernity's emotional fallout typically blame disruptions in traditional social patterns and relationships that once had a protective effect, changes in people's lifestyles, and greater individual and interpersonal uncertainty as society becomes more dynamic for a number of new social problems, not just increased rates of mental illness (Duong et al. 2011). What these accounts by experts and laypersons have in common is the tangential position of mental illness, especially anxiety disorders, in Vietnam's developmental trajectory. However, development is not just a standardized set of economic benchmarks (Escobar 1991), but also entails their social and emotional impacts. As I have argued in the preceding chapters, anxiety plays a critical role in Vietnam's transition to a market economy. The relationship between mental health and developmental imaginaries shapes the lived context of emergent diagnoses and how they rearticulate long-standing notions of health and the good life.

In Ho Chi Minh City's psychiatric hospitals and clinics, imaginaries surrounding chronic anxiety that articulate various ideals of emotion and selfhood take multiple forms. The most dominant of these is the Western biomedical approach that constructs a broad range of emotional distress as a health problem to be treated with medical intervention. While the use of biomedical diagnoses and treatments outside of the West introduces new perspectives through which to address psychiatric disorder as well as understand the self, it also has the potential to create conflicts between competing traditions of mental health care. Imposing Western standards of normative behavior around the world reduces the personal and cultural meanings of suffering to signs of an underlying disease. This makes people more legible to medical institutions that focus on treating individual symptoms at the expense of recognizing community and state-level factors. The spread of biomedical psychiatry is neither uniform nor inevitable. Indeed, the growing acceptance of diagnoses such as generalized anxiety disorder (GAD), major depressive disorder (MDD), and post-traumatic stress disorder (PTSD) in Vietnam does not necessarily mean that biomedical categories are in the process

of replacing preexisting ones. Rather, tensions between competing medical traditions are dynamic, and this chapter presents a portrait of anxiety disorders in Ho Chi Minh City in 2008.

While doctors at the Ho Chi Minh City Psychiatric Hospital usually attribute the various symptoms associated with chronic worry to GAD, their patients identify with a different diagnosis altogether: neurasthenia (*suy nhược thần kinh*, lit. nervous/neurological degeneration).⁴ The diagnosis, along with the related notion of *surmenage* (French for “overwork”), has also been recorded among overseas Vietnamese populations and community health workers in Hà Tây Province in northern Vietnam (Phan and Silove 1997; Cheung and Lin 1997; Hinton et al. 2003, 2007; Niemi et al. 2009). My interlocutors regard neurasthenia as a physiological condition caused by an impaired nervous system. Colloquially, the diagnosis also connotes a wide range of psychopathologies, from a delicate psychological constitution to psychosis (Phan and Silove 1999), but here I focus on its anxiety-related components for comparative purposes. Patients’ and doctors’ medicalizations of anxiety articulate different models of emotion, sentiment, and selfhood in Vietnam. In addition to being a way of enacting obligations of sentiment and moral selfhood, worry is also becoming an emotional obstacle to self-realization.

ANXIOUS IDIOMS OF DISTRESS

Worry-related idioms of distress influence the personal and social meanings of chronic anxiety and treatment seeking (Guarnaccia et al. 2003; Nations et al. 1988), and a proper understanding of them may improve doctor-patient communication and treatment adherence (Hinton and Lewis-Fernandez 2010; Nichter 2010). Complaints of “thinking a lot,” for example, frequently index chronic worry (Hinton et al. 2015; Yarris 2011). Anxiety and anxiety disorders may also manifest somatically, such as *chinta rog* (worry illness) in Bangladesh (Rashid 2007), *el calor* among Salvadoran refugees (Jenkins and Valiente 1994), *nervios* in several Latin American populations (Jenkins and Cofresi 1988; Low 1985), and tinnitus and olfactory panic among Cambodian refugees (Hinton et al. 2004, 2006).

Reflecting a medical cosmology that distinguishes between but does not dichotomize mind and body, Vietnamese descriptions of emotional distress frequently invoke somatic states. Worry is associated with weak spleens, loss of appetite, shallow breathing, and stiff necks⁵ (Phan and Silove 1999). Frequent orthostatic panic attacks, often induced by standing upright, among traumatized Vietnamese refugees stem from associations between dizziness and memories of physical violence, malaria, or seasickness during attempts to escape Vietnam by boat. Symptomatic of a weak heart, dizziness metaphorically evokes distress and disorder (Hinton et al. 2007). The common syndrome of being “hit by the wind” (*bị trúng gió*) refers to a variety of ailments caused by harmful winds entering the pores of bodies weakened by overworry, insomnia, and thinking a lot (Hinton et al.

2003). Furthermore, nerves serve as both an idiom of distress and a folk illness in rural and peri-urban northern Vietnam (Gammeltoft 1999; Niemi et al. 2013).

NEURASTHENIA

One of the most well-known objects of inquiry in the cross-cultural study of mental illness, neurasthenia has long been analyzed as a somatic idiom of distress for socially unsanctioned emotional problems (Kleinman 1982, 1986; Kleinman and Kleinman 1991; Skultans 1995). Taken together, historical and cross-cultural scholarship on the diagnosis highlights the processes of social interaction that organize perception, emotion, and coping responses around what is most at stake for sufferers, their friends and family, and their healers. As originally defined by the neurologist George Beard in *American Nervousness* (1881), neurasthenia is a chronic disease of the nervous system that manifests as a host of psychic and bodily complaints, including exhaustion, memory loss, sleep disturbance, and various aches and pains, and results from the degeneration of nerve tissue due to overuse. Proclaimed a uniquely “American disease,” its popularity among the white upper class was blamed on the pressures of rapid industrialization and urbanization, which took a heavy toll on the swelling numbers of “brain workers” required to maintain the country’s new economy. Thus, it encapsulated prevailing concerns about living too fast and the excessive demands for financial and psychic resources in early twentieth-century America (Lutz 1991; Campbell 2007). As neurasthenia became linked to modernity, the development of a neurasthenic American subject became a simultaneous construction of a modern one (Luthra and Wessely 2004).

Despite the purported Americanness of neurasthenia, the diagnosis spread to Europe and its colonies. Colonial officers in the early twentieth century became wary of the vulnerabilities of their positions, succumbing in near-epidemic proportions to “tropical neurasthenia,” a lethargic state brought on by an inability to adjust to a climate unfamiliar and unsuitable to Europeans. Furthermore, that only whites received this diagnosis reinforced the idea that the malady was reserved exclusively to those deemed sensitive and cultured enough to suffer from it (Anderson 1997). Whereas neurasthenia in the West was associated with the strains of modern life, tropical neurasthenia was blamed on Westerners’ separation from modern civilization and indicated the dangers of administering indigenous populations, thereby emphasizing white civility.

After French officers in colonial Indochina framed tropical neurasthenia as a *malaise de civilisation*, between World Wars I and II, the Vietnamese urban elite began to diagnose themselves as neurasthenic, for two principal reasons. Identifying with neurasthenia suggests an “appropriation from below” in which some Vietnamese individuals characterized themselves as suffering from an excess of civilization (Monnais 2012). The medicalization of anxiety in Vietnam during the 1920s and ’30s was both produced by the desire for evidence of civilized modernity,

viewed by many Vietnamese as necessary to national independence, and indicative of a growing medicalization of Vietnamese society (Edington 2021). However, since then, the status of neurasthenia in Vietnam as proof of one's own enlightened—if overburdened—state of mind has changed dramatically.

MEDICALIZING WORRY: NEURASTHENIA

Readers familiar with the foundational work of Arthur Kleinman and his associates on neurasthenia in China will recognize broad similarities between the Chinese and Vietnamese cases. A Chinese protectorate from the second century BCE until 938 AD, Vietnam retains Sinitic-derived features in several domains. Most relevant here is the somatopsychic orientation of health in which instances of mental illness are interpreted primarily through bodily symptoms. Chinese medicine (*thuốc bắc*, lit. northern medicine) and Vietnamese medicine (*thuốc nam*, lit. southern medicine; or *thuốc ta*, lit. our medicine) share underlying theories of health, illness, and medicine and are commonly practiced alongside biomedicine throughout Vietnam (Craig 2002; Monnais, Thompson, and Wahlberg 2012). However, while Kleinman's study of China during the 1970s and '80s examined the conceptions of neurasthenia shared by doctors and patients alike,⁶ in 2008 only patients at the Ho Chi Minh City Psychiatric Hospital labeled their illness neurasthenia.⁷ Most of the patients in the city's public psychiatric hospitals and clinics have lower- or middle-class backgrounds, as wealthy Ho Chi Minh City residents can afford to be treated at private clinics or international hospitals.

Core symptoms of neurasthenia include insomnia (*mất ngủ*), thinking a lot (*suy nghĩ nhiều*), exhaustion (*mệt mỏi*), and headaches (*nhức đầu*). Patients' prioritization of somatic symptoms shaped the quality and interpretation of the experience of neurasthenia into a primarily physiological one, as opposed to the intrapsychic experience of GAD and MDD in the West. Only one of the patients began her foray into professional treatment for her symptoms at a psychiatric clinic. Rather, most patients suffered for years before being referred to the psychiatric hospital by primary-care physicians. Echoing similar findings among overseas Vietnamese populations (Gold 1992; Hinton et al. 2007), psychologically oriented complaints were rarely volunteered and were presented with less frequency and urgency.⁸ Indeed, doctors resorted to eliciting information from them with direct yes/no questions about chronic worry, depression, suicidal ideation, and hallucinations. After his appointment, Bình, a fifty-two-year-old man, admitted to me that he did not understand his official diagnosis of depression or what it had to do with his symptoms. Suffering from insomnia for years before seeking treatment, he was unable to fall asleep because he could not stop himself from thinking at night. However, Bình quickly glossed over questions about any sources of sadness or anxiety—both of his sons had substance abuse issues—as if they were irrelevant to his health concerns. A causal link was attributed to his

worries, but they were considered a categorically separate domain from the reason for seeking treatment.

Despite the somatopsychic orientation of Vietnamese health beliefs, many patients recognize the psychic basis of their complaints. Regardless, treatment seeking is directed toward physical complaints. The psychological causes of neurasthenia seem detached from many other patients' explanatory models because they were not pathologized. When depressed moods and anxiety were recognized as symptoms, many patients did not tell anybody about them because they were "normal" (*bình thường*) and "natural" (*tự nhiên*). Patients who admitted emotional distress rarely identified a specific cause, instead only mentioning a generally stressful situation. The separation of the psychologically oriented etiology from the physiologically oriented frameworks of symptoms and treatments reflects many of the patients' emphasis on their discrete symptoms over an underlying disorder. For example, often used interchangeably with worrying, thinking a lot is blamed by many patients as one of the main reasons for their loss of sleep. Indeed, doctors often ask patients if they had been thinking a lot when probing for anxiety-related symptoms. Yet patients do not seek treatment for cognitive hyperarousal but rather for insomnia. Many doctors even describe benzodiazepines such as Valium and Xanax as sedatives (*thuốc ngủ*) instead of anxiolytics (*thuốc chống lo âu*) to their patients to convince them to comply with their prescriptions (Tran et al. 2020).

While biomedical models of mental illness dichotomize mind and body, the Vietnamese medical cosmology posits a more intertwined connection between them (Phan and Silove 1999; Nguyễn 2004). For example, the nervous system connects the workings of the body with the physical environment and conveys feelings such as stress or sadness. Understandings of how *strés* operates have been mapped onto existing beliefs about worry's impact on the nervous system. However, *strés* is mostly used in reference to the problems of modern life and does not carry the moral valence of worry. The nerves (*dây thần kinh*) themselves are a network of fibers that spread outward from the brain and are required to control one's own body and behavior (Craig 2002). Nervousness or tension (*căng thẳng*) implies nerves stretched to a breaking point (Hinton et al. 2003). Nerves may be compromised by environmental factors (e.g., sudden temperature or wind fluctuations) and by dwelling on distressing matters. Furthermore, descriptions of psychiatric illnesses in Vietnamese medical texts often invoke physical ones (Phan, Steel, and Silove 2004). Phượng, a fifty-seven-year-old inpatient at the Central Psychiatric Hospital II in nearby Biên Hòa, regarded her depression merely as a symptom of neurasthenia, not as her primary diagnosis. She reported that before she became ill she could produce tears when she cried, which would alleviate the felt experience of sadness. However, she had since lost the ability to cry and could only fixate on troubling matters without recourse to the solace provided by crying. Phượng's daughter, who was visiting her, added that Phượng seldom laughed,

another marked change. Hence, her chronic anhedonia was interpreted as a “broken” ability to laugh or cry.

Notions of health in Vietnam are explicitly related to strength, emphasizing an internal and stable source of energy and the ability to cope with the everyday stresses of work and a changing environment (Craig 2002). Descriptions of being drained of strength (*hết sức*) imply a finite amount of energy that may or may not be replaced (Hinton et al. 2003). By noting that they were “tired inside the body” (*mệt trong người*), several patients specified that they were exhausted from an internal source instead of from physical activity. Strong nerves, in particular, are associated with vitality, determination, and intelligence—qualities necessary to the fulfillment of family and work obligations (Craig 2002). Conversely, weak nerves put people at risk for a range of maladies, from mild headaches to insanity. Sometimes regarded as a milder version of neurasthenia, the folk illness of nerves (*bệnh thần kinh*) compromises people’s capacity to meet their obligations (Gammeltoft 1999). According to the ideal of strong nerves, “healthy individual bodies know how to behave and position themselves socially” (Gammeltoft 1999, 144).

Given the barrage of reasons for their complaints, patients worried about being unable to replenish their energy, strength, and health. For example, Hạnh, a forty-four-year-old marketplace vendor, had a bad fall two years prior to seeking treatment at the psychiatric hospital. The resulting spinal injury forced her, on doctor’s orders, to lie down for most of the day for nearly two months. During this time, fears of permanent paralysis led to heart palpitations that continued after her back recovered. She found sleep unrestful, even after sleeping ten hours. These complaints were deemed nonthreatening by a number of cardiologists in Ho Chi Minh City, one of whom told her that her symptoms were merely “neurasthenia of the heart” (*suy nhược thần kinh tim*) and referred her to the psychiatric hospital. That the heart (*tim*, Vietnamese; *tâm*, Sino-Vietnamese) is the traditional locus of the psyche (*tâm lý*, lit. heart and reason) compounded Hạnh’s fears of becoming mentally compromised. Physical strength is correlated with an emotional strength that is characterized by resilience in the face of difficulties. Hạnh’s hopes focused on regaining the ability to do her work “normally” again, a matter not just of economic productivity and survival but of proper morality as well.

Because moral personhood in Vietnam is enacted through the performance of gendered social roles, many patients like Hạnh describe their exhaustion and weakness in terms of being unable to perform formerly simple activities that are crucial to successful home and work lives. When asked what measures they took to relax, women reported doing household chores to divert themselves from worrisome thoughts.⁹ (Conversely, men often resorted to watching TV, reading newspapers, or drinking alcohol as a distraction.) Performing domestic affairs increases women’s productivity and contributions to the family but perhaps elides the personal significance and implications of their feelings. Complaints and hopes for recovery are couched in an idiom of social obligations, communicating not only

the severity of their symptoms but also their moral standing. Women's symptoms, in particular, are thus inextricable from the gendered emotional labor necessary for families to function properly.

Hạnh's continued concerns over threats of paralysis, restless sleep, and heart palpitations compounded her other worries, including a husband prone to gambling and two feckless adult sons. Despite receiving little comfort or support from them, she continued working long hours in the marketplace to fulfill the sentimental obligations of a wife and mother. Worries about her own health were couched in concerns and disappointments with regard to her family life. Hạnh's husband told her she was worrying needlessly, and I suspected she would agree with this. However, the inability to control her worry and thought processes is what was socially expected of her. Frequent worriers are seen as people who accept the responsibility to be concerned for others and to work to ensure their well-being. For Hạnh, worry is less a symptom or negative coping style, as it is framed within biomedical psychiatry, than a burden that defines her place in the family.

Although neurasthenia diminishes patients' abilities to perform their responsibilities toward their loved ones, the diagnosis still lends them social and moral legitimacy because it is proof of how much they endure for others. Moreover, the emphasis on physical symptoms allows patients to avoid the stigma attached to mental illnesses by legitimizing bodily expressions of emotional distress. Even if aware of anxious or depressive moods, patients may rationalize or hide their emotional problems, given that a person's virtue during periods of suffering is assessed on heroic stoicism. As an ethical practice, endurance without complaint is a form of sacrificing for others that maintains a sociomoral order. This is a conscious decision that patients make, but it also happens through the imagined encouragement or plight of loved ones motivating them to persevere (Gammeltoft 2021). Patients in their twenties and thirties frequently cite caring for their young children as both a cause of anxiety and the reason they did not give up. For Hạnh and Binh, whose grown children did not fulfill their moral duty to reciprocate care for their parents as they got older, this motivation itself must have been a source of strain.

Almost all of the interviewees' ideal course of treatment involved pharmaceuticals. Stemming from the diverse array of tonics and herbal remedies used in Vietnamese and Chinese medicine, treatment preferences emphasize medications for a variety of ailments. Biomedicine is understood to alleviate symptoms but does not cure an illness or address its underlying causes. Moreover, it has powerful short-term efficacy but also comes with more adverse drug reactions than Vietnamese or Chinese medicine (Craig 2002). Thus, recourse to psychopharmaceuticals is seen as an acceptable short-term treatment strategy. That many psychoactive drugs are intended for long-term use undermines adherence to them (Tran 2020).

However, patients recognized that neurasthenia is rooted in social and financial difficulties. Different circumstances would resolve their complaints, and most did not seek out psychiatric care expecting anything other than short-term relief

for their physical symptoms. Patients accepted that medication would not remove the stressors that caused and exacerbated their symptoms, in part because there was no expectation that those parts of their lives were under the domain of medical knowledge or mental health. Many had long been modifying their symptoms with prescription medications, supplements, and herbal tonics. These drugs are not aimed at directly transforming the self but instead at supporting it. Indeed, they allow patients to avoid the intense scrutiny of one's own feelings and behaviors within psychotherapy while maintaining their social and moral models of selfhood. That is, patients did not seek pharmaceuticals to mitigate their anxiety. Rather, they wanted medications to reduce their headaches, exhaustion, and insomnia enough that they could worry more, not less.

PSYCHOLOGIZING WORRY: GENERALIZED ANXIETY DISORDER

The Ho Chi Minh City Psychiatric Hospital's outpatient clinic is largely staffed with medical residents eager to put their training into practice and prove their worth as doctors. Many lament the lack of funding for psychiatric services compared to that for other medical specialties in Vietnam, due to pervasive attitudes that psychiatry is more quackery than science. Others had patients who trusted the advice of family members or neighbors more than their own doctors.¹⁰ One strategy of establishing doctors' expertise over patients is discrediting patients' explanatory models. Most doctors at the outpatient clinic were surprised to discover how many of their patients endorsed a diagnosis of neurasthenia and generally dismissed it as a simple problem of health illiteracy. Even common terms for neurasthenia among patients, *suy nghĩ thần kinh* (nervous thinking) and *suy yếu thần kinh* (nervous weakness), were indicative of the extent of the nationwide lack of proper education about psychiatry because these were, according to one resident, not "real words." At best, in this view, patients merely misspoke or misremembered the proper term. Upon learning of patients' identification with neurasthenia, Dr. Quang, thirty-six, segued into a discussion of how rural patients attributed psychiatric problems to ghosts and resorted to herbal remedies or amulets before consulting a physician. That he implicitly grouped the diagnosis with spirit possession and other forms of Vietnamese "superstition" is ironic, since neurasthenia is an American invention. Once embodied as evidence of civilized modernity in Vietnam, neurasthenia has become proof of people's backwardness.

Cross-cultural studies on the tension between biomedical practitioners' and patients' understandings of sickness often frame it as the difference between a system of knowledge that is Western, rational, and scientific and one that is local, meaningful, and symbolic. However, although patient's models of neurasthenia are influenced by Vietnamese medical beliefs, this dichotomy is not applicable here, since both GAD and neurasthenia have biomedical origins. Rather, the

primary difference between how patients' symptoms are understood lies not just in the medicalization of worry but also in its psychologization, which Yang (2013, 294) defines as "managing socioeconomic issues in psychological terms." Cartesian models of selfhood posit an individual's private thoughts and feelings as the locus of personal identity (Tran 2017). Moreover, that the only three patients (one woman and two men) in the study who endorsed their official diagnoses of MDD or GAD are in their twenties reflects generational changes in ways of defining the self. However, that their explanatory models did not differ markedly from explanatory models of neurasthenia suggests that these diagnoses are not mutually exclusive for patients. The cultivation of emotional awareness and reflexivity reflects the imperative found in many neoliberalizing economies to encourage personal responsibility and self-management (Zhang 2014; Yang 2014). This project of self-realization assumes that its emancipatory potential comes from exercising individual agency and choice.

However, these undertakings are aimed most directly at Ho Chi Minh City's middle and upper classes. GAD operates on a liberal theory of emotion as something that individuals can possess and therefore control. Both doctors and patients medicalize anxiety, but only the former casts it in a self-reflexively psychologistic register. In contrast to the notions of sentiment that frame worry as a social obligation that individuals must endure, doctors' models of emotion cast worry as personal feeling that individuals must learn to manage. Furthermore, within biomedical psychiatric discourse, individuals who are more attuned to themselves are supposedly better able to create "emotionally democratic" relationships and be independent enough to help themselves and others (Furedi 2004). By highlighting emotion as the crux of patients' illness experience, GAD invites patients to consider their feelings, their causes, and their consequences with the self at the center of their own analysis.

Doctors told me that one of their main tasks is to properly educate patients about their illness. However, most of their efforts to do so are directed at younger and middle-class patients who, they believe, are capable of understanding the diagnosis. In order to properly medicalize their suffering, patients would need to frame their symptoms as underlying GAD and to understand their distress in terms of their own emotions so that they could address the conditions in their lives that led to chronic anxiety. Doctors assumed that with the proper knowledge and tools, patients could properly transform themselves into self-aware and self-sufficient individuals. For example, after finishing a diagnostic interview, Dr. Hùng continued making typical small talk before asking a patient in her twenties what she wanted out of life. She told him that she didn't know repeatedly, until he tried a new strategy. Dr. Hùng chided her for not knowing what she wanted. "How could you not know? It's simple!" He told her she needed to take a step back from her situation and figure out what she wanted. To this she responded, "I don't know how." The transition from "I don't know" to "I don't know how"

is revealing: the former is a relatively simple declaration—an admission that the patient did not have a piece of information—but the latter is focused inwardly and highlights a deficiency not just of knowledge but of the self. What brings it about is the doctor's invocation of a new technique of the self: to search her feelings for the answer.

However, within contemporary biomedical psychiatry, patients are increasingly not the experts of their own emotions (Furedi 2004). Often prescribing benzodiazepines or serotonergic antidepressants for GAD and MDD, some doctors at the outpatient clinic occasionally advise patients to seek the counseling services upstairs from the outpatient clinic, where they would be encouraged to engage in further self-analysis. Others, however, dismissed psychotherapy as “just talking” (*nói chuyện thôi*) to their patients. According to both psychiatrists and psychotherapists, patients with an intimate understanding of their interior lives are more able to control the self. Stressors as disparate as household or workplace conflicts are addressed through a meticulous reflection of individual motivations and reactions. Both doctors and counselors assumed that patients' emotional issues are always present, if latent; and doctors assured me that rates of psychosomatization (*tâm thể hóa*) throughout the country were high and that nonpsychiatric hospitals were needlessly clogged with people who actually needed psychiatric care. (No official statistics, however, are available to substantiate their claims.) For them, the core of patients' illness experience is defined largely by its emotional qualities.

However, doctors do allow patients' socioeconomic circumstances to guide the diagnostic interview, despite GAD's diagnostic criteria. In its earliest forms in the *DSM-III*, GAD could be applied to anyone suffering from persistent anxiety for a given period because the criteria did not require that the anxiety be disproportionate in intensity to its cause (Horwitz and Wakefield 2012). Its later iterations require that anxieties not be rooted to a situational reason. That is, anxiety is pathological only if it is deemed “for no good reason.” While insisting to me that GAD could be the result of any number of causes regardless of their validity, doctors explicitly honed in on potential causes to hasten the process. For example, questions about marital status or the age of patients' children served as proxies for worries related to spousal conflicts or school tuition, respectively. These inquiries recognize and legitimize patients' refusal to disentangle worry from its social context. One of the most common criticisms of biomedical psychiatry is that it medicalizes people's suffering and ignores the experiential richness of their illness. Indeed, the rise of psychopharmaceuticals over other psychotherapeutic measures as a primary form of treatment is often associated with an emphasis on biological processes over a rich network of meanings used in the healing process. However, in the clinical encounters at the outpatient clinic, the doctors advocate complex understandings of the illness experience that draw from patients' personal lives and social contexts; it is the patients who medicalize their illness in a manner that minimizes the significance of their feelings.

CONCLUSION

While biomedical frameworks of anxiety and anxiety disorders assume their universality (Hinton and Good 2009; Horwitz and Wakefield 2012), attending to their sociocultural and political-economic contexts provides a more nuanced conceptualization of normative and pathological forms of anxiety. The notions of worry, weakness, and health that are expressed in the explanatory model of neurasthenia shape the experience and interpretation of anxiety by relating moral selfhood to distress and disorder. Conceptualizing worry through the lens of sentiment or emotion and as neurasthenia or GAD gives patients and doctors, respectively, different models of and possibilities for the self. Doctors assume that redefining selfhood in emotive terms is a more accurate mode of self-understanding than one defined by relations of sentiment. According to them, accepting the diagnosis of GAD better equips patients to control their emotions and themselves, a purportedly empowering step toward improving their lives. In doing so, they are freed from the constraints of their sentimental ties and transformed into modern subjects (Rose 2006). However, as articulated in clinical settings, these powers of the self are contradicted by the ways the self is marked by vulnerability. When the trials of everyday life take their toll and, in turn, are psychologized and pathologized by biomedical discourses, the emotive self is constructed as a source of power that is inherently vulnerable—a vulnerability that increasingly can be addressed only by biomedical expertise (Illouz 2008).

Although doctors dichotomized GAD as modern and neurasthenia as backwards, patients' understandings of neurasthenia and GAD are not mutually exclusive. Many patients are indeed aware of and want to manage their emotions and their selves, but do so for the purposes of maintaining their own moral integrity and sentimental bonds to others. As distinct yet complementary diagnoses, neurasthenia and GAD complicate notions that Ho Chi Minh City's "age of anxiety" is the result of modernist narratives of progress. For many patients, neurasthenia is more meaningful than GAD because the treatment pertains to their model of disease. Emotional problems are not considered a medical domain, let alone something to discuss with a doctor. Because the primary sources of worry are deemed unresolvable, treating neurasthenia is a way to at least reduce the suffering of patients who are willing to endure some of it. Anxiety itself is too closely intertwined with its causes to be treated or even medicalized and pathologized to begin with. Thus, it is not a symptom of mental illness but an appropriate response to difficult circumstances. In the context of neurasthenia, worry cannot be fixed by medication or self-work because it is knitted into structured hierarchies, relations, and obligations. While the proximate cause of neurasthenia is related to depleted nerves, its ultimate cause is attributed by patients to social conditions, reflecting an approach to psychiatry found throughout East Asia that emphasizes intrapersonal factors less than biomedical ones (Borovoy 2005; Kitanaka 2012; Ma 2012).

Instead of seeking agency in an individuated selfhood, patients draw on a moral discourse of sentiment to frame neurasthenia as a testament to their care and concern for others. Lee (2011) argues that contemporary biomedical diagnoses replaced neurasthenia as a diagnostic entity in China because explicit emotional expression has become more socially acceptable; in this era of “emotional liberalization,” people find it easier to express their suffering in the psychologically oriented idiom of depression. However, among the lower-class patients I spoke to at the Ho Chi Minh City Psychiatric Hospital, the very conceptualization of emotion, not its expression, prevented them from readily embracing GAD. Their doctors advocated broad mental health outreach, especially in rural areas, to improve biomedical literacy and correct patient perspectives on psychiatric diagnoses. On a case-by-case basis, however, they rarely explained GAD to lower-class patients and instead stressed the importance of drug compliance. After all, most of the patients were more keen to discuss their medications than their emotional problems. However, this shared focus on pharmaceuticals allowed patients to bypass the self-analysis that the doctors theoretically endorsed. What the doctors did not seem to understand is that the widespread acceptance of GAD as a diagnosis requires changing not just how patients understand anxiety disorders, but also how they understand anxiety itself.

Võ Văn Kiệt Street is now a six-lane highway, making the Ho Chi Minh City Psychiatric Hospital a lot easier to access. Much-needed renovations of the building have also been completed, most notably the removal of the inpatient ward’s iron bars, a legacy of the hospital’s former use as a colonial prison. Changes have not been limited to the hospital’s material structure and surroundings. When I returned for follow-up research less than a decade later, not a single patient mentioned neurasthenia (Tran et al. 2020). Instead, they spoke of GAD and MDD. Any death knells for neurasthenia in Vietnam, however, are likely premature, as the famously protean diagnosis has long been readily adapted to address new sources and forms of modernity’s ailments (Bhola and Chaturvedi 2020). Regardless, presuming that the turn toward more contemporary biomedical diagnoses goes beyond a simple terminological update, this shift implies that a broad reconfiguration of the self is under way for many Ho Chi Minh City residents.