

**A COLD OF THE HEART:
JAPAN STRIVES TO NORMALIZE DEPRESSION**

by

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To my parents, with gratitude.

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In 1999, the Japanese government began approving the use of SSRIs, those antidepressant medications including Prozac, Zoloft and Paxil that had years earlier triggered the “Prozac Revolution” in the United States. Before then, depression was not commonly diagnosed in Japan, and it was argued that the infrequency was due to cultural factors. Since 1999, however, rates of diagnosis have surged and depression has garnered increasing attention in the popular media. As a result, the mainstream conception of depression is shifting from that of a serious mental illness affecting a small number of individuals to a less severe condition from which virtually anyone can suffer. In short, depression is becoming “normalized.”

Based on 18 months of ethnographic fieldwork in clinical settings in Tokyo from 2001 to 2003, this dissertation argues that Japan is “fertile ground” for the normalization of depression and that depression is increasingly resonating because of its ability to encapsulate the pressures and insecurity that are dominating the lives of many individuals. This normalization represents a medicalized response to a variety of novel stresses – especially layoffs, financial insecurity, and overwork – that many citizens are facing in the new millennium, with many of these stresses stemming from Japan’s ongoing economic restructuring. Depression is emerging as a means of discussing the impact of these stresses on the lives of working adults, especially men. The

increasing focus on depression, therefore, represents changes in social experience and the increasing recognition of those changes.

By showing the degree to which the emerging understandings of depression in Japan are embedded in the socio-economic context and by comparing Japan's "depression boom" with America's Prozac Revolution, this dissertation examines depression's capacity to operate as an idiom of distress within which modes of personal suffering are imbricated with wider socio-economic forces.

TABLE OF CONTENTS

<u>LIST OF FIGURES</u>	x
<u>LIST OF TABLES</u>	xi
<u>ACKNOWLEDGMENTS</u>	xii
<u>I. JAPAN BECOMES DEPRESSED</u>	1
<u>A. QUESTIONS FROM AMERICA’S PROZAC REVOLUTION</u>	6
<u>B. THE UNIQUENESS OF JAPANESE MENTAL HEALTH CARE?</u>	9
<u>C. MEDICALIZATION</u>	12
<u>D. THE HISTORICAL MOMENT</u>	16
<u>1. Transitions</u>	17
<u>2. Continuities</u>	20
<u>E. JAPAN’S “DEPRESSION BOOM” VS. AMERICA’S “PROZAC REVOLUTION”</u>	22
<u>F. CONCLUSIONS</u>	25
<u>G. METHODS, DATA, AND PRESENTATION</u>	26
<u>II. THEORIES OF SUFFERING AND DISTRESS</u>	30
<u>A. THEORIES OF SUFFERING</u>	30
<u>1. Biomedical vs. Sociological Approaches</u>	32
<u>2. Social Suffering</u>	33
<u>B. DEFINING “DEPRESSION” – DSM AND ICD</u>	38
<u>C. LANGUAGE AND THE POLITICS OF “DISORDER”</u>	41
<u>D. MODELS OF DEPRESSION</u>	44
<u>E. IDIOMS OF DISTRESS & THE VALIDITY OF THE INTERPRETIVE APPROACH</u>	47
<u>F. PROZAC ENTERS THE PICTURE</u>	52
<u>G. STIGMA</u>	55
<u>H. DISRUPTIONS</u>	61
<u>I. DOMESTICATION</u>	63
<u>J. CONCLUSION</u>	66
<u>III. HISTORY OF JAPANESE MENTAL HEALTH CARE</u>	68
<u>A. ANCIENT PERIODS - TREATMENT AND CHARITY</u>	68
<u>B. EDO PERIOD 1600-1868 - SPIRITUAL AND HERBAL THERAPIES</u>	70
<u>C. MEIJI & PREWAR ERAS 1868-1945 – WESTERN MEDICINE & CONFINEMENT</u>	72
<u>D. MORITA THERAPY</u>	77
<u>E. NAIKAN THERAPY</u>	83
<u>F. FREUD, I.E., THE LACK THEREOF</u>	87
<u>G. POSTWAR PSYCHIATRY & BEYOND – INSTITUTIONALIZATION</u>	93

<u>H. QUESTIONING THE CRITICS – A DEEPER LOOK AT INSTITUTIONALIZATION</u>	99
<u>I. IN THE SHADOW OF KANPO – PATTERNS IN JAPANESE PHARMACOLOGY</u>	103
<u>J. KANPO</u>	105
<u>K. CONCLUSION</u>	111
<u>IV. STOICISM AND SADNESS</u>	116
<u>A. KEY WORDS</u>	117
<u>B. GAMAN</u>	118
<u>C. SEISHIN</u>	121
<u>D. AWARE</u>	126
<u>E. CONCLUSION</u>	129
<u>V. STRESS SOCIETY</u>	134
<u>A. POSTWAR SECURITY AND ITS DEMISE</u>	134
<u>B. THE LAYOFF</u>	138
<u>C. SUICIDE</u>	145
<u>D. KAROUSHI</u>	153
<u>VI. WARD AND CLINIC</u>	157
<u>A. CASE STUDY INTERVIEW</u>	158
<u>B. MR. KAN</u>	171
<u>C. THE WARD</u>	173
<u>D. THE BOXER</u>	178
<u>E. INPATIENT TREATMENT</u>	182
<u>F. THE OUTPATIENT CLINIC</u>	185
<u>VII. PATIENTS: IN THEIR OWN WORDS</u>	197
<u>A. MRS. ICHI</u>	201
<u>B. MRS. NI</u>	205
<u>C. MR. SAN</u>	211
<u>D. MR. YON</u>	217
<u>E. MR. GO</u>	226
<u>F. CONCLUSION</u>	232
<u>VIII. PROGRESSIVE CLINICIANS</u>	237
<u>A. DR. UTA - PSYCHIATRIST</u>	239
<u>B. DR. YUTAKA ONO - PSYCHIATRIST</u>	245
<u>C. PERSPECTIVES FROM CLINICAL PSYCHOLOGY</u>	261
<u>D. DR. AKA - CLINICAL PSYCHOLOGIST</u>	265
<u>E. MR. ANDREW GRIMES - COUNSELOR</u>	274
<u>F. CONCLUSION</u>	282
<u>IX. IMAGES AND DISCOURSES</u>	285
<u>A. NEW WORDS</u>	288
<u>1. “Schizophrenia”</u>	289
<u>2. “A Cold of the Heart”</u>	291
<u>3. “Counselor”</u>	293

<u>B. PSYCHO-DOCTOR</u>	297
<u>C. UTU-NET</u>	304
<u>D. TELEVISION COMMERCIAL</u>	317
<u>E. CONCLUSION</u>	329
<u>X. CONCLUSION</u>	335
<u>BIBLIOGRAPHY</u>	346

LIST OF FIGURES

<u>Figure 1</u>	Let's Go to the Mental Clinic! (Keio OB Psychiatry Research Group, 1996)	1
<u>Figure 2</u>	Souma Incident. Woodblock by Kokunimasu, printed 1893. [Image from Okuda Yasuo's Shisetsu: Matsuzawa byouinshi 1879-1980. Iwasaki Gakujutsu Publishers, 1981]	74
<u>Figure 3</u>	Number of Psychiatric Beds - International Comparison. (Japanese Ministry of Health, Labor and Welfare, 2001)	95
<u>Figure 4</u>	Number of Psychiatric Beds - International Comparison - Japan Added. (Japanese Ministry of Health, Labor and Welfare, 2001)	96
<u>Figure 5</u>	PsychoDoctor [DVD cover]. (copyright Nippon Television Network, 2002)	297
<u>Figure 6</u>	Case 1: 40 year old male. (copyright Utu-Net Committee, 2005)	305
<u>Figure 7</u>	Case 2: 32 year old male. (copyright Utu-Net Committee 2005)	307
<u>Figure 8</u>	Case 3: 28 year old female. (copyright Utu-Net Committee, 2005)	309
<u>Figure 9</u>	Case 4: 24 year old female. (copyright Utu-Net Committee, 2005)	311
<u>Figure 10</u>	(copyright GlaxoSmithKline)	317
<u>Figure 11</u>	(copyright GlaxoSmithKline)	318
<u>Figure 12</u>	(copyright GlaxoSmithKline)	319
<u>Figure 13</u>	(copyright GlaxoSmithKline)	320
<u>Figure 14</u>	(copyright GlaxoSmithKline)	321
<u>Figure 15</u>	Aera magazine cover: Shokuba no utsu (Workplace Depression).	329

LIST OF TABLES

Table 1 America's Prozac Revolution vs. Japan's Depression Boom 340

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*Many of our patients have lost their jobs. They're
poor. They have a lot to be depressed about.*

Japanese psychiatrist working in a
blue-collar neighborhood in Tokyo

*Why are Japanese now becoming depressed?
Because of drug companies, of course!! [laughs]*

Japanese psychiatrist

I. JAPAN BECOMES DEPRESSED



Figure 1 Let's Go to the Mental Clinic!
(Keio OB Psychiatry Research Group, 1996)

In the medical section of a Tokyo bookstore, I find a book that exemplifies the current effort to put a new face on Japanese mental health care. The title reads, *Let's Go to the Mental Clinic!* (*Mentaru kurinikku e ikou!*)(Keio OB Psychiatry Research Group 1996)(Figure 1), and the cover features cartoon caricatures of salarymen¹, office ladies and little animals... all very cute. One man is getting dragged by a cow; another is hugging his bunny. One woman is struggling

¹ *sarariiman* - Japanese colloquial term for white-collar worker.

with a phone stuck to her head; a dog taps onto a computer. The images are colorful and charming, yet each character exhibits its own hint of struggle. The man with the briefcase looks confused... the woman holding the book looks tired.

Together, the images convey a commitment both to the recognition of adversity and the promise of lightheartedness. Stressed-out workers can no doubt sympathize with the caricatures' expressions of exhaustion and befuddlement; and the cartoons exhibit a sense of innocent levity that perhaps eases some of the anxiety burdening those readers shopping for expert advice on painfully private questions. After all, the book is about seeking psychiatric care, and so the cover presents a comforting message – one that typifies that found in most of the increasingly visible books on depression in Japan these days. That message is, “Don't be afraid of psychiatry. It's OK to need help. 'Depression' is not a bad word. Life *can* return to normal.”

I encountered *Let's Go to the Mental Clinic!* just a few months into my field research. I had come to Japan in 2001 ready to explore the ramifications of what I thought was a rather odd development: only two years before, the Japanese Ministry of Health, Labor and Welfare had finally started authorizing the use of SSRIs (selective serotonin reuptake inhibitors), which were the wonder drugs for depression that included Prozac, Zoloft, and Paxil (Solvay Corporate Communication 1999). These were the drugs that had launched what later became known in the United States as the “Prozac Revolution” during the 1980s and '90s. Millions of Americans and Europeans had taken SSRIs, and many of those individuals claimed to have improved appreciably as a result. Drug makers had made billions of dollars, psychiatrists had claimed a new and seemingly outstanding tool in their medicinal arsenal, and “Prozac” had become a household word. SSRIs had indeed made their mark. Yet, they had only recently arrived in Japan.

Why it had taken so long? After all, the Japanese are infamous for taking medications, as evidenced most vividly by the fact that Japan is the second largest pharmaceutical market in the world, second only to the United States (Thomas 2001:3; Class 2002). Furthermore, Japan has a top-notch medical system, with universal coverage for all citizens. How, therefore, could a drug that had “revolutionized” American mental health care take so long to come to Japan? This was question number one, and I started the project curious for an answer.

Given that SSRIs were finally there, however, I was also interested in the question of what type of impact they were having on psychiatric treatment and on public discourse about mental health care more broadly. Would the drugs catch the public imagination the way they did in the United States? Would comedians start joking about “happy pills”? Would medical ethicists start cautioning against overmedication? Were the drugs shifting people’s attitudes toward psychiatric medications, i.e. were people who had previously not considered seeking psychiatric treatment now taking a new route? In sum, was a Japanese-style Prozac Revolution already underway, a little late, but thriving in its second debut?

Upon my arrival, I realized that my hunches were on target. SSRIs had sold at an increasing rate each year, and drug makers were confident of even higher sales in the future (Landers 2002). The number of new books being published on depression was rising, and the attention given to depression in popular magazines and newspapers was increasing. There was no doubt that depression was becoming an object of public concern. But interestingly, the drugs themselves were taking a back seat to the illness. Unlike the Prozac Revolution in the United States, the phenomenon in Japan did not seem to be drug-driven. No articles spoke of “happy pills,” and few spoke of neurotransmitters and the correction of chemical imbalances. Instead, the

attention given to depression was centering not on a treatment per se, but on the problem itself, and the discussions often ventured into issues regarding the workplace and overall societal stress. Indeed, a phrase often invoked in these articles and books was one which had come to characterize the times – “Stress Society” (Saito 2002; Totomi 2005; Osugi 2004). Additionally, most of the articles were targeting men, which was interesting given that Western research had long asserted that depression affected women more than men by a ratio of two to one (Niolon).

So, what was going on here? Was this a Prozac Revolution thinly disguised? Was it merely the story of a successful drug entering yet another market? Or, was there a cultural critique in action? Was depression providing a new avenue upon which to discuss the stresses that working people in Japan were increasingly experiencing in the context of Japan’s continuing economic difficulties? Ultimately, was the unfolding story of Japan’s experience with SSRIs looking like a story about drugs, about suffering in its universal sense, or about Japan more pointedly? Perhaps it was all of the above.

This dissertation represents my attempt to assess the current state of affairs regarding the treatment of depression in Japan – to determine whether a Japanese-style Prozac Revolution is underway as a result of the recent introduction of SSRIs, and if so, whether or not it is offering useful points of comparison with that phenomenon experienced in the United States and Western Europe.

In short, I argue that depression is in the midst of becoming “normalized” in Japan. Its definition is shifting from that of a serious mental illness that affects only a small number of individuals to a lighter, less severe condition from which virtually anyone can suffer. Additionally, this normalization represents a medicalized response to the economic stresses that many citizens

are facing as a result of Japan's ongoing economic restructuring – a process now in its second decade. As a concept, depression is emerging as a means of discussing the impact that this restructuring – especially the layoffs, financial insecurity, and overwork that accompany it – are having on the private lives of working adults, especially men. The increasing rate of diagnosing depression, therefore, represents changes in social experience and the increasing recognition of those changes. Many Japanese citizens are experiencing a level of insecurity not seen since the post-war era, and depression is being increasingly applied as a label for this new experience. Spurring the application of the new label has no doubt been the introduction of SSRIs and the concomitant marketing by pharmaceutical manufacturers. However, such marketing alone cannot account for the degree to which depression is resonating in the public sphere. This dissertation argues that Japan is “fertile ground” for the normalization of depression and that depression is increasingly resonating because of its ability to encapsulate the pressures and insecurity that are dominating the lives of many individuals. In short, depression is emerging as a socially-acceptable tableau upon which to talk about personal stress, which is a significant development in a society known for encouraging individuals to maintain a dignified silence during times of private suffering. By showing the degree to which the emerging understandings of depression in Japan are embedded in the socio-economic context and by comparing Japan's “depression boom” with America's Prozac Revolution, this dissertation examines depression's capacity to operate as an idiom of distress within which modes of personal suffering are imbricated with wider socio-economic forces.

A. QUESTIONS FROM AMERICA'S PROZAC REVOLUTION

My interest in this question of a possible Japanese-style Prozac Revolution was inspired by several sources. I was particularly interested in the debates generated by the Prozac Revolution in the United States. As I will explore in chapter two, these debates brought several lines of inquiry together. The first line concerned the potential for over-prescribing SSRIs, especially for people who were not really “sick.” Peter Kramer, in his landmark book, *Listening to Prozac*, coined this phenomenon “cosmetic psychopharmacology,” and he asked whether or not psychiatrists were using SSRIs more to help otherwise normal patients enhance their personalities so they could compete better in the workplace, rather than to treat people who were really suffering with a “real” mental illness (Kramer 1993). Though *Listening to Prozac* came out in 1993, the issue is still being debated today.

A second line of questioning concerned the allegation that pharmaceutical companies were concealing negative information about the efficacy of their drugs. The most vocal criticism along these lines came with Peter Breggin's *Talking Back to Prozac*, in which he asserted that SSRIs had more side-effects than drug manufacturers cared to publicize and that in some cases patients taking the drugs actually experienced an increase in suicidal thinking (Breggin and Breggin 1994). In subsequent books, he also made the case against using SSRIs and other psychiatric drugs on children (Breggin 2000; Breggin 2002). Though he too started these critiques in the early 1990's, he was certainly prescient, for in 2004 New York State brought charges against GlaxoSmithKline, the manufacturer of Paxil, alleging that the company concealed research results showing that Paxil demonstrated either negligible impact (i.e., it performed no better than a placebo) or negative impact on children during test trials, with the worst outcome being an increase in suicidal ideation

(Harris 2004). In short, New York State, along with Breggin and other critics, have accused certain players in the pharmaceutical industry of being selective in their presentation of the data.

A third line of questioning concerns the broader issue of psychiatric labeling. Argued most strenuously by Herb Kutchins and Stuart Kirk in their 1997 book *Making Us Crazy*, critics assert that the psychiatric community and drug makers benefit by labeling an increasingly expanded range of behavior as “disordered” (Kutchins and Kirk 1997). In other words, whereas in times past, we might have considered a state of melancholy, or being down, having the blues, etc., as a normal expression of sadness, the psychiatric community is working to redefine these feelings as illnesses, with the result being an ever-rising number of psychiatric diagnoses. This was also true, according to critics, in terms of diagnosing more women’s behavior than men’s as disordered, in terms of diagnosing homosexuality as a mental illness, and in terms of racism’s operating behind the scenes of many diagnostic categories. Indeed, whereas the diagnostic guideline for psychiatry – the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM) – started out in 1952 as a small book containing 106 categories and 130 pages (APA 1952), today its updated version, DSM-IV-TR 2000, contains 374 categories and 943 pages, and the list continues to grow (APA 2000). For each category added to the list of disorders, so say the critics, psychiatrists and drug makers cash in, and people struggling with otherwise normal life situations – stress, bereavement, loss, failure, being female, being black, etc. – are wrongly labeled as being mentally ill.

Taken together, these three lines of criticism suggest that America’s experience with SSRIs has had a dark side. Though SSRIs have garnered legions of satisfied patients, it is also true that there are questions about antidepressant therapy that still need answers. Are the drugs

as effective as their makers are claiming? Are they safe? Are they being used to mold personalities? If so, what type of personalities are patients aiming for? Are the drugs helping label normal people as mentally ill? If so, what types of normal behaviors are especially vulnerable to re-labeling, and why? Are the drugs being prescribed unequally for men and women, for whites and minorities, for the rich and the not-so-rich? If so, what were the demographic routes through which the drugs are achieving their popularity?

Furthermore, given that most of the people taking these drugs are American, and given that most of the critics of these drugs are American, it seemed plausible that the Prozac Revolution and the questions it generated might suffer from a bit of cultural insularity. Could it be that the Prozac Revolution actually says more about American cultural life in the 1990s than it says about the science of depression?

As an anthropologist, I knew that these questions begged for cross-cultural studies. We needed to look at how SSRIs were faring in societies whose ideas about psychological health differed from those common in the United States. But, when I commenced this project, very few such studies existed.² So, given that SSRIs had finally crossed the Pacific in 1999, given that the questions about America's Prozac Revolution had long been out on the table by then, and given that pharmaceutical companies had high hopes for the Japanese market, I thought that Japan might be an appropriate test case for determining whether America's Prozac Revolution was a local and culture-based phenomenon or whether it was becoming a world phenomenon.

² Though numerous studies examined depression from a cross-cultural perspective, few focused specifically on antidepressant medications.

B. THE UNIQUENESS OF JAPANESE MENTAL HEALTH CARE?

Along with the literature calling America's Prozac Revolution to task, there is a separate line of research that bears on the question of how to assess the cultural side of depression and its treatment. This literature is comparative, and it seeks to pinpoint the particular cultural factors that influence the experience of, diagnosis of, and treatment of mental illness. Doctors in Japan have been interested in this line of research for decades, but it wasn't until the 1970s that they got their most elaborate analysis. It came from a psychiatrist named Takeo Doi. Doi wrote two books – *The Anatomy of Dependence* (Doi 2001) and *The Anatomy of Self* (Doi 1985) – that brought differences between Japanese and American notions of selfhood to the forefront, and these books are still used today in courses on psychological anthropology and on Japanese society. One of Doi's main arguments was that Japanese people had their own unique concepts and emotions regarding the place of the individual in the social context, and that these concepts and emotions differed significantly from their counterparts in the West. Doi added that particularities in this mode of thinking had consequences in terms of the forms of mental health and mental illness found among Japanese people.

Other studies such as David Reynold's *Morita Therapy* continued in this vein of linking culture and psychopathology by examining a form of therapy found almost exclusively in Japan that is based on Zen notions of self-development (Reynolds 1976). Additionally, several scholars over the past 30 years have examined a form of social phobia that appeared to be found almost exclusively in Japan. It is called *taijin kyofushou*, and its importance lies in the fact that sufferers report a fear of embarrassing other people, as opposed to a fear of embarrassing themselves (T. Takahashi 1985; Naisho 1990). Presumably, this so-called "culture bound syndrome" is generated

by the particularities of social life found only in Japan.

In keeping with these interests in notions of self, culturally-appropriate therapies, and culture-bound syndromes, much of the ethnographic literature on the cultural aspects of mental health care in Japan has striven to establish the uniqueness of and influence of the Japanese cultural context. This literature has asserted that Japanese modes of child-rearing, educational practices and philosophies, linguistic conventions, and normative values regarding self-expression have all contributed to a basic cultural profile that gives rise to disorders, prevalence rates, and treatment strategies that differ from those commonly found in the West (Ikuta et al. 1994; Kirmayer 1991; Mann et al. 1992; Nakakuki 1994; Radford et al. 1991). What is important about this literature for this project is that those few scholars who wrote in the 1990s about the curious fact that Japan seemed uninterested in SSRIs suggested that it was precisely these cultural particularities that accounted for the disinterest. They argued that depression was a Western concept that did not resonate within the Japanese context – that depression was simply not very Japanese.³

But there was a problem: if these types of cultural differences contributed to Japan's lack of interest in antidepressant therapies during the 1980s and '90s, then why was Japan now making an about face? Why were SSRIs now selling so well? Why were books like *Let's Go to the Mental Clinic!* becoming popular? Had there been a cultural shift of some kind? Had Japan become psychiatrically Americanized? Had pharmaceutical advertising merely succeeded in piercing through a few cultural barriers? Or, had the literature asserting such cultural-psychopathological links perhaps overstated its case?

³ “Japan is very hesitant about anti-depressant drugs. That is mainly because of the culture.” Statement from Solvay (maker of Luvox) Investor Relations webpage (Solvay S. A. 1998).

Concerning the latter possibility, I think it safe to suggest that many of the bio-medical treatments that work efficaciously around the world do so precisely because the commonalities of human physiology oftentimes transcend the particularities of culture. The Sabin solution, for example, inoculates against polio in the Amazon the same as it does in the Hamptons precisely because the Sabin solution simply inoculates against polio, period. Armed with these types of bio-medical successes around the world, members of the mainstream psychiatric community have striven to distance themselves from the field's psychoanalytical roots and instead ally themselves with their bio-medical colleagues in medicine's other subfields. In so doing, they have asserted that the bio-medical model is the model through which mental illness should be conceptualized, thus challenging the proposition that mental health and mental illness are culturally constructed. Indeed, mainstream psychiatry has sought to demonstrate that people in various cultures suffer from the same basic disorders and that many of the treatments successful in one culture are successful in others.

Not surprisingly, this line of thinking has garnered support among Japanese psychiatrists. In the past fifteen years especially, several Japanese clinicians have conducted research projects designed to pave the way for the application of a single, international, bio-medical set of diagnostic and treatment guidelines. As part of their strategy, they have sought to establish the validity of using Western diagnostic assessment tools on Japanese patients. To do this, clinicians will find a suitable group of patients, give them translated versions of a diagnostic inventory, analyze the answers, then determine any variation in the way that Japanese and Western patients respond (Kitamura et al. 1989; Nakajima et al. 1995; Tseng et al. 1992). Much of this research has pinpointed slight variations in terms of symptom presentation and habits of answering

questions on questionnaires. However, a theme that permeates this research is that by pinpointing these slight differences, then suggesting modifications for these differences, Japanese clinicians can then proceed to use Western diagnostic and treatment regimens without further regard for this question of cultural differences. In short, recent research by Japanese clinicians has sought to undercut the claims made by earlier anthropologists and clinicians about the relevance of culture in the question of how to diagnose and treat psychiatric problems.

C. MEDICALIZATION

This desire by Japanese psychiatrists to import American assessment techniques, and by extension American pharmaceutical therapies, adds an additional layer of complexity to the question of how these new antidepressant medications – SSRIs – are being appropriated in the Japanese cultural context. On the one hand, there is a school of thought, still represented most explicitly by Takeo Doi, that suggests that the Japanese have certain normative values, notions of self, and emotional patterns that differ from those common to the West. As such, mental health care has to be sensitive to these Japanese characteristics. Given that *taijin kyofushou* is still a common diagnosis and a common subject of clinical research in Japan, it is clear that Japanese clinicians themselves realize that, at least to a certain extent, when a new patient enters the room, culture enters too.

At the same time, there is a desire to internationalize. The Japanese psychiatric community sees itself as part of the global psychiatric community, and, as such, it seeks to publish

its research in English, host international conferences, and contribute to the global bio-medical psychiatric enterprise.⁴

What transpires from this local-global tension within the Japanese psychiatric community is a fervent interest in the question of just how “Japanese” Japan’s mental health care system is and should be. Indeed, most of the psychiatrists that I talked with during my two-year fieldwork period were familiar with cross-cultural psychiatric research, and most even knew the names of one or two Americans who specialize in psychiatric anthropology. When I explained my research project to doctors, on a number of occasions they responded with “Oh yes, that sounds like Arthur Kleinman.” And given that Arthur Kleinman, one of the few American psychiatrists with degrees in anthropology, has through his writings articulated the promise and outlined the methods of cross-cultural psychiatric research, it was certainly exhilarating to arrive in the field and discover that many of my informants were already in synch with the goals of “psychiatric anthropology,” the interdisciplinary field that Kleinman, along with his colleagues Byron and Mary-Jo Good and a few other researchers, have worked to establish.

The point here is that many of the Japanese doctors that I interviewed were aware that public understandings of depression were undergoing a shift and that this shift was being driven in no small part by pharmaceutical companies’ desire to promote the drug that had finally been authorized for use there. On top of that, however, they were aware that this shift comprised not just a shift in treatment habits, as, for example, would happen when the sufferer of some rare allergy discovers a new medicine recently-created to target that very allergen. This type of shift

⁴ One major event in this regard took place in August 2002, when the World Psychiatric Association held its international conference for the first time in Asia. The conference was held in Yokohama, Japan, and it attracted approximately 5,000 psychiatrists from around the world.

would entail no re-thinking of values or behaviors. It would just mean a new pill – certainly welcome, but not very complicated.

Shifts in thinking about depression, however, are oftentimes more complex than that, for they can involve a re-thinking of basic attitudes about larger issues. Whenever this type of re-thinking takes place – in which an issue that had beforehand not been conceptualized as a medical issue is now coming to be seen as such – this process is called “medicalization.” In some cases, medicalization is a very good thing. Whereas lepers used to be seen as suffering from a divine curse, we now separate the person from the disease and treat the disease with medications. The condition has been fully medicalized, and treatment has brought relief to millions. Homosexuality, however, is another story. The American Psychiatric Association (APA) used to consider it as a mental disorder, i.e., they had medicalized it. But after intense lobbying by gay rights activists who did not appreciate the notion that their sexual preferences qualified as a disease, the APA voted in the late 1970s to de-medicalize it (Kutchins and Kirk 1997:55-99). Other controversies over which conditions are indeed “medical” conditions continue today. Conditions such as menopause, alcoholism, behavioral addictions (gambling, nymphomania, etc.), attention-deficit disorder, and others continue to challenge our thinking as to the nature of certain behaviors, experiences, and personal characteristics.

Mild to moderate depression is one of these conditions for which interpretations of causation, essence, and even very existence are still debated. Though severe depression seems to be diagnosable around the world according to a single set of criteria, and though the use of antidepressant medications with severely depressed patients has widespread support even among the less-than-diehard proponents of biomedicine, how to handle what psychiatrists call the

“milder” forms of depression is still contentious. What qualifies as “mild depression” to the psychiatrist might qualify to the marriage counselor as a bad marriage, to the psychoanalyst as the lingering effects of abuse, to the economist as an underpaid worker, or to the teacher as a lonely child. How one characterizes a problem and its source determines how one deals with that problem. Critics of bio-medical psychiatry suggest that psychiatry’s singular propensity is to prescribe a pill and in the process gloss over the real problem that the individual is suffering from. Psychiatrists respond, however, saying that the effects of that pill bring the patient to a stable enough state of mind such that he/she is then able to address the underlying issue more effectively.

So, in a Japan that has seen its economy stagnate for over a decade, with layoffs becoming more and more common, with many families becoming mired in debt, with the economic security that two generations of workers after the war struggled to achieve steadily evaporating, with young men opting out of the salaryman lifestyle of their fathers and choosing the *fureetaa* (“free timer”) lifestyle instead, with the hailed national education system suffering from “classroom collapse” and “school refusal syndrome,” and with many of the other problems that the collapse of the post-war economic bubble has brought with it, should it be any wonder that many Japanese find themselves struggling with a sense of loss unlike anything they’ve experienced since the end of the war?

Are the new pills helping?

D. THE HISTORICAL MOMENT

The treatment of depression is undergoing major changes in Japan, and several sources both domestic and international are watching to see how things unfold. In 2004, the New York Times ran an article entitled “Did Antidepressants Depress Japan?” (Shultz 2004). In 2002, the Wall Street Journal ran one entitled “Drug Companies Push Japan to Change View of Depression” (Landers 2002). Articles by Japanese newspapers include such titles as “Depth of Despair” (Karino 2003), “Aggressive Marketing by Drug Companies Giving Antidepressants a Lift” (Japan Times 2003b), and “Psychiatric Care Still Mired in Dark Ages” (Matsubara 2001).

What is clear, therefore, is that depression has come to Japan, that SSRIs are making inroads there, and that drug manufacturers have good reason to be optimistic. What is equally clear is that optimism and economic security for many middle and working class people in Japan have declined steadily since the so-called “bubble economy” burst back in 1990-91, resulting now in a malaise for which a national suicide crisis has become a major symbol.

The drugs, the profits, the recession, and the suicides cannot be separated. They are each coalescing to create the “depression boom” that now characterizes part of the shifting mental health landscape. The first task of this study, therefore, is to describe the current situation and to include therein an analysis of its causes and consequences.

To that end, I will examine the situation via a three-site analysis. The first site consists of the clinical environment, or more specifically, clinical environments. I will describe my observations and experiences in a psychiatric ward and in an outpatient clinic. The second site consists of narratives obtained from one-on-one interviews with clinicians and patients. The third

site consists of images featured in public discourse, namely television, the internet, and print media.

In the course of describing those three sites, I will discuss two groups of factors that I see undergirding the depression boom. The first group includes transitions; the second group includes continuities. In short, I will be arguing that in the process of Japan's "becoming depressed," to borrow a sentiment from the New York Times' article mentioned above, some things are changing whereas other things are staying the same. Both groups of factors, however, are contributing to the primary shift, i.e. the fact that more people are being diagnosed with depression, that more antidepressant medications are being sold, and that there is increasing public concern with what depression is all about.

1. Transitions

The first group – the transitions – operate on five fronts. The first transition concerns the dominant pattern of mental health care. There is now a shift from institutionalization as the dominant model of care to a search for alternative models including outpatient treatment, talk therapy, and other non-institutional models. This transition represents efforts begun long before the introduction of SSRIs, however, namely the efforts of schizophrenic patients and their families to reduce the stigma of mental illness and reform Japan's mental health care system. The shifting attitudes currently underway regarding depression operate within this wider context of shifting attitudes toward mental illness and mental health care more broadly speaking.

The second transition concerns subtle shifts in attitudes toward the expression of negative emotions. Japan has a long history of valuing stoicism both as a moral injunction, as found in

Buddhism, and as an aesthetic sensibility, as found in literary and artistic traditions. But the suicide rate has forced the nation to recognize that the holding-in of negative emotions can go too far, and so one of the goals of progressive clinicians has been to encourage individuals who are struggling with personal problems not to fear the voicing of those problems, even to strangers in the form of doctors and counselors. The shift in treatment strategies that accompanies the legitimation of depression as a psychiatric problem relies on the breaking down of ideas regarding the inappropriateness of expressing these feelings of sadness and stress.

The third transition concerns insecurity. In short, the economic restructuring now extending into its second decade has generated shifts in many of the norms that once governed Japan's corporate culture. Many corporations are having to shift from a seniority system to a meritocracy; the number of personal and corporate bankruptcies is continuing to rise; and layoffs are becoming an object of fear for many middle aged men who are utterly unprepared for the prospect of losing their jobs at the only company they have known. Coming to grips with such insecurity, or, in the case of suicide victims and of "death by overwork" victims, of precisely *not* coming to grips with this insecurity, is a factor at the forefront of the expanding discourse on depression.

The fourth transition concerns medicalization. For years, "depression" did not resonate in Japan because the traits that the international psychiatric community associated with mild to moderate depression were, until the introduction of SSRIs, not commonly viewed in Japan as objects of medical concern. They were viewed more as a matter of character than biology. In keeping with psychiatry's image as a system for hospitalizing people long-term, only the most severe of mental conditions became viewed as true medical problems. The era of Freudianism,

with its emphasis on complexes, reactions, adult manifestations of childhood traumas, unresolved issues, and other “psychological,” as opposed to bio-medical, problems, simply passed Japan by. The result has been a chasm between medical issues and psycho-social issues. But that chasm is now closing, and depression is building a bridge between the two sides.

The fifth transition concerns normalization. Until the introduction of SSRIs, the image of depression was one of a serious mental illness, one that rendered a “normal” person quite abnormal in the public eye. A necessary step in reducing that stigma and paving the way for the expansion of antidepressant therapy has been to soften depression’s image. Pharmaceutical advertising, government-sponsored public awareness campaigns, and publications by progressive doctors and psychologists have all endeavored to redefine depression as a temporary condition that can affect anyone. The most representative image in this regard is the phrase “a cold of the heart” [*kokoro no kaze*]. Mentioned in almost all newspaper articles on depression and stress, “a cold of the heart” encapsulates the psychiatric community’s efforts to de-stigmatize depression and encourage people to view it not as a mark of permanent disability or insanity, but as a condition, much like a cold, that is temporary, mild, treatable, common, and nothing to be ashamed of.

These five transitions, then, comprise processes of change that are contributing to Japan’s “becoming depressed.” They are issues that become visible in all three sites of analysis – clinical settings, patient and clinician narratives, and media representations – and, as such, they comprise “themes” than permeate the various discourses on depression.

2. Continuities

At the same time that these five transitions are having an effect, however, there are also three additional elements that are contributing to Japan's becoming depressed, only these processes, however, mark continuities more than transitions. These three continuities are: the importance of *kanpo* (Chinese herbal medicine) and other "traditional" East Asian modalities of care, the importance of fulfilling social roles, and the place of Japanese ethnic identity – Japaneseness – in the conceptualization of mental illness. I do not wish to suggest that these so-called continuities represent static phenomena continuing from centuries past. Indeed I believe that virtually everything in the realm of culture is in a constant state of flux. However, changes take place along different trajectories and at different rates, and the continuities that I describe here merely represent phenomena that predate, by decades at least, the arrival of SSRIs and are exhibiting a conservative force on the way SSRIs are being used and the way mental illness is being conceived.

First, in terms of the importance of *kanpo* and other East Asian systems of medicine, let it suffice that, as Emiko Ohnuki-Tierney and Margaret Lock explained in the 1980s, these traditional ideas about health and healing continue not only to provide an alternative to biomedicine but to influence the way biomedicine is viewed and delivered. This influence can be seen in the general attitude toward psychiatric medications, with the mode of prescribing looking not at all like the "miracle drug" model that has so permeated the use of Prozac and other antidepressant drugs in the United States. I will suggest that this lack of a miracle drug model and the concomitant disinclination of doctors and patients to put SSRIs on a pedestal stems from a cautionary stance toward Western medicines that is based, at least in part, on a philosophy of

natural healing common to traditional Asian medical systems. At the same time, however, I will suggest that this cautionary stance is, paradoxically, contributing to the expanding use of SSRIs in Japan. I do not wish to suggest that ideas about *kanpo* have remained unchanged for centuries, but instead that some of the basic ideas regarding *kanpo* exert a shadow over the way certain non-*kanpo* drugs are used.

Second, in terms of normative values regarding social roles, I will suggest that the continuing importance of these values factors into the way that patients interpret their conditions and the way that doctors treat those conditions. Whereas much of the literature on depression in the United States has centered on a language of “becoming” and “overcoming,” with goals being to resolve longstanding emotional issues, improve the self, achieve happiness, prevail over past failures or self-imposed limitations, and/or achieve other psychotherapeutic aspirations, the language used by Japanese patients and clinicians is much less ambitious, and it usually centers on notions of “returning”: returning to normal, going back to work, re-creating a stable home life, and so forth. In keeping with the importance placed on social roles, I will also suggest that the characterization which best describes patients’ symptom profiles is not “somatic,” as is often suggested, but instead is “socio-somatic.” Though this sounds like a rather pedantic distinction, it actually has repercussions for how clinicians establish frameworks with which to characterize psychiatric complaints. Whereas the dominant axis for diagnosis is along the lines of a psychological vs. somatic distinction (mind vs. body), I suggest that a third axis – the social – should be factored into the way complaints are diagnostically interpreted. A “socio-somatic” mode of symptom presentation transcends the simple Cartesian dualism inherent in the psychological vs. somatic divide by recognizing that patients themselves are combining social

factors with physical factors in the way they present their situations.

Third, in terms of “Japaneseness,” there is indeed a long tradition in Japan’s mental health care system, going back to the 1920s, of viewing certain problems as deriving from particular aspects of Japanese culture and biology. The primary example in this regard is anxiety. From Morita therapy (a Zen-based therapy founded in the 1920s) to the fact that the Japanese today take ten times more anxiolytics than any other people, anxiety has become a marker of Japanese identity. Operating alongside this are beliefs about the Japanese’ propensity to work hard, to devote themselves wholeheartedly to their duties, to be reserved, to behave respectfully toward strangers and other people not in one’s in-group, and to control their expressions of emotion. In my discussions with patients and doctors about why so many Japanese are now being diagnosed with depression, these ideas about what it means to be Japanese pop up – sometimes, as in the case of one progressive clinician, Dr. Yutaka Ono, as assertions of direct causality, but other times as soft-spoken admissions that being Japanese and living as a Japanese comes with inherent downsides and that those downsides give rise to certain psycho-social vulnerabilities. I will suggest that ideas about depression and anxiety’s mirroring certain problems to which being Japanese contributes a degree of vulnerability actually helps promote the idea of depression’s being an “everyman’s” problem.

E. JAPAN’S “DEPRESSION BOOM” VS. AMERICA’S “PROZAC REVOLUTION”

Upon characterizing as thickly as possible the current state of affairs regarding the diagnosis and treatment of depression and the public discourse on depression, a final task is to compare and contrast Japan’s “depression boom” with America’s Prozac Revolution. To this

end, I will suggest that there are five differences.

First, I will contrast the two in terms of which object lies at the center of the issue. America's Prozac Revolution was drug-focused. It was the drug – the SSRI – that took center stage; and discussion centered on the purpose, chemical mechanisms, physiological consequences, and ethical and medical implications of the drug. On the other hand, the Japan's depression boom is condition-centered. The discourse centers not on the medications, but on the condition itself and its consequences.

Second, depression in the United States has, for at least the past thirty years, been feminized. Women have been the primary image of the depression patient, and women are diagnosed with depression at a rate of about 2:1 over men (Nazroo 2001). In Japan, depression does not seem to be following this pattern. Instead, depression there is slightly masculinized, with the struggling salaryman as the dominant image, and with men and women appearing to be diagnosed at about equal rates.⁵

Third, one of the criticisms at the heart of the Prozac Revolution was the possibility, first voiced by Peter Kramer, that SSRIs were running the risk of being used more as “cosmetic psychopharmacology” than as a serious medical treatment for a unambiguously biomedical problem. He feared, then, that SSRIs may be overused and that they may be overused for the wrong reasons. In Japan, however, the stigma against seeking mental health care treatment is so strong that one is hard pressed to envision Japanese individuals seeking to tweak their personalities via a psychiatric drug. Additionally, with the suicide rate still alarmingly high, most

⁵ I say “appearing to be” because there is no hard data yet on this. I base the claim, therefore on my own observations in the clinic and ward and on the estimates given in conversations with doctors.

doctors agree that the problem in Japan is not one of over-diagnosis of depression and overuse of SSRIs, but precisely the opposite, at least at this point in time.

Fourth, the primary concept undergirding the use of antidepressant medications in the U.S. is “chemical imbalance.” With that single phrase comes a way of viewing depression that purposely ignores psychological, sociological, environmental, and other approaches to understanding what depressive symptoms are actually about. In Japan, “chemical imbalance” is rarely part of the public discussion of depression. In its place is “stress,” a catch-all concept that has come to symbolize many of the problems that people are struggling with given the many shifts underway as Japan continues to struggle with its ongoing economic woes.

Fifth, the process of medicalizing depression in the United States as a result of the popularization of SSRIs narrowed the gaze, so to say, as far as mainstream thinking about what “depression” actually was. SSRIs created such hype that the notion that they were sufficient, unto themselves, as a treatment became a mainstream way of thinking. SSRIs pushed other modes of therapy – psychotherapy, cognitive-behavioral therapy, herbal therapies, etc. – to the sidelines (Gardner 2003). In Japan, on the other hand, medicalization is, paradoxically, expanding the gaze. Along with the spread of pharmaceutical treatment for depression, there is a concomitant spread of non-medical treatments, mainly counseling and clinical psychology.

In short, I suggest that these are the five main differences between Japan’s depression boom and America’s Prozac Revolution. And over the course of the remaining chapters, I aim to bring into relief the implications of these distinctions not only in terms of understanding the impact that historical-cultural contexts have on medical care but in terms of highlighting the struggles that lead individuals to seek mental health care, of calling attention to those individuals

in Japan are who striving to improve mental health care there, and of calling into question the usefulness of the term “depression” in the first place.

F. CONCLUSIONS

In sum, I argue that the transition from depression’s being seen as a severe mental illness that affected just a handful of individuals to its new and unfolding image as a milder condition that can affect anyone has come about not merely through successful pharmaceutical advertising, but also by several other factors, some of which can be summarized as “transitions,” others as “continuities.” Depression’s becoming normalized stems from a convergence of these transitions and continuities, and as such comprises a multifaceted historical process consisting of economic factors; the stigma against mental illness; ideologies about the self, the expression of emotions, and the fulfillment of social roles; notions of ethnic identity; and alternative philosophies of healing based in traditional East Asian medical systems. The picture of depression, at least as taken in Tokyo from 2001 to 2003, contains all of these elements.

Based on an examination of these processes, I suggest, ultimately, that the result is a much-needed expansion of the number of alternatives available to those individuals struggling with personal problems. The medicalization of depression is indeed bringing more people into clinics for help, and it is encouraging more people to be on the lookout for signs of depression and vulnerability in their friends and colleagues. However, in a manner not in keeping with the process of medicalization generally speaking, the medicalization of depression in Japan is also promoting the growth of other, i.e. non-medical, modes of treatment, namely clinical psychology and counseling. So, whereas medicalization is often criticized for forcing a narrowing of the gaze

toward psychological problems, I suggest that the situation in Japan is generating an expansion of the gaze, with the result being that medical treatments *and* non-medical treatments are becoming normalized. Given that, for so many years, there has been almost no treatment – medical or non-medical – for the struggles and feelings that are becoming characterized as depression, the changes underway today are providing hope and care for many who very much need it. Especially in a country in which the suicide rate has reached such high levels, anything that can help reduce it is progress.

G. METHODS, DATA, AND PRESENTATION

This project is based on eighteen months of field research conducted in Tokyo from 2001 to 2003. As an affiliate of a major teaching hospital, I was granted access to both the psychiatric ward and the outpatient clinic. On the ward, dressed in a white coat, I accompanied residents and medical students on their weekly rounds and participated in follow-up discussions, talked with patients and care-givers, and participated in recreational activities. In the out-patient clinics, I observed hundreds of clinical sessions, interviewed psychiatrists and medical students, and recruited patients for one-on-one interviews outside of the hospital. Outside of clinical settings proper, I interviewed psychologists, psychiatrists, social workers, nurses, patients, patients' rights advocates, Ministry of Health, Labor and Welfare representatives, a Diet member, and other individuals involved in the mental health care arena.

The popular media – namely newspapers, magazines and television – served as an additional source of information. Articles and television programs targeting depression were by this time becoming a regular component of public discourse. Interestingly, during my fieldwork

period Japan's first television commercial for antidepressants aired, as did its first television drama centering on the practice of a psychiatrist. It was also the time that the Ministry of Health, Labor and Welfare took the bold step of officially changing the name for "schizophrenia" in its effort to reduce the stigma attached to mental illness. August 2002 also marked Yokohama's hosting of the World Psychiatric Association's international conference, which is held only once every three years. This was the first time the WPA had held its conference in Asia.

In short, several "firsts" occurred during the fieldwork period, with each of them contributing to my efforts to understand the broadening interest shown toward depression and toward mental health care more generally.

As I will explain in subsequent chapters, my goal was to obtain and analyze some of the voices of depression in Japan. As such, I was interested in narratives – narratives as they existed in the articles in popular magazines and newspapers, in the minds of clinicians, in the minds of patients, and in the minds of people who were struggling to make sense of the condition they were in whether it became characterized as "depression" or not. In short, I wanted to see which ideas were "in the air" so to speak, and I wanted to examine the impact that the introduction of SSRIs were having on those ideas. Given that my sampling of informants was only an opportunity sample, my findings are not generalizable. However, the voices recounted here are indeed the voices of people who, in one way or another, have something to say about personal suffering, loss, and sadness in today's Japan.

Chapter two places the central issue – the medicalization of depression – in its broader theoretical context by reviewing several literatures: that on the cross-cultural study of suffering, that on defining and modeling depression, that on the Prozac Revolution in the United States, and

those on stigma, disruptions, and domestication. Together, a review of these literatures will highlight the problems involved in assuming that the condition called “depression,” especially in its mild and moderate forms, is as straightforward as the mainstream psychiatric community suggests. Instead, these literatures emphasize the importance that cultural processes play in terms of mediating many of the problems that, in one place, might lead to a diagnosis of depression but which in a different place may be characterized differently but with equal validity given the local context.

Chapter three reviews the history of Japanese psychiatry in order to show the particular structural problems that have for years steered Japanese clinicians away from the treatment of milder, more gray-area conditions such as depression. The chapter also discusses some of the concepts that are often used in discussions of self, maturity, normality, health, and other qualities that factor into discussions about how to distinguish mental health from mental illness. The goal of the chapter is to explain how and why depression, even as late as 1999, was a relatively new concern in Japan, both among doctors as well as the general public. I suggest that the reasons for depression’s not resonating for so long in Japan were not due merely to ideological or “cultural” factors, but also to narrow institutional factors stemming particularly from the way that the mental health care system was funded and organized in the prewar and postwar eras.

Chapter four examines three quasi-philosophical concepts – *gaman*, *seishin*, and *aware* – that factor into the discussion of how sadness, endurance, perseverance, and the acceptance of struggle are commonly viewed in Japan.

Chapter five examines the factors behind the notion of “Stress Society,” which is a phrase used commonly in newspapers and television shows to describe Japan’s current state of affairs.

An increase in layoffs, a high suicide rate, and an increase in the number of men who work themselves to death all contribute to the sense that Japan is suffering from more stress today than at any time since the end of the war.

Chapter six begins the presentation of ethnographic data as obtained during my fieldwork. I begin with a description of the institutional settings in which I worked. I describe life in a 40-bed psychiatric ward as well as the activities I observed in a busy out-patient clinic.

Chapter seven presents narratives from four depressed patients I interviewed one-on-one.

Chapter eight presents the narratives of four clinicians – two psychiatrists and two psychologists – who are dedicated to improving the way that Japanese clinicians treat depression and to altering the way that Japanese citizens view depression.

Chapter nine examines the new images of depression as they are presented on television, in popular magazines, and on the internet.

Chapter ten offers my closing thoughts on the developments that have taken place since SSRIs arrived in Japan and the significance of those developments in terms of a wider understanding of the socio-economic stresses that have become so common in Japan these days.

II. THEORIES OF SUFFERING AND DISTRESS

Anthropology's greatest contribution to twentieth-century sociology of knowledge has been the insistence that human knowledge is culturally shaped and constituted in relation to distinctive forms of life and social organization. In medical anthropology, this historicist vision runs headlong into the powerful realist claims of modern biology.

Byron Good (Good 1994)

A. THEORIES OF SUFFERING

“Suffering” is a broad and contested term. It can refer to virtually any state of being characterized by the experience of pain however physically, psychologically, or socially defined. Examples include a broken leg; a mental illness; a failed relationship; the death of a loved one; the effects of war, racism, poverty, oppression; growing old, dying; indeed the endurance of all the myriad experiences that comprise, as many have called, “the human condition.” Suffering is, therefore, a catch-all concept.

At the same time, however, its breadth does not diminish the need to make suffering a central concern, for it carries the potential to bridge various fields in the social and natural sciences and subsume their aspirations under a single rubric given that, at their core, such fields are oftentimes dedicated to understanding and alleviating human suffering. As C. Wright Mills asserted back in 1959, establishing the relation of “personal troubles” to “public issues of social structure” is a feature of “all classical work in social science” (Mills 1959:7).

How to achieve such a goal, however, is problematic because even if we accept, as step one, the concept of suffering as a site for analysis, step two demands that we decide how to undertake that analysis, and here we have a multitude of perspectives: how to characterize or

quantify it, how to identify its causes, assess its impact, treat it, prevent it, determine how much of it we are willing to tolerate, even derive wisdom from it. There are any number of questions stemming from a single example of suffering, and there are any number of lenses through which we can make our observations.

Generally speaking, however, the multitude of perspectives can be divided into two broad camps: the materialist and the relativist. A materialist approach asserts that suffering can be reduced to measurable, physiological elements, and, in considering those physiological elements as the primary unit of analysis, a materialist views suffering mainly in terms of the physiological pathologies through which it is manifested. A materialist perspective, therefore, seeks to funnel the concept of suffering into manageable, treatable, phenomenon.

Alternatively, a relativist approach takes a broader perspective, even though its ultimate aim of understanding and relieving suffering aligns with that of the materialists'. Relativists look at the bigger picture, noting the distal causes of those events and circumstances that give rise to suffering. War, poverty, oppression, inequality, family environment, workplace norms, religious injunctions, etc. – a relativist approach to suffering examines the links between these wider social factors and their later-stage consequences in the clinician's office. Grounding themselves in the Durkheimian assertion that social facts explain other social facts, relativists are quick to uncover the man-made elements at the heart of suffering.

Both the materialist and relativist approaches are necessary. It is not so much that they operate antagonistically (though this is sometimes the case), but that they are looking at a given problem through different ontological lenses, with one seeking truth in the thing itself, the other focusing on that truth provided for by the context which defines a thing. There are multiple

realities to every problem, and both materialist and relativist perspectives offer their own insights. Contemporary studies in medical anthropology, social medicine, and other medical social sciences derive theoretical and methodological vigor from both the materialist and relativist positions.

1. Biomedical vs. Sociological Approaches

In terms of examining “suffering” broadly defined, the main representative of the materialist approach is biomedicine. Operating under an array of pseudonyms including “Western medicine,” “modern medicine,” “cosmopolitan medicine,” and so forth, biomedicine aims to apply the scientific method to questions of how to treat various forms of suffering, especially suffering as it manifests itself in physical pathologies. Biomedicine takes the individual as its primary unit of analysis, and it seeks to diagnose and treat that individual through the administration of drugs and procedures that, according to empirical theorizing and evidence, are deemed by the medical and scientific communities as offering hope.

At its best, biomedicine has brought the world countless treatments, has alleviated or at least reduced the suffering of millions of people, and has come to represent some of the most heralded of all human inventions. The polio vaccine, penicillin, antibiotics, etc., etc.... the list of biomedical success stories is long.

But biomedicine does not represent the end-all-be-all of how to understand and ameliorate suffering, and indeed the relativist camp is critical of some of the assumptions of materialist theory, the most basic being the ongoing efforts to minimize the emphasis on environmental influences in the diagnosis and treatment of disease. Ever determined to historicize ideas and institutions, to remind us that culture influences the way we think, feel, and act, and to prevent the

inaccuracies that derive from biological determinism, researchers in the relativist school of thought foreground the linkages between person and environment. The result is what we can call a “sociological” stance. Clinical psychology, medical anthropology, epidemiology, public health, social medicine, medical sociology, social work, are all examples of disciplines that rely heavily on sociological perspectives.

From these sociological perspectives, biomedicine is seen as not necessarily wrong or misguided, but as limited in its purview, narrowly focusing its gaze on those drugs and procedures that can target one individual at a time. Sociological perspectives seek a broader view of the problem, examining the environmental context in which the problem occurs as well as the environmental contributions to the existence of the problem in the first place. For example, whereas a doctor, representing the biomedical perspective, is charged with treating the patient who enters the office with symptoms of dysentery, the public health official, the medical anthropologist, or the social medicine specialist would explore the reasons why the community in which that patient lives has water unsanitary enough to promote the spread of such a preventable disease in the first place. The exploration may bring to light the economics of poverty, the strings of which may extend to national and even international arrangements. National-level politics and global capitalism are particular targets in many sociological studies.

2. Social Suffering

One concept that has gained particular attention as a lens onto these wider and more distal causes of personal suffering is that of “social suffering.” Developed by Arthur Kleinman, Byron and Mary-Jo DelVecchio Good, Margaret Lock, Veena Das, and other medical anthropologists,

“social suffering” refers to those “devastating injuries that social force can inflict on human experience” (Kleinman et al. 1997:ix). As the introduction to the book entitled *Social Suffering* by Kleinman, Das and Lock explains,

Social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems... [It] points to the often close linkage of personal problems with societal problems. It reveals too the interpersonal grounds of suffering: in other words, that suffering is a social experience” (Kleinman et al. 1997:ix).

The concept of social suffering, therefore, merges many of the problems that medical anthropologists and other social scientists have been examining over the past two decades, and it does so by linking the experience of the individual with wider social, economic, and political forces so as to focus attention not on the person or the society, but precisely on the interdependence of the two. In so doing, “social suffering” grounds itself in some of the most foundational principles of cultural anthropology, namely the endeavor to link the personal and the cultural. Social suffering’s particular contribution, however, lies in its focus on injustice – its determination to expose the wider causes of suffering, thereby redefining suffering from something that an individual experiences alone to something that is, one, experienced collectively and, two, generated oftentimes consciously by those in positions of power.

Studies of social suffering, therefore, are doggedly interested in causation, and they trace those causes to even their most distant sources. But causation is not the only concern. Suffering is oftentimes not experienced in identical ways by different individuals or by different groups, but is instead mediated by cultural factors including religion, class, gender, ethnicity, normative values, aesthetic sensibilities, and other elements that influence the way that individuals interpret their experiences and circumstances. Examinations of suffering, therefore, must take into account

the frames of reference that give rise to local interpretations of experience. How a particular experience comes to be interpreted as “suffering,” or not, is therefore a central question to studies of social suffering.

One site that brings together questions of both causation and interpretation is that of ordinary, daily life – what the cultural studies community labels formally “everyday life” or, in some cases, “the Everyday”(Certeau 1984; Bennett and Watson 2002; Kandiyoti et al. 2002). “Everyday life” comprises those socio-economic and political circumstances that have become so normalized in the minds of individuals operating within those circumstances that they have acquired a sense of being natural. They have become legitimated. It is these institutionalized, normalized, legitimized, common-sensical aspects of life that, when they generate suffering, are particularly malicious, for in their normalcy lies an obfuscation of their etiologies and the benefits that accrue to those maintaining the conditions. Kleinman et al. refers to these legitimized forms as suffering as the “soft knife’ of routine processes of ordinary oppression” (Kleinman et al. 1997:x). If we posit, then, that suffering can stem from these “routine processes,” then factors such as job security, work ethics, rules governing marital relationships and domestic life, normative values regarding the expression of emotions, religious injunctions, notions of citizenship, standards of etiquette, daily communication patterns, and any number of factors governing everyday life can be examined as either risk factors or prevention factors as far as the experience of suffering goes. We need not look only at war zones and areas of extreme poverty to find examples of social suffering. Suffering can occur even in peaceful, affluent environments. It is these more silent forms of suffering that characterizes the struggles that citizens of modern industrial societies often face. Though these silent sufferings may not garner the attention of

starvation, refugee camps, terrorism, and other more dramatic situations, the prevalence of suicide in industrial societies even during peacetime makes clear that all is not necessarily well in the lands of plenty.

Many studies of mental illness focus on the ills of everyday life, and many of these studies operate with questions about social suffering firmly in the forefront. One of the best examples in this regard is Nancy Scheper-Hughes' *Saints, Scholars, and Schizophrenics* (Scheper-Hughes 2001). In this text, Scheper-Hughes provides a broad-based "cultural diagnosis" of the pathogenic stresses that contribute to Ireland's having one of the highest rates of schizophrenia in the world. Linking prevalence rates with a host of social factors, Sheper-Hughes suggests that the disintegration of village life, the out-migration of marriageable women from the villages to the cities, the pressure placed on youngest sons to take care of their parents, the spatial segregation of men and women, and child-rearing practices grounded in a puritanical Catholicism all together lead middle aged men to a state of anomie [Durkheim's word](Durkheim 1997:184), which in turn generates the mental breakdowns labeled and treated there as schizophrenia. By revealing a culture in the process of dying, and by placing the otherwise bafflingly high prevalence rate of schizophrenia within this cultural context, Sheper-Hughes succeeds in showing that schizophrenia in Ireland is best understood through a de-medicalization of the problem. She shows that if one wants to understand something about why so many men are being diagnosed with schizophrenia there, one should look outside of individual cases and uncover the wider social ills that have coalesced to infect the cultural environment in which these individuals are struggling to survive.

Other ethnographies may not place the concept of social suffering center stage, but they oftentimes allow the concept to sit on the sidelines, ready to enter when needed. After all, though

many mental illnesses, as indeed most other forms of human suffering, vary directly with poverty, war, displacement, and other more overtly man-made circumstances, there are enough cross-cultural studies demonstrating the universality of mental problems to show that finding man-made causes is not necessarily a frontline concern. Schizophrenia, for example, has been found in all countries studied, as has bipolar disorder and major depression (Warner 2004). We need not associate, therefore, prevalence rates with politics, inequalities, and some of the more overt displays of power, at least not initially. There are other questions that also need answers.

Ethnographies by medical anthropologists interested in mental illnesses have demonstrated time after time that although many mental illnesses have prevalence rates and symptom profiles that appear universal, there still remain several features of mental illness that are contingent on socio-cultural factors (Lutz 1985; Schieffelin 1985). For example, Richard Warner has found that the course and prognosis of schizophrenia is better in agrarian societies than it is in modern industrial societies (Warner 2004). Obeyesekere has found that depression among the Sri Lankans is mediated by Buddhist attitudes toward revulsion (death, feces, etc.) (Obeyesekere 1985). Several ethnographers and clinicians have called attention to the existence of “culture-bound syndromes” that exist only in circumscribed areas and which embody particular components of the local culture (Guarnaccia 1993; Helman 1987; Sumathipala et al. 2004; Yap 1965). As well, epidemiologists have long noted that the prevalence of suicide varies directly with poverty levels and/or with periods of extreme social transformation (Whitley et al. 1999; Warden 1998).

Studies placing mental illness in their social contexts, therefore, have shed light on the ways in which suffering is socially constructed. From studies of the political origins of everyday suffering to studies of how the work of culture mediates the severity, prognosis, and form of

mental illness, contemporary studies are seeking to better dissect the nature of “suffering” in its broadest, social sense. One diagnosis in particular that brings together these issues is depression.

B. DEFINING “DEPRESSION” – DSM AND ICD

“Depression” brings together questions about social suffering as well as questions about the nature of emotions, normality, selfhood, and culture. There are several literatures devoted to the various aspects of depression: justifying it as a biological entity, examining its existence cross-culturally, depicting its effects, uncovering its etiology, establishing its prevalence rates, and so forth. Indeed there is not just a single depression literature, but several, with the self-revelatory “depression narrative” having become a cottage literary industry unto itself (Styrons 1991; Shields 2005; Solomon 2002).

The many voices participating in the conversations over depression, then, are revolving around the central question of just what depression “is.” Is it a disease, a symptom, an emotion, a pattern of thinking, a universal affliction, a cultural construct, a convenient vehicle for selling drugs, a still-hidden scourge affecting millions, an immediate reaction to stress, a long-lasting consequence of traumatic childhood experiences, a personality trait, a product of genes, an evolved capacity, an illness of modernity, a mark of artistic brilliance, a sign of victimization, a chemical imbalance, a medical problem, an existential problem, a social problem, or perhaps just a house of cards? “Depression,” then, is the table upon which are laid innumerable theories about why humans seem to be suffering so much. It is for this reason that I often place the term in quotation marks. I merely wish to highlight the fact that it is difficult to speak of “depression” as if it were a single concrete thing whose existence is verifiable. One can only speak of

“depression” in the indeterminate sense, something like “religion,” whose meaning becomes more difficult to pinpoint the more one attempts to do so.

With its ambiguity and complexities established, however, any critical study of depression must begin with the recognition that there does exist a standard definition – the one generated by the American and international psychiatric communities and encapsulated in the DSM and ICD respectively.⁶ According to the DSM-IV-TR, “major depressive episode” is diagnosed if the patient experiences at least five of the following symptoms for at least two consecutive weeks:

1. depressed mood
2. diminished interests in nearly all activities
3. marked weight loss or weight gain (in the absence of dieting), or, increased or diminished appetite
4. insufficient or excessive sleep
5. markedly increased or decreased activity level
6. loss of energy
7. feelings of worthlessness or guilt
8. difficulty concentrating
9. repeated thoughts about death or dying (Morrison 1995).

This list of symptoms is all that one gets from the DSM. The text does not explore causation, nor does it recommend treatment. The purpose of the text is merely to present diagnostic criteria in a check-list format; therefore, it is easy for a non-psychiatrist to view such an objective list of symptoms as being cut off from the oftentimes complex experiential bases that one would expect to accompany a manifestation of personal suffering. This is precisely the intent. The medicalization of depression, as encapsulated in this short list of symptoms, is a view of depression divorced from the question of causation. It is as if depression were not “about” anything other than these symptoms. Just as coming down with the flu need not warrant a

⁶ The ICD (International Classification of Disease) is the diagnostic criteria for general medical conditions that is endorsed by the World Health Organization and used in many countries. In terms of mental health diagnostic guidelines, the ICD and the DSM are very similar.

psychological exploration into one's past traumas or present circumstances, so too does the psychiatric community intend for depression, and most other mental illnesses for that matter, to bypass the question of "aboutness."

But suggesting that this "aboutness" is a non-issue is indeed unsatisfactory for most medical social scientists, as well as for most clinical psychologists and other more psycho-socially oriented clinicians. They are intensely concerned with what depression is "about."

For the most part, however, the biomedical perspective has become the hegemonic one, and "about-ness" has taken a back seat to the search for the right medication and dosage. The DSM and the ICD both classify mental illnesses according to the principal (critics would say the "assumption") that mental illnesses are physiological in nature, most often reflecting an "imbalance" of chemicals in the brain.

The DSM is frequently referred to as the psychiatric "bible."⁷ Though clinical psychologists have alternative ways of viewing certain of the conditions found in the DSM, there exists no "clinical psychology bible." There is, therefore, a text disparity: biomedical psychiatry has succeeded in codifying its principles into a single text, whereas clinical psychology lacks a single organizing vision and a single vision-explaining text. The result is that there are "standards" within the field of psychiatry that one is hard pressed to find in clinical psychology. And with the standards compiled in easy-to-read form, diagnosing a problem bears the appearance of being a straightforward, step-by-step process. If a patient has A, B, and C symptoms for so-and-so period of time, then chances are she is suffering from "X disorder."

⁷ Kutchins and Kirk's book's subtitle: "DSM: The Psychiatric Bible and the Creation of Mental Disorders" (Kutchins and Kirk 1997).

This mode of diagnosis – of reframing patients’ symptoms in keeping with the templates outlined in the DSM – has become the dominant mode of diagnosis for both American and global psychiatry.

C. LANGUAGE AND THE POLITICS OF “DISORDER”

Perhaps the best example of how psychiatry recasts psycho-social problems as biomedical ones is found in the language of the DSM. Since the creation of the first DSM back in 1952, there has been a shift in the language used to describe the problems that psychiatry treats. Back then, the language of Freudian psychodynamics was paramount, and terms such as “response,” “reaction,” “complex,” and “issue” were used throughout the first DSM (APA 1952). As psychotropic medications began demonstrating their usefulness especially with schizophrenic patients during the 1950s, however, the field of psychiatry started veering away from its psychoanalytic roots and merging more and more with mainstream medicine. As more drugs came to market, psychiatry itself became increasingly medicalized, with the result being that by the 1970s, the American Psychiatric Association had become virtually hostile to the psychodynamic language used in the DSM’s earlier editions. The DSM-III, completed in 1980, marked the sea change away from psychoanalysis, with the language of “reactions” being replaced by the language of “disorders” (APA 1980). In this single term lies much of the gaze-directing power of the DSM.

A “disorder” is a problem that exists squarely within the body of a single individual. It does not refer to social phenomena; it is not a matter of interpersonal relationships; and it connotes a “brain” problem as opposed to a “mind” problem. A “disorder,” therefore, is

something that a single individual has; and treatment should target that individual, as opposed to anything going on around that individual. If the individual has a problematic family situation, a miserable job situation, a bad marriage, an oppressive social environment, abusive parents, an abusive government, a loss for which he is not culpable, or any other life event or circumstance generating the stresses he is currently suffering from, those factors are minimized by the use of the term “disorder.” “Disorder” points our gaze directly at the individual, making us assume that it is the individual, and nothing or no one else, that needs treatment. Though “disorder” enjoys the facade of objectivity, it is actually a manipulative term, one that has been put in service by a once-interdisciplinary clinical community keen on remaking itself as a “real” medical specialty, i.e. one that decided to see itself as one that treats individuals suffering from actual physiological pathologies. Characterizing ailments as “disorders” gives the illusion that psychiatry is merely responding to problems that already exist “out there” the way a dermatologist would respond to eczema; but within that term lies a history of the psychiatric community’s consciously striving to distance itself from its psychoanalytic origins. “Disorder” came into popular usage by decisions made within the American Psychiatric Association in its efforts to weed psychodynamic theory and methods out of psychiatry proper. Quite literally, the Association strove to redefine itself and the pathologies it treated, and it did so through a shift in language, with “disorder” being one of the new key words. It was a splendid choice, for “disorder” erects a wall between physiology and psychodynamics; it steers our gaze firmly in the direction of the former; and it does so so effortlessly and logically as to bypass the question of what we all may be missing.

By the same token, many sufferers find liberation in the term “disorder.” After all, it is easier to admit to having a “depressive disorder” than admitting that one’s marriage is turning

sour. It is easier to be diagnosed with “adjustment disorder” than to admit that the move to the new city was a failure. It is easier to have one’s son diagnosed with “attention deficit hyperactivity disorder” than to admit that his father neglects him. “Disorder” relieves us all of responsibility, and this is no doubt a welcome development, especially given Freud’s propensity to blame the family, and especially the mother, for so many adult pathologies. Not only does “disorder” bring a halt to the “blaming the mother” scenario, it halts virtually all efforts to attribute blame. It renders the search for causation a non-issue. Therefore, within the psychiatric frame of reference, bad families, bad bosses, bad jobs, bad governments, bad choices, and so forth do not factor into the clinical equation. “Disorder” steers attention away from all of those issues. For many sufferers and for the family members of many sufferers, this is a good thing, for it lets them off the hook.

But should everyone be let off the hook? Should the sources of problems not be sought? Should clinicians not explore the complexities of problems instead of lumping them together under one of a limited number of diagnostic categories? Is the depression of a young soldier who has lost both legs in a war he no longer believes in the same as the depression of a mother who has just given birth to a child with severe birth defects? Should the question of what the depression is about supersede the mere labeling of the problem as “depression.” To what degree should this “about-ness” complicate a diagnosis of depression?

As far as the DSM goes, depression is a matter of symptom presentation, not causation. “About-ness” directs attention toward etiology, and DSM diagnoses are not concerned with etiology beyond the mere assumption of chemical imbalances (and there is no discussion in the

DSM about the possibility of chemical imbalances themselves being caused by environmental circumstances).

Most of the critics of depression agree, however, that what gets reduced to “mild depression” or “moderate depression” in psychiatry is almost always “about” something else, and that it is these other issues that should be the primary focus of attention. Additionally, there is ambiguity as well as cultural variation in terms of what events and circumstances can give rise to negative emotional states (Kleinman and Good 1985). In short, whether something is interpreted as depression, or as weakness of character, grief, spirit possession, semen loss, or any other of the myriad non-psychiatric problems seen around the world is a matter of just that – interpretation. In the absence of laboratory tests to demonstrate whether a given set of symptoms is indeed depression or anything else, the entire diagnostic process is one of interpreting what the patient and other sources of information about the patient (usually family members) say. Taking seriously this problem of interpretation is central to the question of whether this thing called “depression” actually exists.

D. MODELS OF DEPRESSION

To understand current thinking about the existence and interpretation of depression is to delve into a multitude of theories. But for analytic purposes, most of these theories can be generalized into six basic models, and a brief review of those models will shed light on the range of perspectives that makes the study of depression such a contested domain.

The biological model. The biological model asserts that depression is a disease, with its physiological pathology being a matter of deficiencies in neurotransmitter activity, especially

serotonin and norepinephrine (Overstreet and Janowsky 1991; Janowsky et al. 1972). This neurotransmitter dysfunction is most commonly referred to as a “chemical imbalance in the brain.” The field of psychiatry premises its treatment of depression on the biological model, with medications being the primary mode of therapy. This is the model of depression presented in the DSM and the ICD.

There is an assumption in the biological model that the primary variable regarding an individual’s susceptibility to depression is not personality, environment, or early childhood experience, etc., but is instead genes (Kendler et al. 2001). The majority of biological research on depression asserts that some individuals are born with a higher genetic loading, i.e. a higher genetic predisposition, for depression than others. Like Huntington’s Disease, depression is here viewed as an inherited problem, one that may be triggered by environmental causes, but one that is nonetheless best treated through biomedical interventions.

Evolutionary models. In the past twenty years, evolutionary psychologists have applied Darwinian theory to the question of why emotions exist and have come up with an adaptationist model of depression (Thierry et al. 1984; Gilbert and Allen 1998). According to this model, the behaviors that accompany depression are adaptive to individuals who have lost a competition in that they function as a way of signaling to the victor that there will be no more challenges to his/her authority. The loser submits by stopping the behavior that is generating the loss, by making that strategy visible to others, and by withdrawing from the situation to formulate what to do in light of the defeat. In short, such behaviors constitute both a submission strategy and a “figure out what to do next” strategy. According to Nesse and Williams, sadness and depression function to “stop current losses and prevent further ones” (Nesse and Williams 1994:216). This

theory claims to account for how depression, seemingly a maladaptive trait, could have been maintained through natural selection.

Psychological models. There are several psychological models of depression. The psychodynamic model, introduced by Freud, suggests that adult susceptibility to depression is rooted in early childhood experiences, especially the experience of loss (Freud 1995). This notion that early experiences of loss can have lasting effects throughout the lifetime has been influential throughout the modern history of mental health care (Hale 1994). Building on Freud's theories, John Bowlby asserted, in what came to be called "attachment theory," that a child's experience of separation, especially from the mother, can mold the child's emotional developmental trajectory, with the consequence often being a vulnerability to depression later in life (Bowlby 1989). Also building on Freudian theory, Aaron Beck formulated a cognitive model of depression which asserted that depression stems from cognitive distortions, i.e. inaccurate assessments of one's own abilities and personality (Beck 1979). In short, Beck suggested that negative thoughts create negative moods. As these negative thoughts become habitual, a depressive mood becomes the norm.

The behaviorist model. Behaviorists believe that depression is a learned response to the environment (Skinner 1979), and they often rely on Seligman's model of "learned helplessness." Seligman used laboratory situations to study how dogs (Seligman et al. 1968) and rats (Seligman and Beagley 1975) reacted to a negative stimulus (electric shocks) beyond their control. After repeated stimulation, the animals took on the passivity, dulled affect, and lethargy that often characterize humans diagnosed with depression. Seligman concluded that with enough negative stimuli, combined with the individual's learning that he/she has no control over the stimuli, the

individual will eventually give up responding to the stimuli. This giving up as a result of realizing his/her lack of control over the environment lies at the heart of “learned helplessness.” From this model, “depression” is merely a biomedical gloss for “learned helplessness” (Seligman 1974).

The sociological model. In their highly influential study, *The Social Origins of Depression*, Brown and Harris discovered that a woman was less likely to develop depression if her current lifestyle included one or more of the following factors: 1) she worked outside of the home, 2) she had a close relationship with at least one other person, 3) she had three or fewer children under the age of 14 at home, or 4) she had not lost her mother before the age of eleven (Brown and Harris 1978). The more of these factors she had in her life, the less likely she was to come down with depression. The study made an impact because it challenged longstanding views suggesting that depression stemmed from psychological or biological factors. Brown and Harris situated the vulnerability to depression primarily in one’s immediate social environment, and they pinpointed the particular components of the environment that operated as primary risk factors.

E. IDIOMS OF DISTRESS & THE VALIDITY OF THE INTERPRETIVE APPROACH

Taking an untraveled road in the analysis of depression, Arthur Kleinman and Byron Good have systematically challenged not only the existing models of depression, but the validity of the concept itself. Or, to be more precise, they have challenged the validity of mild and moderate depression, i.e. the diagnoses which the majority of depressed patients around the world are given. As they state, “[since] symptoms serve as the criteria for depressive illness, and since symptoms vary significantly across cultures, the difficulty of establishing the cross-cultural validity of the category “depression” must be faced” (Kleinman and Good 1984:4).

Kleinman faced this need for validity by focusing attention on depression's operating as but one of many idioms of distress. According to him,

When we are under great social pressure, say, for example, as the result of serious school failure, work conflict, or life crisis such as loss of a spouse, we are shocked out of our ordinary common-sense view of our world and forced to search for alternative ways of making sense of our conditions. In traditional societies, religious and moral idioms of distress as well as bodily complaints communicated what was amiss and shaped the social form of distress. Increasingly, in contemporary Western society, the process of modernization has weakened these older forms of dealing with trouble. Although they still are significant channels for expressing problems, they are being superseded by psychological idioms ranging from a general language of stress to more specific existential and affective expressions. These new idioms convey discontinuities in one's social world not as sin, chest pain, or oppression by the forces of evil, but rather in a language of intrapsychic angst, personal demoralization, and often self-defeating, morbidly introspective hopelessness. There is no scientific evidence to indicate that a discursive, open expression of personal problems as guilt or depression is either more cognitively "advanced" or "healthier" than the other idioms of distress which convey emotion indirectly and through silence, but often with great subtlety and eloquence.

For the anthropologist, the idiom is the symptom. The problem may be misfortune, owing to the obdurate social sources of misery, indistinguishable from similar problems in radically different cultures or historical periods, but the peculiar expression of misery as depression, anxiety, backache, or fear of being possessed results from the particular cultural apparatus of language, perceptual schema, and symbolic categories which constitute distress in one or another mode. Thus cultural idiom orders the interpretation of distress (Kleinman 1988:71).

As Kleinman makes clear, idioms of distress can represent any number of personal, social, or even political problems. It would be inaccurate, therefore, to think of idioms of distress as a model to explain merely depression, for Kleinman's point in presenting the model was to challenge the idea of depression's being a universally applicable category in the first place. In other words, it is not that idioms of distress serve as models of depression, but that depression is but one of many idioms of distress. The point is to bring to light those symptom profiles that matter to individuals in a particular cultural context. In other works, Kleinman uses the example

of neurasthenia, a set of physical complaints affecting psychiatric patients in China that included lack of energy, fatigue, weakness, dizziness, headaches, anxiety, and a wide assortment of other recurring but vague physical complaints (Kleinman 1990, Kleinman 1980).

By focusing on idioms of distress, the idea of depression's existing as a biological entity outside of a cultural context is called into question, and the existence of other modes of expressing and experiencing sadness, loss, and distress are held up as alternatives. The most well-researched idioms of distress, other than neurasthenia, include *ataques de nervios* among Guatemalans (Guarnaccia et al. 1993; Guarnaccia et al. 1996), chronic fatigue syndrome in the United States (Starcevik 1999), *taijin kyofushou* in Japan (Suzuki et al. 2003), semen loss in India and Sri Lanka (Nichter 1981; Obeyesekere 1985), and soul loss among numerous societies (Shweder 1985).

Given that stress operates at the intersection between self and environment, placing the idioms by which these situations are experienced and expressed serves to link the physical realm with the social realm. In so doing, the idiom of distress model operates as a summation of how somatic problems and social factors intersect. In short, characterizing a problem as an idiom of distress invokes a socio-somatic model of the nature of the problem – one that exposes the limits of each of the dominant models of depression described above.

Several medical anthropologists, epidemiologists, psychologists, and psychiatrists have since taken up Kleinman et al's emphasis on idioms of distress. (Parsons and Wakeley 1991; Parsons 1984; Keyes and Ruff 2003). In terms of theoretical orientation, these studies are inherently interpretative, for they endeavor to obtain and analyze local discourses and meanings. Ethnographers have ventured into local arenas armed with open-ended questions designed to

extrapolate those concepts that resonate at the local level. Antipodal to bringing in outside categories and seeking appropriate translations for those categories, these studies begin with a blank slate and attempt to construct as emic as possible a framework of reference. The rationale for this approach is summed up in Kleinman's term, the "category fallacy," which is the assumption that the diagnostic categories used in one cultural context are directly translatable, and therefore valid as is, for use in other cultural contexts (Kleinman 1987). The category fallacy is a projection, and the problem with it is that without looking at those categories that exist a priori vis-a-vis the imposed category, one runs the likelihood of missing the concept that has the most local resonance. Even though, for example, a DSM diagnostic category such as "mood disorder" may be translatable into other languages, this is not to say that individuals in that country use that category to describe their own states of being. If we look only at issues of translation, then we can miss the point, with the point being the discovery of locally-relevant categories. To prevent the category fallacy, step one of a cross-cultural study of mental illness categories should begin with a tossing out, at least temporarily, of DSM categories so that the ethnographer can then start afresh in seeking how informants themselves construe those things that English glosses as "emotion," "disorders," "states of mind," etc.

In terms of depression, this attempt to reveal local definitions, concepts, and frames of reference has been fruitful. Catherine Lutz, for example, has discovered that even the basic distinctions between "thought" and "emotion" do not resonate among the Ifaluk in the South Pacific (Lutz 1985). For them, "depression" has virtually no meaning because they do not accept the premise that sadness and happiness are diametrically opposed. In a similar vein, Charles F. Keyes has found that mourning rituals and processes among farmers in rural Thailand serve as

critical mediators in terms of bereavement (Keyes 1985). He argues that the “work of culture” embodied in these rituals and processes function successfully such that any discussion of risk factors for depression must take these cultural phenomena into account. Richard Schweder demonstrates that in non-Western countries around the world, the concept of “soul loss” has far greater relevance than “depression” has and that its relevance is unequalled by that of any other standard psychiatric diagnosis (Shweder 1985).

These studies agree that “depression” is, to some degree, a cultural construct given that it makes sense only in a limited number of societies. However, they do not go so far as to suggest a radically relativist position, i.e. that “depression” has no biological elements at all, for they all recognize that some sort of articulation of experiences comparable to “loss” and “sadness” is present in all societies (Murphy et al. 1967). Therefore, few researchers in the medical social sciences would adhere to a radical Whorfian position asserting that the emotional states of one group are incomprehensible to other groups. To do so would be to claim that biological universals regarding human emotions do not exist. Though early “culture and personality” studies operated with such an assumption in mind, ethnographic data eventually proved the assumption false. Few researchers today advocate for a radical relativist perspective regarding human emotional states. However, this is not to say that culture plays no role in the experience, interpretation, and expression of emotion. After all, it is difficult to experience a “true” emotion, i.e. an emotion not interpreted through cognitive efforts, an emotion not filtered through language. The second we label an emotion as this or that, we have filtered it through language, ideology, experience, and all the other factors that comprise the thing we call “culture.” This is part of the reason that emotions are so difficult to study, for it is virtually impossible to isolate and

make independent variables of them. We can only interact with the expressions of emotions – verbal expressions, behavioral expressions, physiological expressions, etc.

Also, if the approach of the Ifaluk is universalizable (Lutz 1985), then perhaps we are barking up the wrong tree in even discussing “emotions” as being an entity separate from thought, language, and those other modes of expression in the first place. Cartesian dualities are indeed still with us.

Let it suffice that the radical separation of biology and culture so far as depression is concerned is no longer taken seriously in the medical social sciences. Instead, the goal in current research is to assess the various relationships between the two, with the assumption being that depression, its variations, its counterparts, and indeed virtually all emotional states for that matter have both biological and cultural elements to them. Hence, there is a need these days to hyphenate the adjectives – bio-cultural, ethno-medical, psycho-social, bio-psycho-social, etc. – attached to those interdisciplinary studies endeavoring to untangling, as well as questioning the divides between, biological and cultural realms.

F. PROZAC ENTERS THE PICTURE

Following Kleinman and Good’s call in the mid 1980s for an interdisciplinary approach to the study of culture and depression, a new variable entered the picture. In 1987, Prozac was released in the United States, and in just a few years, it became the best-selling of all psychiatric medications, earning hundreds of millions of dollars for its manufacturer, Eli Lilly (Prozactruth.com). By the mid 1990s, the drug had entered markets in many other countries and had become first-line treatment for depressed patients around the world (Shorter 1997). Initially,

the success of Prozac and other SSRIs gave credence to the biomedical claim that depression was both a universal phenomenon and a biological one. Indeed, one is hard pressed to conclude that depression is not a universal, biological phenomenon given that so many millions of people in dozens of countries have been treated successfully with SSRIs.

But, Prozac's success did not go unchallenged. Peter Kramer's best-selling book, *Listening to Prozac*, made the culture-biology debate more complicated, and it made the need for nuanced bio-cultural approaches ever more immediate. Kramer asked whether Americans were using SSRIs not so much to treat mental illness, but to boost personalities in ways that would bring success in a fast-paced business world. He coined this mode of treatment "cosmetic psychopharmacology" (Kramer 1993:xvi). If Kramer's fears were substantiated, then questions about the nature of what was being diagnosed as "depression" would have to be answered. Was it an illness or a personality trait? Did the problem lie in the individual or in the business culture that placed undue demands on otherwise shy people who did not fit the assertive, type A personality mold. Was psychiatry in the business of treating illness or fine-tuning people's personas? Were SSRIs medical drugs or something else? If cosmetic surgery was a legitimate field of medicine, then why not cosmetic psychopharmacology? In terms of medical care, just what did "legitimate" mean, anyway?

As Kramer ruminated years after publication:

To my mind, my book was never really about depression. Taking the new antidepressants, some of my patients said they found themselves more confident and decisive. I used these claims as a jumping-off point for speculation: what if future medications had the potential to modify personality traits in people who had never experienced mood disorder? If doctors were given access to such drugs, how should they prescribe them? The inquiry moved from medical ethics to social criticism: what does our culture demand of us, in the way of assertiveness? (Kramer 2005).

Such questions were not easily answered, and to date, they are still being debated.

Another vocal critic of Prozac and other antidepressant medications is psychiatrist Peter Breggin, whose book *Talking Back to Prozac* called attention to the drug's many side effects: sexual dysfunction, panic, anxiety, and even suicidal ideation. He also issued a general charge against Eli Lilly and other pharmaceutical makers, asserting that they had manipulated the drug approval process to the degree that there now exists a "medical-industrial complex" devoted more to profit-making than improving public health (Breggin and Breggin 1994:190).

At the time of this writing, legal challenges to SSRIs' effectiveness have taken on new urgency. In 2004, New York attorney general Eliot Spitzer filed a lawsuit against GlaxoSmithKline alleging that the company withheld data obtained during clinical trials pertaining to suicidal ideation in adolescents (Harris 2004).

A third line of attack, however, comes in a book entitled *Prozac on the Couch* by psychiatrist Jonathan Michel Metzl (Metzl 2003). Metzl traces the history of psychiatry's so-called miracle drugs (Milltown, Valium, and Prozac) since the 1950s and calls attention to the gendered images used in both the marketing of the drugs and in the actual patterns of prescribing the drugs. In short, Metzl shows how

clinical and popular talk about these medications often reproduces all the cultural and social baggage associated with psychoanalytic paradigms – whether in a 1956 *Cosmopolitan* article about research into tranquilizers to "cure" frigid women; a 1970s *American Journal of Psychiatry* ad introducing Jan, a lesbian who "needs" Valium to find a man; or Peter Kramer's description of how his patient, "Mrs. Prozac" meets her husband after beginning treatment.

Prozac on the Couch locates the origins of psychiatry's "biological revolution" not in the Valiumania of the 1970s but in American popular culture of the 1950s... What he urges is an increased self-awareness within the psychiatric community of the ways that Freudian ideas about gender are entangled in Prozac and each new generation of wonder drugs (Metzl 2003:excerpt from book jacket).

Metzl's assertions about the gendered foundations for the Prozac Revolution in the United States parallel Kleinman's theories about local idioms of distress in that, through Metzl's analysis, depression, especially women's depression, comes off looking less like a biological disease and more like an "American" idiom of distress grounded in stereotypical images, originating in the 1950s, of the white, middle-class, middle-aged, dependent and stressed out housewife.

In sum, then, the Prozac Revolution has brought to the fore three main lines of attack against the universalistic, biological claims of the pharmaceutical industry regarding depression: that cosmetic psychopharmacology is possible, that side-effects of the medicines have been downplayed or even hidden, and that the illness and its treatment are comprised more of cultural images than biological realities.

In spite of these attacks, however, there has emerged a clear winner, at least for now. Since the dawn of the Prozac era, Eli Lilly, GlaxoSmithKline (maker of Paxil), Pfizer (maker of Zoloft), Solvay (maker of Luvox), and Wyeth (maker of Efexor) and other drug manufacturers have made billions of dollars from the sale of SSRIs. Millions of people have used the drugs, and many of these people have reported improvement as a result of the treatment. SSRIs have become the most successful of all drugs in the history of psychiatry.

G. STIGMA

Aside from the theoretical questions about the nature of depression, one problem that depression sufferers as well as sufferers of anything potentially labeled a "mental illness" are forced to face is the problem of becoming stigmatized.

In *Stigma: Notes on the Management of Spoiled Identity*, sociologist Irving Goffman put forth what has been considered for decades the most thorough explication of stigma. Goffman defined stigma as “an attribute that is deeply discrediting” (Goffman 1963:3) but clarified that stigma was not merely a matter of attribute, but a matter of images, judgements, and ideas that become associated with the attribute. It is these preconceptions, given that many of them are simply inaccurate, that comprise the greatest danger inherent in the stigma. As Goffman explained, “A stigma, then, is really a special kind of relationship between attribute and stereotype” (Goffman 1963:4). A stigma is not the attribute itself, but the socially-constructed assumptions about the attribute. Therefore, the stigma is separate from the attribute itself. The stigma is a social process, and it is the social process that causes, in most cases, the greatest harm to the individual.

As to what attributes are most often stigmatized, Goffman lists three: 1) abominations of the body, 2) blemishes of individual character, and 3) membership in a particular race, nation, or religion (Goffman 1963:4). Abominations of the body can include diseases, deformities, statistically abnormal body shapes or sizes, mental illness, or any physical attribute than can be labeled negatively by a stigmatizing group. Blemishes of individual character can include criminal activity, mental illness, non-conformity, unpatriotic behavior, certain political beliefs, and other traits that suggest either a flaw in judgement or a flawed ability regarding judgement. Attributes regarding group membership can include racial categories, religious affiliations, or almost any other minority status (Goffman 1963:4).

However, having one of these attributes does not in and of itself constitute a stigma, for a stigmatized attribute requires that those in positions of power actually discriminate in some way

against those having the attribute. Therefore, this negative judgement, and the forms of discrimination that accompany it, are the necessary prerequisites for stigma.

Since Goffman published his study back in 1963, stigma has become an important object of study for social scientists, especially sociologists. From a practical perspective, sociologists are particularly concerned with the impact of stigma on the distribution of life chances in such areas as employment, marriageability, housing, health, crime, and life expectancy (Farina et al. 1968; Fine and Asch 1988; Link et al. 1987; Morone 1997). From a more theoretical perspective, sociologists have endeavored to understand the precise mechanisms – psychological, social, economic, political, etc. – by which stigmas are produced and maintained by the stigmatizers, and internalized, accepted or challenged by those being stigmatized (Ainlay et al. 1986; Pinel 1999).

Such studies have led to a refinement of the concept of stigma, with perhaps the most comprehensive conceptualization being put forth by Link and Phelan in their 2001 article “Conceptualizing Stigma” (Link and Phelan 2001). According to Link and Phelan, stigma is a multifaceted process that contains several elements, all of which must be in place in order for the situation to warrant the label “stigma.” As Link and Phelan explain, “we apply the term stigma when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold” (Link and Phelan 2001:367). Thus, when we speak of stigma, we are not speaking of a single attribute, for to do so would be to direct our gaze solely at the individual with that attribute. Instead, as Link and Phelan emphasize, stigma requires that we look *around* the individual and the attribute to understand how and why certain individuals in positions of power are successful in attaching additional

descriptors to the attribute, and then examine how those with the attribute are responding to the situation.

Studying stigma is important because we all live in social contexts, and when individuals in positions of power in that social context start judging other individuals there as being in some way flawed, bad, dangerous, untrustworthy, or otherwise non-deserving of equal treatment, then those at the receiving end of such judgements oftentimes experience quantifiable losses as a result. Examples are such victims are legion: AIDS patients, homosexuals, dwarfs, members of ethnic or racial minorities, members of religious groups, obese individuals, those with mental illness or physical deformities – the list goes on and on, and it varies according to time and place.

One group, however, that is perhaps the most universally stigmatized group, and the one for which much of the literature on stigma has been written, is women (Schur 1988). Social scientists still struggle to understand the reasons and mechanisms by which so many assumptions are attached to this group of people merely because of their having a physiology that differs, in some ways, from that of males.

As feminist scholars have discovered, one problem in assessing the impact of stigma is that there are actually several types of stigmas (Stevens and Hall 1988; Hebl and Heatherton 1998; Major and Gramzow 1999). The type of stigma attached to being female differs from that attached to a convicted child molester, which in turn differs from that attached to a blind person. Studies of stigma, therefore, have to take into account the fact that different groups suffer in different ways.

In terms of mental illness, there are two general modes of stigmatizing. The first is directed toward psychotic behavior, and it emphasizes the unpredictability, the bizarreness, and

the dangerousness of those in the midst of a psychotic episode (Phelan and Link 1998; Hinshaw and Cicchetti 2000). Before the advent of anti-psychotic drugs, such characterizations were oftentimes accurate. But one of the crowning achievements of 20th century bio-medicine has been the invention of drugs that can control, at least to a certain degree, psychotic behavior. The result has been the ability of those with schizophrenia to enjoy a level of “normal living” that would be impossible without the drugs. So, the first stigma of the label “mentally ill” is the assumption that the individual is dangerous, unpredictable, and irrational. Additionally, this stigma is often applied not only to a person who has exhibited psychotic behavior, but to that individual’s entire family as well. This assumption of heritability is prevalent in many societies around the world (Weiss et al. 2001), and it can have dire consequences in those societies in which kinship structures and family reputations influence the finding of marriage partners, jobs, loans, housing, educational opportunities, and other items that depend on evaluations by other members of society (Kadri 2004).

A second stigma, however, operates quite differently, for it is associated with a different type of mental state. In terms of depression, anxiety, panic attacks, and other problems of affect, the stigma does not include an assumption of dangerous and irrational behavior, but an assumption that the person is “not up to snuff” so to say, that he/she cannot handle adult responsibilities, cannot be relied upon, cannot lead, cannot be trusted with the well-being of other people, cannot cope, and other assumptions about the inability to handle otherwise normal duties (Schreiber et al. 2000; Spurgeon 2004). This is more subtle than the stigma attached to psychosis, and it works not so much via direct discrimination, but via a process of internalization and concealment. In other words, one of the main manifestations of the stigma against depression

is the decision by the affected individual to keep the condition a secret out of fear of being judged negatively by others (Hoge 2004). In many cases, this leads to a decision not to seek support and not seek treatment. This not-seeking help is one of the main issues that mental health communities in almost all countries are now dealing with. In short, it is not the discrimination itself that is the problem, but the fear of discrimination, with the result being a resistance to seeking help.

One question that stigma specialists are particularly interested in is that of where the stereotyped images associated with a particular attribute come from and how they are maintained. It is a question about production and reproduction. One source that has garnered attention in this regard is language. The words we use to label or describe a group of people helps determine our cognitive image and our emotional response to that group. Hence, there have been a host of movements over the past 30 years or so to re-label certain groups and attributes. In the mental health care field, terms such as “leprosy,” “lunacy,” and “hysteria” have been formally replaced with “Hansen’s disease,” “schizophrenia,” and “somaticization disorder.” But similar re-christenings have taken place regarding ethnic characterizations, physical disabilities, sexuality, and a host of other attributes. Stigmatized groups lead the way in lobbying governments, universities, professional associations, media, and other image-makers to adopt and use such new words, and it is easy to see why the difference between, say, “colored” and “African-American” is a significant one. Language, therefore, is a front-line concern for many efforts to understand and reduce stigma.

Stigma studies take seriously the impact that both the source of the stigma (the attribute) and the stereotypical images attached to the attribute can have on the life of the group being

stigmatized. Such studies also have, at their core, a desire to reduce the impact of the stigma, and so they dedicate themselves to originating and testing methods that can reduce stigma. In terms of mental illness, advances in pharmaceutical treatment and shifts in public attitudes over the past 50 years have resulted in a softening of the once-harsh views, but there is still a long way to go.

H. DISRUPTIONS

In keeping with the various social and cultural approaches to issues involved in mental illness and mental health care, one concept that links suffering, idioms of distress, loss, and the attitudes and ideologies that surround those experiences is the concept of “disruption” as established by anthropologist Gay Becker (Becker 1997). Becker’s research calls attention to the ways in which people use “culture” as a way of creating meaning during those traumatic events that necessitate a rethinking of the expectations and assumptions that until then had organized the individual’s life. Becker’s work focuses on moments, for example, when people lose a loved one, realize that they are infertile, learn that they have a terminal illness, or experience some other catastrophe that, in one way or another, stops their life path as they had previously known it. Becker calls these moments “disruptions.” But her contribution to our understanding of life processes lies in her analyzing how individuals appropriate and re-assemble the ideas, values, and sensibilities available to them in an effort to make sense of the new and painful situation, then move ahead along a different path. “Disruption,” therefore, is about meaning-making under pressure. It is about the way individuals reformulate a life-direction in the face of loss. As Becker explains,

In all societies, the course of life is structured by expectations about each phase of life, and meaning is assigned to specific life events and the roles that accompany

them. When expectations about the course of life are not met, people experience inner chaos and disruption. Such a disruption represents loss of the future. Restoring order to life necessitates reworking understandings of the self and the world, redefining the disruption and life itself (Becker 1997:4).

This process of creating order is nothing new to anthropologists. Indeed, as Becker points out, the “effort to create order is, in essence, what anthropologists study” (Becker 1997:5). One of the beauties of Becker’s work, however, is that it takes the study one step further by seeing the need to create order as a process that, at certain times, is itself forced to undergo drastic changes. The order and meanings that suffice one day become quite obsolete the next. New foundations for order, new meanings, new sources of optimism are then needed. Is this merely a psychological process? Or does culture also play a role? Becker argues for the latter. But she insists that the examination of disruptions requires a shift in the concept of culture. As she explains, a concept of culture

must include those moments in social life when what is normal and habitual is disrupted and gives way to a new realm of possibilities. The preoccupation with culture as a monolithic entity, which prevailed in the preceding era in anthropology, obscured the potential to understand what happens when things go wrong, when events fall outside of people’s experiences of life and their expectations about it (Becker 1997:5).

Such a cultural approach to questions of how to create order and meaning following a disruption resonates with Kleinman and Good’s notions of idioms of distress, for both models suggest that meaning-making is especially necessary at those times when old meanings no longer seem so applicable, when a sense of continuity with the past has been broken.

“Disruption,” then, characterizes many of the experiences for which people come to psychiatrists and psychologists for help. While some of the more biomedical of clinicians may diagnose a problem as “depression” and prescribe a regimen of pills, other observers might characterize the problem as being one of disruption – one in which the construction of new

understandings of the self and the world so as to restore a sense of stability and security is the dominant challenge. Though pills may indeed make such an undertaking easier, they may be insufficient by themselves. To make new sense of loss is to form a new life course, and this is oftentimes a complex and time consuming process. In Becker's mind, it is also a cultural process, for it demands that individuals re-contextualize themselves by aligning themselves with paradigms, with foundations for normalcy, that they might not have considered relevant before. As she states,

It takes times for new ways of thinking to pervade daily life, especially when the old paradigm has been particularly pervasive... These efforts to create continuity after a disruption emerge as a complex cultural process (Becker 1997: 6-7).

Given that many of the individuals who become diagnosed with depression are in the midst of these kinds of disruptions, it is useful to examine the "complex cultural processes" by which these individuals are seeking to find a new source of security and continuity in their lives.

I. DOMESTICATION

The final theoretical problem pertaining to the historical moment of Japan's "becoming depressed" is the fact that SSRIs are an imported drug and that "depression" is, for the most part, an imported diagnosis. As I will explain in chapter three, "depression" did not resonate much in Japan until the importation of SSRIs; therefore, we have to ask about the implications of the importation process. Do the drugs work the same way in the both places? Is the drug changed in the environment into which it is imported? If so, how and why? Or, does the drug change the environment into which it comes? In short, domestication revolves around the question of modification: whether the importation process generates a change in the individuals at the

receiving end or in the thing being imported. The implications of the question are significant, for it is really asking about power. Is the product (and its makers and exporters) powerful enough to change the environment into which it comes? Or, is the environment powerful enough to alter the product in the course of its ingress. Who is calling the shots: the givers or the receivers?

Much of the political-economy literature argues for a globalist approach, which sees the increasingly connected international marketplace as endowed with the ability and determination to impose a set of standards on various processes of economic, technological, and cultural exchange. Most of the anthropological literature, however, offers a different perspective, suggesting that individual locales are exerting their own rights of selection on those processes, such that there is an interplay between global and local forces (Bestor 2004).

In terms of the literature on Japan, there is an increasing number of studies arguing for the strength of the receivers (Tobin 1992; Kelly 2004; Chua 2000). Joseph Tobin has examined these processes in depth, and he suggests that the process of consumption, more than that of production, is determining what succeeds in the various marketplaces of goods and ideas. As he explains,

I have chosen the word *domestication* as the central theme of this introduction to indicate a process that is active (unlike westernization, modernization, or postmodernism), morally neutral (unlike imitation or parasitism), and demystifying (there is nothing inherently strange, exotic, or uniquely Japanese going on here). *Domesticate* has a range of meanings, including tame, civilize, naturalize, make familiar, bring into the home. This book argues that the Japanese are doing all of these things vis-a-vis the West.

The term *domestication* also suggests that Western goods, practices, and ideas are changed (Japanized) in their encounter with Japan (Tobin 1992:4).

In keeping with Tobin's claims albeit talking not about Japan in particular, Stuart Hall asserts that consumption is one of the five elements of the "circuit of culture," and that, as such, it

provides a sight at which meanings are produced (Hall 1998). In short, Hall suggests that a text – whether a book or movie (or even a drug or a diagnosis) – is not something that is merely passively accepted by the audience or recipients, but instead is something whose reception depends of the background and desires of the recipients. Those recipients, in essence, construct and evaluate the item’s meaning (Chandler 2001).

When viewing the reception of items such as medications, medical technologies, and the ideas about health and illness that accompany such medications and technologies, this type of cultural analysis is useful for understanding the process through which an item ends up being accepted, rejected, and/or modified by those at the receiving end of it. In other words, it is important to uncover the means by which a new item can resonate in the cultural milieu into which it is entering. If it can resonate, i.e. if it can establish a link with the hopes and needs of the recipients, then there is a good chance that it will enjoy acceptance. “Resonance,” therefore, is a key word in the discussion of how items succeed in crossing cultural boundaries.

But resonance is certainly not a given, and there are numerous examples of items, practices, and ideas that resonate positively with one group and do just the opposite in another. Such examples include abortion, stem cell research, birth control pills, Ritalin, medical marijuana, cloning, growth hormones, recreational drugs, and many others. What a single therapy means can range from the miraculous to the evil, and so it is important to establish the source of the ideas that people attach to a particular medication or to any imported item for that matter if something is at stake in the use of that item. And when it comes to the attachment of ideas to states of mental illness, we have seen that crossing national or cultural lines offers opportunities to see the meaning-making process in action. The question of the manner in which ideas about depression

and about SSSRIs have been given local meanings in Japan, i.e. the manner in which depression and SSRIs have been, if at all, domesticated, is a question that underlies this entire study.

J. CONCLUSION

“What is at stake” is indeed the question underlying the many approaches to suffering and distress. From the more proximal biomedical perspectives that take only the physiology of the struggling individual into account to the more distal sociological perspectives that seek out the political, ideological, and socio-economic sources of that individual’s suffering, there is a wide range of approaches to the question of how we should conceptualize human distress. In almost all cases, there is something useful in each of the approaches. And this is why any study of any form of suffering is particularly complicated, for it is difficult to establish precisely what “suffering” is. People suffer for different reasons, in different ways, and need different solutions. Additionally, what generates suffering in one person or group might not seem so challenging to another group.

“Depression” is a term that has become increasingly bantered in the examination of suffering in modern industrial societies. Though international studies have suggested that “severe depression” seems to be a universal phenomenon, the more common forms of depression, i.e. its mild and moderate versions, have been the target of debate. Whereas some view it as a biomedical condition warranting pharmaceutical intervention, others see it as an idiom of distress that speaks more to broader social arrangements than individual physiological pathologies. There are no simple resolutions for these divides.

In this dissertation, I will consider each of the theoretical approaches as potentially useful tools and will utilize them as needed. Though I will adopt Kleinman and Good's idiom of distress model as the primary lens through which to view the situation regarding depression in Japan, this is not to say that the other approaches, even the most narrow of biomedical ones, will be discarded. As a matter of personal opinion, I believe that psychotropic medications have their place. I know of many individuals whose lives have been improved by such drugs. By the same token, I am concerned about the increasing power of the one-sided message coming from the pharmaceutical industry – one that is being accepted, more or less at face value, by insurance companies, managed care organizations, the medical community, and the general public. Though medications may be cheaper than other forms of therapy, and though they are successful with a large number of people, this is not to say that alternatives are unnecessary, nor is it to say that the assumptions about safety and efficacy are complete and accurate. In short, the jury is still out on SSRIs and the biomedical approach to mental health care. There are still a lot of questions. In keeping with the diversity of perspectives summarized in this chapter, I hope that the rest of the dissertation will bring into relief the fact that such questions exist and that, in Japan as well as in the US and elsewhere, what is important is that the search for even the most basic of answers as to what mental illness "is" and how it should be treated is still a work in progress.

III. HISTORY OF JAPANESE MENTAL HEALTH CARE

*I hated being in the hospital. They gave me so many
drugs that I basically slept for five years straight.*

former schizophrenic inpatient (personal communication)

A. ANCIENT PERIODS - TREATMENT AND CHARITY

The history of mental illness and mental health care in Japan spans over a thousand years, with the earliest known mention of disordered states being found in a document from 808 entitled *Dairo-ryuiju-ho* – a medical text that discusses epilepsy and mental illness and outlines 13 forms of treatment (much of the following historical review comes from Hiruta 2001). During these early years, most of Japan’s ideas about medicine came from texts imported from China. Ancient Chinese therapies, especially herbal medicines and moxibustion, were among the first therapies that Japan imported, and they have remained in common use in Japan ever since.

In the late Heian period [794-1185], medical texts continued to be written. One which mentioned mental illness was entitled *Yamai no zoushi* [Illness Scrolls], in which descriptions of insomnia, narcolepsy, cross-dressing, hallucinations, and epilepsy are found. Many of these “illnesses” were attributed to spirit possession and, as such, incantations and prayers were considered the best remedy (Hiruta 2001:5). Attributing mental illness to spirit possession continued as a theme until the 20th century, as indeed was the case in many areas around the world (Eguchi 1991). There are several scenes in Japan’s early works of literature – *The Tale of Genji* (Murasaki 2000), *The Tale of Heike* (Tale of the Heike 1990), etc. – that include images of spirit possession.

The *Youro Ritsuryou* Code of 718 distinguishes two groups of mentally ill people: those who are mentally weak, and those who are psychologically handicapped. What is interesting about this set of laws is that both groups were considered “special” in the sense that they did not have to pay taxes and they were to receive leniency by judges if they became involved in legal altercations. In other words, it was built into the law that these people were not capable of accepting adult responsibilities and that, therefore, they deserved a certain degree of leeway whenever they caused problems. Dr. Genshiro Hiruta sees this code as proof of Japan’s, early on, taking a charitable view towards those with mental illness (Hiruta 2001:6).

In the Medieval periods [1185-1600], traditional Chinese medicine continued to inform Japanese medical practices. In the early 1300s, a Japanese monk, Kajiwara-seizen, obtained the latest Chinese Song period medical treatises, and in those texts are mentioned several forms of mental illness including *chuufuu* (palsy, paralysis), *hanshinfuzui* (half of body being paralyzed), *fuuten* (insanity), and *tenkan* (epilepsy), and *fuukyou* (insanity), *monokuruwashi* (craziness)(Hiruta 2001:7).

In the Kamakura period [1185-1333], lower-level monks began offering medical treatment not only to wealthier patrons but to commoners, and certain temples began to specialize in particular diseases and afflictions. Several temples, including *Koumyou-zan-jun’in-ji* (in present-day Aichi prefecture) and *Jousen-ji* (in present-day Osaka), developed a speciality in mental illnesses, and for years thereafter offered incantations, prayers, and water ablutions to people who came from all over the country just for those temples’ assistance (Yagi and Tanabe 2002:6).

B. EDO PERIOD 1600-1868 - SPIRITUAL AND HERBAL THERAPIES

In the Edo period, mass-produced medical texts became popular, and several of these texts described mental illnesses and suggested ideas for treatment. One of the main texts in this regard was the *Ihou-taisei-ron*, which was widely read during the entire first half of the Edo period. It referred to several psychological illnesses including *kenbou* (amnesia), *tenkan* (epilepsy), *tenkyou* (epilepsy and general insanity), and *shinyou* (illness of the heart)(Hiruta 2001:7). This text also described five herbal concoctions for the treatment of *tenkyou*. One medicine was prescribed for people who felt that their *chi* [vital energy] was lacking; another was prescribed for insomnia; another for forgetfulness; another for those whose phlegm had wandered into their heart; even another for those who “had difficulty speaking.” One medicine targeted women who “sing, laugh, and speak in crazy ways” (Hiruta 2001:8).

During the Edo period, according to Hiruta, there were continuing examples of the government’s acting charitably toward those with mental problems. In 1742, a legal document entitled *Gotei-shohyakka-jou* established that when arson, murder, and other major crimes were committed by people deemed insane, it was required that local judges treat them with leniency in keeping with the assumption that such people were not fully responsible for their actions (Hiruta 2001:8).

Edo period laws also protected mentally ill individuals from inappropriate restraint. Restraining someone had to be pursued through a formal application process. It was a characteristic of the Edo period that a neighborhood group of five households – called a *goningumi* (“five-person group,” but many consisted of more than five households) – formed a sort of community policing program. If one of the families in that group wanted to restrain

someone, they had to apply to the *goningumi* for permission. In these regulations, we can observe that 1) there were prohibitions against wrongful imprisonment and 2) families were legally responsible for taking care of their mentally ill members (Hiruta 2001:8).

Temples continued to provide treatment during the Edo period, with temples in Niigata and Hiroshima becoming nationally well-known. In Kyoto, the *Dai-un-ji-kannon-do* temple built an inn where the mentally ill patients and their family members could lodge while seeking treatment (Daiun Shrine 2005). By this time, temples were offering not only spiritual treatments in the form of prayers and incantations, but also traditional Chinese medical treatments including herbal therapies and moxibustion. So, the point is that it was the Buddhist monks who were continuing this tradition of providing care to the mentally ill. It is also interesting that most of the temples that were offering treatment were located outside of major urban areas. Most of these temples were in rural areas, where they could offer a natural environment more in keeping with traditional East Asian medical ideas about healing's working in league with natural processes (Yagi and Tanabe 2002:29).

Toward the end of the Edo period, three major changes took place regarding care of the mentally ill. First, there were people outside of the Buddhist clergy who became specialists in the treatment of mental illness. (One of these, a man named Kagawa, was perhaps the first person in the world to describe a case of anorexia and label it as a disorder (Hiruta 2001:8)). Second, there was a demographic shift from rural to urban areas, and as part of this shift there was growth in the construction of medical facilities tailored exclusively for the mentally ill. These differed from the rural temple facilities in that they did not offer spiritual treatments. Third, Western medical texts started coming into Japan via the Dutch scholars based in Nagasaki. Included in these texts were

descriptions of mental illnesses and prescriptions for treatment. Until this time, Chinese medicine had been the dominant modality of care throughout Japan, and Chinese medical philosophy has asserted that what we today consider “psychological” functions and problems actually lay in the heart and stomach. But in 1771, a Western textbook on autopsies explained the existence of nerves in the brain and claimed that the foundation of consciousness lie in the brain. This began a revolutionary paradigm shift regarding the physiological sources of insanity (Yagi and Tanabe 2002:44).

One ailment, however, that was not reframed as a result of Western psychiatric ideas was that of fox possession. For centuries, bizarre behavior in women had been attributed to the fox demon’s taking control over the woman’s mind and body. This belief continued as if along a separate trajectory from that of other medical developments, and there are even accounts of its existence as late as the 20th century in some rural areas (Eguchi 1991). Perhaps the persistence of fox possession tells more about the role of women in Japanese society than it does about advances in psychiatric treatment.

C. MEIJI & PREWAR ERAS 1868-1945 – WESTERN MEDICINE & CONFINEMENT

Following the Meiji Restoration, Japan imported Western medicine as quickly as it could, with Germany providing the bulk of the imported texts and advisors. It was during Meiji that the foundations for a “modern” psychiatry in Japan were established. However, this did not mean merely advances in treatment, for indeed psychiatry in large part underwent a shift from being seen as a medical problem to being seen as a public safety problem. Issues of public safety came to be viewed as equally important, if not more important, than issues of humane treatment. In just

a few years, social protection became the dominant perspective from which psychiatry was viewed, with isolation and restraint becoming the dominant mode of dealing with disordered individuals (Hiruta 2001:9).

During the Meiji years, slogans such as “Civilization and Enlightenment” became popular, and they operated as glosses for westernization and modernization (Pyle 1996:92-94). As part of its efforts to westernize medicine, the national government promoted university training programs for those who wanted to become doctors. Given that around 80% of the doctors at this time, however, were specialists in traditional Chinese medicine, the government established special programs designed to retrain these doctors into the ways of modern medicine (Hiruta 2001:9).

The bulk of the growth in psychiatric care during this period took the form of private psychiatric hospitals. Though university hospitals were operating as the major centers for training, most of the actual care was being provided at private institutions. The first of these had been built back in 1879, but their numbers continued to increase steadily over the next 50 years (Hiruta 2001:9).

However, these private hospitals were the source of several scandals during these years, with the most notorious one being the so-called Souma Incident (Burns 1997). From 1885 to 1896, the Souma Incident garnered national attention. In 1885, Souma Tomotane, the head of the Souma clan, living in what is now Fukushima prefecture, was confined to a psychiatric institution because of allegedly suffering from an incurable mental illness. However, rumors emerged about his admission to the hospital being part of a plot by his half-brother to inherit the family’s estate. In time, an underling loyal to Tomotane broke into the hospital and helped his lord escape. The story became big news (Yagi and Tanabe 2002:91-92). It contained elements of

intrigue, behind-the-scenes glimpses of Western science, intra-family rivalry, and most importantly, the valorization of loyalty. The single most often-published work of art dealing with mental illness – a woodblock print that is featured either on the cover or in the texts of almost each of the (admittedly, very few) histories of Japanese psychiatry – is a woodblock print of Souma Tomotani being helped to escape from the hospital (copied below).



Figure 2 Souma Incident. Woodblock by Kokunimasu, printed 1893.
[Image from Okuda Yasuo's *Shisetsu: Matsuzawa byouinshi 1879-1980*.
Iwasaki Gakujutsu Publishers, 1981]

The messages of the image are clear: 1) devotion to loved ones should win the day, and 2) psychiatric institutions are not to be trusted; they are scary places, into which innocent people can be incarcerated.

The image of a psychiatric hospital's being a dark, scary institution into which people enter and never emerge – an image that is alive and well even today – can be dated from the

Souma Incident.

However, in spite of the Souma Incident, institutionalization as a mode of dealing with the mentally ill continued to increase. This was not the case just in Japan, but in most Western countries as well (Darton 1999). Remember that Japan was importing most of its ideas about medicine and social organization from Europe, and there it was considered responsible, both in terms of medical care and public safety, to treat the mentally ill in locked institutions.

But locking patients up in institutions was not necessarily the goal of the policies at the time. Granted, the Japanese government supported the construction of private institutions, but the goal was not confinement in institutions, *per se*, but just confinement, period. Therefore, given that most parts of Japan did not have a psychiatric institution nearby, home-confinement became the norm in most areas. The goal was merely to protect the public and maintain social order so as to ensure as “civilized” a society as possible (Hiruta 2001:10).

In 1919, Drs. Go and Kashira published “The State of Private Confinement of the Mentally Ill,” which summarized the results of a 15-prefecture survey. The survey discovered that an alarming number of patients were being kept in filthy, abysmal conditions in animal-like cages. In the words of Dr. Go, “The tens of thousands of the mentally ill in our country, in addition to being inflicted with the misfortune of this disease, are doubly inflicted with the misfortune of being born in this country” (quoted in Hiruta 2001:10).

In response to this survey, the national government started funding the construction of additional psychiatric facilities in the prefectures. The goal was to shift the burden of care and confinement from families who, in the opinion of physicians, were not providing adequate care to larger private institutions who could make use of the latest techniques being imported from the

United States and Europe. Institutionalization, then, was promoted as a sincere effort not only to maintain public safety but also to improve care and quality of life for all those afflicted (Hiruta 2001:10).

The reality, however, was that few hospitals were built. New priorities were taking over the national government's concerns, and the well-being of the mentally ill was moved to the back burner once the impact of the Go and Kashira report wore off. As military demands on government expenditures increased, funding for mental health care dwindled. According to a 1917 survey, there were 65,000 mental patients in Japan. But by 1935, there were only 15,000 beds available nationwide. Though that number had grown to 24,000 by 1941, it had fallen to 4,000 by 1945 (Hiruta 2001:10).

In 1940, a law for "the improvement of national people" [*kokumin-yuu-seihou*] was passed (Hiruta 2001:10). Simply a eugenics law, the new law intended to prevent the "passing down" of mental illness. Therefore, it advocated castration and sterilization of mental patients. Anyone suffering from schizophrenia, manic-depression, epilepsy, and simple-mindedness could be targeted. According to Hiruta, "This was among the darkest of periods for mental patients in all of Japan's history" (Hiruta 2001:10).

It should be noted that all during these periods of Japanese history depression was simply not on the radar as far as psychiatry was concerned. It was not included in the list of conditions for which psychiatrists offered treatment, nor was it included in the list of justifications for admitting someone to a mental hospital. Though the root word for depression – *utsu* – is an ancient root (Shirakawa 1994:53), it was not listed in any of the ancient medical texts described above, nor did clinicians during the Meiji years opt to use much of the imported German

treatments for depression even though there was indeed a great amount of research being done in Germany on depression (I will discuss this in greater detail below). In short, depression garnered little attention by the psychiatric community.

D. MORITA THERAPY

In the absence of depression, however, there were other conditions that, even though they were not dealt with by psychiatrists, were considered at least related to psychiatric problems. The main conditions in this regard were nervousness and anxiety. For these conditions, there were particular forms of treatment that were developed in Japan exclusively for Japanese patients. In other words, Western treatments for these conditions did not take hold; only domestic ones did. And they did so precisely because they differed from those being developed contemporaneously in the West.

The two dominant treatment regimens here (perhaps treatment “philosophies” is a better word) were Morita therapy and Naikan therapy. They were not viewed as psychiatric therapies, per se, nor were they considered “psychological” therapies (Munakata 1986). In comparison with today’s mental health care treatments, they do not fit easily within any of the standard treatment categories (Ohnuki-Tierney 1987:81).

The most famous of the two methods is Morita therapy, originated in the early 1900s by Dr. Shouma Morita, a professor of medicine at Jikei University School of Medicine in Tokyo. As David Reynolds explains in his comprehensive *Morita Psychotherapy*, Dr. Morita was concerned primarily with neurosis, or more particularly, with what he saw as a particularly “Japanese” form of neurosis. In his assessment, many Japanese people had excessively

perfectionist tendencies combined with extreme self-consciousness, shyness, and concern with the judgements and feelings of other people (Reynolds 1976:10). In order to remedy the problems caused by the extreme form of such perfectionism, Morita created a four-stage inpatient treatment regimen that consisted of one week of absolute bed rest in a closed room (no guests and no planned activities), followed by one or more weeks of light work and diary writing, followed by several weeks of heavy work such as gardening and cleaning, and then ending with a slow transition to normal life. This four-stage program became known as “Morita therapy” (Reynolds 1976:10).

The regimen was not “psychotherapeutic” in that it required very little talking, no recounting of childhood memories, and no cognitive or emotional analysis. Instead, it was a somatic treatment – one that relied primarily on physical activity in the form of work. It was, therefore, more a “physical therapy” than a psychotherapy, with the assumption being that once someone has perfected the external, in this case the way one goes about doing the physical work of daily living, then the internal, the psychological, would correct itself accordingly. The logic was that a patient could not think or talk himself back to health; instead, he could only work himself back. If the body led, the mind would follow (Reynolds 1976:10).

According to most commentators, Morita therapy bears a close relationship with the principles of Zen Buddhism (Krech 2004). Both are anti-intellectual, anti-emotive, and aspire to help individuals transcend the distractions generated by their own conscious minds. Seated meditation, a primary methodology used by Zen practitioners, is after all a somatic technique, a matter of manipulating the body so as to help bring about a higher awareness. *Koans*, another hallmark of Zen, also represent an effort to transcend the limitations of cognition. “What was your

face before you were born?” cannot be answered via a rational approach, for the question presents a logical impossibility. It makes “no sense.” This going beyond “sense” is precisely one of the basic tenets of Zen. Once one has realized the limits of sense – i.e. rational thought, cognition, and the things that we normally think about, talk about and think with – only then is the individual on his way to discovering something “truer” about himself, life and the world.

Morita’s emphasis on the physical has a Zen-like ideological/spiritual component to it. Morita therapy plays on the notion of transcending the ideas with which, and the objects about which, we normally think. It posits that the bulk of our thoughts are oriented around the non-acceptance of life as it is: we seek to discover because we cannot accept our current ignorance. We plan the future because we cannot accept the limitations of the present. We ponder what might be taking place over there because we are not sufficiently immersed in what is taking place right here. We desire experiences, things, people, etc. precisely because we cannot accept that what we have already is enough. Most of our cognitive faculties, according to this Zen-like approach, function to make us focus all too exclusively on our immediate selves. For Morita, we are simply too full of ourselves. As Reynolds explains, “When self-consciousness fills our attention we cannot attend to the other aspects of our world which require our interest and attention” (Reynolds 1976:10). Once we get over ourselves, then we can begin the process of acceptance, i.e the acceptance of things “as they are” [*aru ga mama*], which, according to Morita, is the ultimate goal of personal development and the key to mental health. As Ohnuki-Tierney explains:

The goal of Morita therapy is for the patient to achieve a state of *aru ga mama*, which means to accept reality as it is. This includes the acceptance of oneself, with all one’s weaknesses. It is based on the view that no individual is perfect and that a lack of self-confidence is shared by all. Thus, one must accept oneself as *aru ga*

mama, and must learn to work around one's weaknesses. In the therapy, it is therefore important to break the cycle of hypersensitive introspection. The basic philosophy of Morita therapy contrasts sharply with that of psychoanalysis, which emphasizes self-examination and introspection (Ohnuki-Tierney 1987:81-82).

So, Morita's insistence on letting go of one's attachments to oneself and focusing on simple physical tasks during therapy is a way of withdrawing from the pressured image of ourselves that we have constructed such that we can relax a bit, free from distractions and expectations, and try to step back, catch our breath, and clean our slate so we can consider the fact that alternatives to this anxious mindset do indeed exist. In essence, Morita therapy offers sanctuary from the rat race, not only the one "out there" but the one internalized in our own patterns of thought and behavior, with the promise of emerging with a new perspective.

Though Morita himself did not practice Zen Buddhism, and though he himself asserted that there was no direct relationship between his theories and Zen, many commentators and proponents of his ideas continue to draw connections between the two (Reynolds 1976:47). As Reynolds explains,

Morita explicitly disclaimed any strong connection between his therapy and Zen Buddhism. There is no doubt, however, that Morita was strongly influenced by Zen modes of thought, both in his personal background and through the general socio-cultural setting of late nineteenth- and early twentieth-century Japan... It [Morita's therapy] was essentially Buddhist in its emphasis on accepting one's experience of suffering as a means of transcending misery and losing one's self in productive effort for the good of one's fellows... Cure must come from abandoning the self (Reynolds 1976:119-20).

Buddhism and Morita therapy, therefore, appear to flow from the same wellspring of ideas. As Reynolds adds,

Simply put, Zen doctrine holds that the misconception that there exists a "self" is the source of all man's hesitation, suffering, and desire... The parallel with Moritist thinking is apparent. It is precisely too much self-consciousness that results in the

misdirection of one's attention and energies. The cure in Morita therapy lies in losing oneself in work (Reynolds 1976:169).

In short, both Zen Buddhism and Morita therapy offer a methodology for self-development that prioritizes action, in the form of work, over thought and word, with the understanding being that thoughts and words can remove ourselves from ourselves. Both Zen and Morita therapy assume that there is a truer "self" that is difficult to become aware of precisely because people are so preoccupied the pettier aspects of their existence, which in most cases means an excessive concern with first person issues: I want this, I am that, I think this, I feel that, etc.. When people can shift focus from the "I" and the tedious process of thinking to the simple "doing" of something, then they can let go of the attachments and fears that account for their anxieties. Both Morita and Zen, then, share the assumption that the individual is not defined by what he thinks of himself and that the self is not something that should be "defined" at all. Attempts at definition are bound to fail because they are barking up the wrong tree. The point is not to clarify, but instead to experience. One is cognitive, the other physical. As one grows in his ability to experience the world both around him and within him, the need to operate in opposition to that world will diminish. Once one is grounded physically, i.e. in physical activities, the internal – the mind and heart – will follow suit. Both traditions, therefore, seek to reduce conflict and opposition, especially that which exists so frequently in the minds and behaviors of individuals, and to do so through a focus on simple, routine, physical activities.

Many writers on Morita therapy explore the degree to which not only the ideologies underlying the therapy, but the particular kind of neurosis that the therapy targets is also culturally constructed (Russell 1989). Morita himself asserted that two types of neurosis – *taijin-kyoufu-shou* (social anxiety, anthropophobia) and *shinkei-shitsu* (nervous temperament, nervous

personality type) – stemmed from social institutions and values that, though not unique to Japan, were perhaps more oppressive or at least more pervasive in Japan than in other countries. These institutions and values included the emphasis placed on fulfilling one's duty, suppressing one's personal desires, finding identity within the social context, and reading other people's wishes without relying on verbal, i.e. explicit, communication. As Reynolds explains,

Japanese culture shapes the basic neurotic character in certain ways. Both in the cultural history and in the personal history of the Japanese people extreme sensitivity to interpersonal signals and cues has been strongly reinforced. In order to function smoothly in Japanese society today one must be careful to pick up small expressions of preferences and desires from significant others and to control the expressions of one's own preferences and desires. Except under certain culturally sanctioned conditions (such as social drunkenness), expressions of anger, hostility, bluntness, and sexuality are strongly controlled and suppressed. The anthropophobic (*taijin kyofushou*) Japanese neurotic patient clearly shows this national character trait to an extreme. He is so sensitive to detecting cues from others and processing and controlling his own emissions that he cannot function in society (Reynolds 1976:122).

In short, Reynolds suggests that *taijin-kyofu-shou* is “cultural” in the sense that it represents a dysfunctional exaggeration of a trait that in its non-dysfunctional manifestation is considered a cultural norm. The dysfunctional condition represents merely the extreme version of a behavior that otherwise has strong cultural support.

Though the language Reynolds uses to describe “Japanese character,” as if it constituted a singular entity, is no doubt dated (Reynolds was writing in the 1970s), his assertion of the “Japaneseness” of social anxiety certainly resonated at the time and still resonates among Japanese clinicians and in public discourse on mental illness (Ohara 2000). In essence, Dr. Morita was the first to assert under the guise of medicine that there existed in Japan a “cultural” type of psychopathology and that it could be corrected via a cultural form of therapy.

In an era in which the uniqueness of Japanese character was being asserted officially by a government determined to achieve parity with the West, it is easy to see how Morita's theories and treatments could easily catch on. It was an imperial era, in which the government leaders were asserting both domestically and abroad that the Japanese were inherently different, and superior, to other Asians. The idea that the Japanese would suffer from their own form of anxiety could certainly be acceptable within the framework of an exclusionist, nationalist discourse. Anxiety, from then on, would be colored with and supported by notions of Japanese cultural identity. Anxiety became a "cultural" pathology. And as I will discuss in chapter 8, the idea of anxiety as being both a cultural disposition and a condition needing treatment still resonates today.

E. NAIKAN THERAPY

This link between anxiety and Japanese cultural identity was also found in the second psychiatric treatment regimen developed and popularized during the early 20th century: Naikan therapy. Naikan, which translates as "looking within" or "inward awareness," was the name of the therapy created around 1937 by Yoshimoto Ishin (Sakuta et al. 1996). Ishin considered anxiety as a condition stemming from the inadequate appreciation of one's debts to other people, especially to one's parents, and especially to one's mother (Nara Training Center). Ishin considered gratitude as the state of mind capable of calming anxieties, interpersonal and internal conflicts, behavioral problems, and most of life's other difficulties. Once a sufferer has realized that his negative emotions – anger, fear, sadness, etc. – have been based on an inaccurate reading of the past and a false sense that people have not loved him enough, then he will be freed from those negative emotions, thereby allowing him to live a less-troubled life.

Naikan therapy requires three components: a setting, a physical activity, and a mental activity (Nara Training Center). The setting consists of a small room containing nothing other than a cushion. The physical activity consists of the patient's sitting on that cushion from 6:30 a.m. until 9:00 p.m., with breaks only for meals and trips to the bathroom. The mental activity consists of the patient's ruminating on three questions and three questions only. Those questions are, in order:

1. What are all the good things that others have given you and done for you since you were born?
2. What have you done for the benefit of others?
3. What troubles have you caused others?

There is a particular order of people, however, that comprise the "others." Ideally, the patient is to start therapy by considering each question in reference to his mother: what he received from his mother, what troubles he caused his mother, etc.. He is also to consider each question from the vantage point of different time periods: what he received from his mother at birth, at age one, at age two, etc.. Only after he has exhausted each question for each age of his life regarding his mother should he proceed to the other important people in his life. Though in most cases it is assumed that the first person to consider should be the mother, the next the father, and so forth, there is flexibility allowed within this sequence. If one was raised by an aunt, by grandparents, or by someone else, the treatment follows accordingly. The goal is merely to reflect on those who have provided love and care for the patient – precisely who those persons are is not a problematic issue (Sakuta 1996).

Naikan therapy assumes that the exercise will lead the patient to a recognition that he 1) has been given a great deal by other people, 2) has not done much to aid those who have given so much to him, and 3) has instead caused them significant trouble. This reappraisal of one's life and

the relationship between him and his care givers should, in theory, result in both shame (at the difficulties he has caused and for his ingratitude) and gratitude (for all the things he has indeed received). According to Naikan, this combination of shame and gratitude leads to a healthy and proper state of mind, one that is more realistic than the state of anxiety and ingratitude that existed before. Once this awareness of the truth of one's past has taken hold, the sufferer is able to participate more fully in social life and proceed without the negative emotions that had dragged him down previously (T. Suzuki 1989).

In contrast with Freudian psychodynamics, it is interesting to note that Naikan therapy does not include as one of its points for contemplation the consideration of all the negative things that people have done to the sufferer. There is no reflection on the abuse one may have experienced at the hand of a parent, the pain experienced during a traumatic childhood, the abandonment, conflict, neglect, or any other type of negative experience. This is not by accident, for Naikan adamantly steers patients away from this type of exploration. In direct opposition to many forms of psychoanalysis, Naikan therapy de-emphasizes past traumas and treats the examination of painful memories of what others did to us as impediments, not as pathways, to personal growth. Though Naikan, unlike Morita therapy, shares with most forms of psychoanalysis a concern with the past, it nevertheless directs that concern in a particular direction, with the goal being for that concern to lead the sufferer to a single, pre-determined destination.

Whereas psychoanalysis oftentimes emphasizes family conflict, Naikan emphasizes filial piety; and in an era in which one's duty to the state was coterminous with his duty to family, such a psychological theory and the treatment regimen stemming from it could easily circulate in the

prevailing political winds. Though the treatment was new, the ideas upon which it was based were not. Filial piety has a long history in Japan. Isshin merely transposed it from a Confucian principle into a psychological therapy, with the assumption being that a virtue can pave the way for psychological health.

It is interesting to note that both Morita and Naikan therapies steer attention away from consideration of the harm done to the patient by other people. Both therapies entail a particular attitude towards social life, which is that the social world is not the source of one's problems. By emphasizing work in the here and now (Morita), and by emphasizing only the positive things received from other people (Naikan), both therapies cut off the possibility of blaming others or even of questioning others from the outset. In terms of social thought, both therapies are built upon an uncritical acceptance of social life as it is, and each assumes that it is the patient's responsibility to mold his/her thoughts and behavior so as to flow in step with the everyday social context. Examinations of past trauma at the hands of other people are off the table. Critical explorations of socio-political circumstances are also off the table. Nothing outside the individual is to blame. The contrast with Freud cannot be starker.

In keeping with the idea of past traumas being off the table, neither Naikan nor Morita deal much with depression. *Utsubyou* (depression) is rarely mentioned in the writings on either treatment. It is clear, then, that anxiety and depression were viewed as separate issues. Anxiety was a clinical problem, something for which a sufferer could consult an expert and undergo treatment. Anxiety was also very "Japanese." Anxiety resonated. Depression, however, was a different matter, one for which the clinical sciences did not have much to say.

F. FREUD, I.E., THE LACK THEREOF

Before concluding this section on pre-war Japanese mental health care, there is one issue that deserves attention, and that is the question of clinical psychology. In the above histories, there was no mention of either Freudian therapies, Jungian therapies, or therapies by any of the other great names in Western psychology. This is not a matter of oversight. In the few histories of Japanese mental health care that exist, there is indeed scant reference to any aspect of the field of psychoanalysis. From the perspective of a historian, it is difficult enough to explain what did happen, but it is perhaps even more difficult to explain what did *not* happen. Why did psychoanalysis and Freudian theory not take hold in Japan? Though there are no easy answers, I will put forth a few speculations that might shed light on the issue.

In the early 20th century, when the West was enamored with the new theories of psychoanalysis being generated by Sigmund Freud and his colleagues, Japan did not seem interested in such theories. Though there is debate as to the scope of Freud's influence in Japan prior to World War II, it is safe to summarize that influence as being minimal outside of a small circle of clinicians and writers. The Japanese Neuropsychiatric Association devotes neither a chapter, nor even a major section within a chapter, to Freud in its encyclopedic *100 Year History: the Japanese Psychiatric Association*, published in 2003 (*Nihon seishin gakkai* 2003). Yagi and Tanabe's *History of Psychiatric Treatment in Japan*, published in 2002, includes a chapter entitled "The Introduction of Western Psychiatry [to Japan]" which contains a subsection on German psychiatry, yet there is no mention of Freud (Yagi and Tanabe 2002:114-18). A Japanese professional journal, *Seishin-igaku rebyuu (Psychiatry Review)*, devoted an entire edition in 2001 to the history of Japanese psychiatry, but within that edition Freud's name is not

mentioned once (*Seishin-igaku rebyuu* 2001). At least according to the writers of these histories, Freud's imprint on the pre-war development of Japanese mental health care was negligible. In keeping with these histories, Emiko Ohnuki-Tierney explains,

As a corollary to the absence of psychological explanations for illness causation, in Japan there is little emphasis on psychotherapy. It has often been pointed out that Freudian psychoanalysis has never been widely accepted, despite the fact that the Japanese have eagerly adopted many Western technological and intellectual innovations. Western psychotherapy continues to be little appreciated, and is even viewed with suspicion. Even most of the members of the Japan Psychoanalytical Association have not received training in psychoanalysis. The membership of this organization was a mere 300 in 1959, and the Japan Psychoanalytical Society, the national chapter of the International Psychoanalytical Association, had only 41 members in 1959 (Ohnuki-Tierney 1987:81).

This is not to say, however, that Freud's impact was completely non-existent, but merely that it was negligible outside of a small circle of academic followers. In other words, there was little or no application of his theory in actual clinical practice prior to World War II. There is evidence, however, suggesting that his theories did enjoy some popularity within non-clinical settings, especially within a small group of literary specialists and non-clinical psychologists starting in the 1930s (Blowers and Chi 1997).

In an article entitled "Freud's Deshi: The Coming of Psychoanalysis to Japan," Blowers and Chi trace the histories of four men who strove to bring Freudian theory to Japan (Blowers and Chi 1997). Three of the four – Heisaku Kosawa, Kiyoyasu Marui, and Yaekichi Yabe – actually traveled to Germany and received brief training in psychoanalysis by Freud or one of his students. Upon their return to Japan, they spent years translating works of Freud into Japanese. Though they attempted to promulgate psychoanalysis through their translations and teaching efforts at their respective universities (they were each professors), there is little evidence that their activities resulted in psychoanalysis's achieving either popular appeal as a social theory or

professional appeal as a tool for treating patients. In essence, Blowers and Chi's article – one of the only of its kind to trace the development of psychoanalysis in Japan – reads more as the personal histories of four men rather than as a broader history of the international spread of an idea. Though these men managed to translate most of Freud's major books into Japanese, and though they founded two national associations dedicated to the study of psychoanalysis, there is little in Blowers and Chi's history to support the supposition that psychoanalysis ever “caught on” in Japan in any way approximating its development in Europe and the United States. In fact, Japan's most well-known psychologist of the era, Dr. Shouma Morita, the founder of Morita therapy, simply dismissed psychoanalysis as an idea without clinical relevance, declaring that it lacked the means of curing anything (Blowers and Chi 1997:116).

Why was this? Why did a theory that was considered one of the most groundbreaking contributions to 20th century science and culture in the West simply not take hold in Japan at a time when Japanese scholars and doctors were following Western scientific developments with rapt attention? It was clearly not for lack of exposure, for translations of Freud's books existed as early as the 1930s. It was also not a matter of state-level interventions, for Freud's books were not banned or condemned by the government. I found no research that deals precisely with this question of why Freud never caught on in Japan; therefore, any comments here are purely a matter of speculation. However, it is important to remember that during the period in which Freudian theory was becoming popular in Europe and the United States, i.e., from the early 1900s to the second World War, Japan was in the midst of a steady, and at times harsh, transition toward a military state, in which dissent was limited in most years with the exception of the few years following the enthronement of the Taisho Emperor in 1912. This period, known as the

period of “Taisho Democracy,” witnessed a brief outpouring of public dissent and public participation in government. However, the period was brief, and the government soon resumed its restrictions (Kodansha 1993:1500-1).

Freudian theory is, at least in part, a theory of dissent. Perhaps represented most elementarily by the title of the book, *Civilization and its Discontents*, Freudian theory presents human life from a presumption of conflict: conflict between son and father; between id, ego and superego; between the individual and society; and between human nature and life in modern industrial civilizations. Though not necessarily revolutionary in the political sense, Freudian theory calls attention to the conflicts that humans have not with a particular government but with the overall state of affairs regarding life in a state-level society.

Given that since 1868 Japan had been struggling to become a modern, industrial, Western-style society, it is not surprising that a theory that emphasized the contradictions and problems of life in such a society would fail to resonate. In pre-war Japan, after all, policy-makers had been striving to unify the populace under the proposition that all citizens were linked in a “family state” under the paternal leadership of the Emperor. Given political efforts to subsume the individual within the social, to couch the aims of government within the language of filial piety, and to energize the population toward the goals of catching up with Western “civilization,” it seems natural that a theory that emphasized the conflicts not only within, but innately within, each of these ambitions would clash with the dominant political psychology of the times. Freudian theory did not mesh well with Japanese efforts toward nation-building along the lines of filiality, and it did not mesh well with Japan’s mobilizing its populace for the building of an imperial military power.

If we combine this disconnect between Japan's political climate and Freudian fundamentals with a reminder about the ongoing tradition of treating mental illness as a private, family-level affair in which sufferers were to be confined and hidden away, then it becomes easier to see how the Japanese could ignore Freudian theory, viewing it as yet another Western contrivance, like individualism and free-market economics, that did not apply to the Japanese context. Given that the Japanese had demonstrated since early Meiji that they could selectively import, that they could value, say, Western technology while devaluing, say, Western ideologies, it should come as no surprise that they could selectively import aspects of Western medicine as well.

A third speculation for Freud's lack of popularity has to do with discourses on things "psycho-spiritual" in Japan during the modernization era. Some of the catch phrases used during the period – phrases such as "Japanese spirit/Western technology" (Hunter 2005:16) – capture the dualism undergirding the ambition of the times: the desire to adopt those aspects of Western science, technology, administrative practices, etc. that were useful in a mechanistic, objective, impersonal sense, while at the same time promoting those cultural and pseudo-psychological "traditions" that allegedly constituted Japanese ethnicity, national identity, and "spirit." Within this dualistic mode of thinking, factory designs, banking systems, industrial production strategies, military strategies, medical technologies, etc., were seen as acceptable items to be imported from the West. These items could be selectively appropriated without undermining the theories about Japanese ethnicity and spirit that policy-makers were using to promote their political agenda.

Theories of mind and theories of the relationship between self and society, however, were different. These theories were not mere technologies to be imported and controlled as leaders saw fit. Instead, these theories – psychoanalysis included – offered radical ideas as to the nature

of individuals and societies and the nature of the relationship between the individual and society. Perhaps these were ideas that Japanese policy-makers did not want to import, for such ideas challenged the goals of Meiji reformers as they propagandized the notion that all Japanese were members of a national family, with a collective history, culture, and blood line (Smith 1983:15-17, Pyle 1996:127).

For a social or psychological theory to resonate in Japan during the imperial era, it had to be able to operate within the framework of Japanese-style nationalism. Freudian theory was hard pressed to do this. On the one hand, the Japanese government was struggling to strengthen its hold over its citizens by promoting the idea that all citizens were linked to, dependent upon, and obedient to the Emperor, in whose name all national policies were made (Pyle 1996:127). On the other hand, Freud was asserting that the needs of the individual operated, by nature, in opposition to the needs of modern society, thus resulting in an irreconcilable conflict between self and society (Freud 1989). This line of thinking opposed virtually everything Japan was telling itself at the time. As a result, the only psychological theories that received much play were those, such as the one established by Shouma Morita, that could operate within the larger political discourse on the idea of Japanese exclusiveness as far as matters of “spirit” were concerned.

Again, these comments represent only speculation on my part. But whatever the causes, the net result is that Freud never became a matter of significant public attention prior to the war. Though a handful of professors attempted to popularize his theories, interest remained for the most part confined to small academic circles. The broad shadow that Freudian theory cast over 20th century American and European social thought, mental health care and popular culture had no counterpart in Japan.

G. POSTWAR PSYCHIATRY & BEYOND – INSTITUTIONALIZATION

In the aftermath of World War II, Japan strove to strengthen its medical infrastructure (Japanese MHLW). Vaccination and nutrition programs were established, public water facilities were built, new qualifications for medical practitioners were mandated, and the building of private hospitals was subsidized (Japanese MHLW). The 1950s were a growth era for many industries in Japan, including medicine. Part of the efforts included a shift from a German model to an American model in terms of both care and clinical training. In terms of mental illness, rather than prioritizing public safety, new laws were instituted that placed greater emphasis on providing care and removing sufferers from the cages they had been confined to in their family's homes (Lecount 2002). One strategy in particular that was adopted was the construction of both prefectural and private hospitals, with the goal being to bring a belated yet final end to home-confinement.

The hospitalization movement, therefore, began in earnest in the early 1950s. The Mental Hygiene Law of 1950 made involuntary admissions possible, and the numbers of inpatients soon swelled (Lecount 2002:6). According to David Lecount, in 1954, following a wave of hospital constructions, a national survey on the state of the mentally ill in Japan was conducted and the results showed that the number of mentally disabled totaled 1,300,000 persons and that 350,000 of them required hospitalization. The survey also showed that available bed space was only one-tenth of that. Construction, therefore, increased; and by 1960 the number of beds increased to 85,000 (Lecount 2002:6). Historians of mental health care call this era the "hospital boom" (Hiruta 2001:11). The boom was supported by government subsidy given that national health insurance covered most, and in the cases of those with low incomes, all the cost of hospitalization (Hiruta 2001:11).

The mental health care system suffered a jolt, however, when in 1964 the American ambassador to Japan, Edwin Reischauer, was stabbed by a young man who had a history of psychiatric problems (Chapin 1964). Though Reischauer survived, the incident was considered a national disgrace. Just at a time when the country was striving to regain a place of respect in the international community, demonstrate its economic vitality, and build on its relationship with the United States, realizing the vulnerability of its most visible and high-ranking foreign visitors no doubt came as a shock. In the incident's wake, the national government legislated new requirements for the mentally ill, easing rules regarding involuntarily admission in the name of increasing public safety. It increased subsidies for the establishment and construction of new private hospitals, and by 1970 the number of inpatients had increased to 250,000 (approximately 29 beds per 10,000 people)(Lecount 2002:6). Policymakers did not want any more men like the one who stabbed Ambassador Reischauer out on the streets.

This movement toward even greater reliance on institutionalization contrasted with developments in the West, for at this time the United States and most European nations were promoting the expansion of community treatment facilities (Tajima 2001). They were doing so in response to the then-popular "anti-psychiatry" movement (Szasz 1984), which had argued that a great number of individuals were being locked away in institutions even though advances in alternative therapies, including drugs and behavioral treatments, had opened up the possibility of those patients becoming able to live better lives outside the protective confines of a hospital. In response to such criticisms, the "community treatment" model began catching on (Dixon 2000). Under a community treatment model, patients were to be moved out of locked facilities and gradually re-introduced to the world outside. This entailed the use of new facilities such as group

homes (in which several patients lived together in a house with a full-time paid assistant), work-training programs, and outpatient care. This was considered a viable and effective “next step” from that of asylums (Dixon 2000).

As the following chart shows, most of the industrialized world for which we have data started adopting this model in the early 1960s.

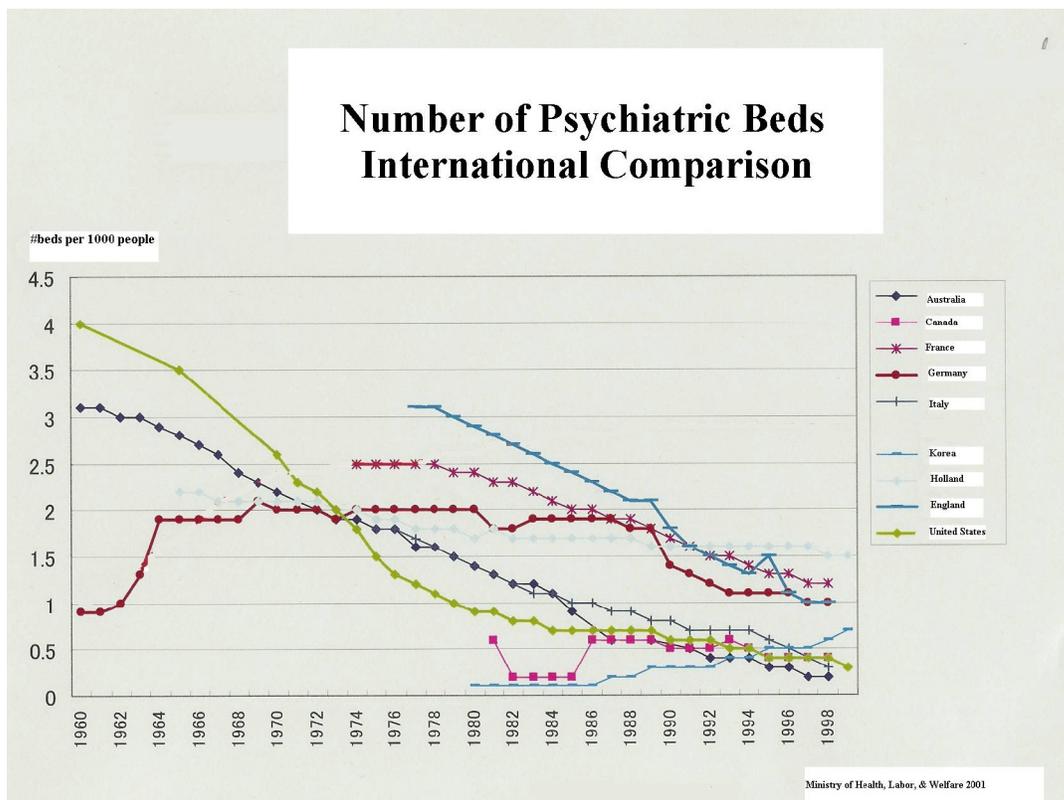


Figure 3 Number of Psychiatric Beds - International Comparison. (Japanese Ministry of Health, Labor and Welfare, 2001)

But with Japan’s determination not to let another national embarrassment at the hand of a mentally ill person happen again, the trend toward community treatment did not take hold. Indeed, Japan bucked the international trend. The following chart is the same chart shown previously, only this time Japan has been added (in red).

Number of Psychiatric Beds International Comparison

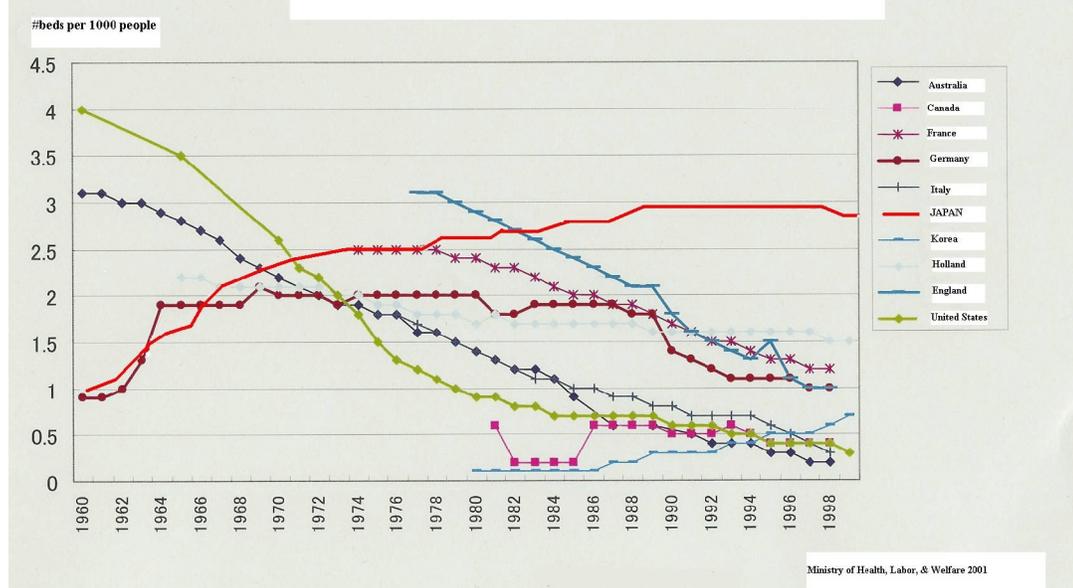


Figure 4 Number of Psychiatric Beds - International Comparison - Japan Added. (Japanese Ministry of Health, Labor and Welfare, 2001)

As the chart shows, the 1960s were a time of tremendous expansion of the private psychiatric hospital industry. Thousands of patients were admitted, and most remained admitted for years. Soon, not only did Japan earn the opprobrium of having the highest number of psychiatric beds per capita, but also the longest duration of hospitalizations (Japan Times 2002; Wehrfritz and Takayama 2002). In short, Japan embarked on a policy of confining patients to locked facilities for as long as possible. The goal was, at least in part, one of isolation and confinement for the purpose of public safety (Tajima 2001).

Reminiscent of the Souma Incident, Japanese psychiatry since the 1960s has been haunted by high-profile scandals. The most dramatic of these occurred in 1984, when it was discovered

that two patients at Utsunomiya Hospital, a private hospital located north of Tokyo, were beaten to death by hospital staff in front of other patients and staff (Salzberg 1994:2). When survivors asked what had happened, the hospital administration responded with assertions that each of the individuals had died from epileptic seizures. As Stephan Salzberg explains:

Subsequent investigation revealed that, at the time of the deaths, there were only three doctors on staff for 944 patients, seriously below minimum standards... Locked wards and isolation rooms were so cramped and filthy as to be virtually uninhabitable. The list of revelations was so long and shocking that Utsunomiya's impact could not be contained within Japan's borders, unlike previous incidents (Salzberg 1994:2).

Japanese human rights groups called the International Commission of Jurists to investigate, and the ensuing investigation resulted in hearings before the United Nations Sub-Commission on the Prevention of Discrimination and Protection of Minorities. In a scathing report, the Sub-Commission concluded that "the present structure and function of the Japanese mental health services created conditions which are conducive to inappropriate forms of care and serious human rights violations on a significant scale" (Salzberg 1994:3). Under this and other forms of international and domestic pressure, the Japanese government enacted sweeping reforms in the mental health care system, culminating in the Mental Health Law of 1988. Reforms included the demands that patients be able to communicate with family members, that independent Psychiatric Review Boards be created to process and evaluate patients' complaints about their treatment, and that admissions policies be revised so that patients could not so easily be admitted involuntarily. In short, the government stepped into the admissions process, and it required that doctors and government officials start working together to ensure that only those patients who posed an immediate danger to themselves or to others were involuntarily admitted (Salzberg 1994:3).

In 1993 and 1995, additional laws were passed encouraging both a reduction in the reliance on institutional care and an increase in efforts to provide the community-based treatments necessary for mental patients to leave the hospital and start living either on their own or in less restraining facilities (Salzberg 1994:39). In 1997, the Ministry of Health and Welfare established a national licensing system for psychiatric social workers, thereby funneling government funds toward the effort to re-socialize patients. With a national license, services by psychiatric social workers could now be paid for by national health insurance. Job training programs, psychological services, and other outpatient treatment regimens were also mandated by new laws (Kita 2002).

As early as 1994, and as recently as 2002, however, critics were asserting that the 1988 reform efforts had failed. As Salzberg continues,

The response of the Japanese government to domestic and international pressure following the revelations of the mid-1980s followed an all too familiar pattern: institute “reforms” to ease immediate criticism, and hope that no one will notice that the reforms mask the lack of fundamental change in government policy of commitment. Seven years after reform of Japan’s mental health law, things appear even bleaker for Japan’s psychiatric patients and their families (Salzberg 1994:2-3).

At the World Psychiatric Association’s meeting in Yokohama in 2002, there were several clinicians and advocates, from Japan and abroad, who echoed Salzberg’s condemnations.⁸ As

⁸ The World Psychiatric Association, which holds its major international conference only once every three years, had decided to host that conference for the first time in Japan. Five thousand psychiatrists and other mental health specialists from all over the world converged upon Yokohama in August 2002, and so it was a landmark opportunity for Japan to demonstrate to the world how far its mental health care system had come since the 1988 reforms.

However, a number of presentations focused on how far Japan had not come since the 1988 reforms. Problems singled out included the low staff-patient ratio law, lack of legal exemptions for mentally ill offenders, lack of oversight of private hospitals, lack of transparency, lack of statistics by government, the too-cozy relationship between the federal bureaucracy and private hospital owners, lack of a medical residency training system, paternalism, the ideology of social defense, and lack of patient rights regarding admissions.

Dr. Tamio Sueyasu of Keio University stated in a presentation entitled “Unfair Staff-patient Ratios of Mental Hospitals in Japan,”

The repeated violence committed on psychiatric inpatients is not sporadic, but frequent. This is a major issue... These problems with violence in past scandals are not just in the past. These problems are alive and well today... In terms of improving psychiatric hospital care, almost nothing has changed in 20 years (Sueyasu 2002).

Dr. David Norman Weisstub of Canada concurred in another presentation, saying that “In Japan, [psychiatric] reform is a failure: too little, too slow, and not convincing” (Weisstub 2002).

Several presenters at the conference made similar claims (Shirashi 2002; Satomi 2002; Toida 2002).

If we can take the criticisms voiced at the WPA conference as an accurate representation of the current state of affairs, then it appears as though little has changed as a result of the 1988 reforms. Community treatment is still behind international standards, stigma is still high, patients are still confined long-term to institutions at levels higher than that of other countries, and laws governing treatment are under-enforced. Perhaps the title of issue 27 of the Japanese professional journal, *Seishin-iryō* [Psychiatry], summarizes the situation. The issue, published at about the same time as the WPA conference, is entitled “Mental Health Crisis,” and it means the *Japanese* mental health crisis (*Seishin-iryō* 2002).

H. QUESTIONING THE CRITICS – A DEEPER LOOK AT INSTITUTIONALIZATION

However, a second look at the situation regarding institutionalization shows that there is more to the picture. Though it seems clear that efforts to reform Japan’s mental health care industry have not been as successful as many would like, there is one issue that requires particular

consideration. It is that of institutionalization. This is the single biggest charge levied against the system – that it hospitalizes more patients than necessary and that it hospitalizes them for longer periods than necessary. Though the criticism might be appropriate for many patients, it might not be appropriate for all.

In terms of current long-term inpatients, there are actually two types: medical admissions and social admissions. Medical admissions include those patients who were admitted for reasons of medical necessity, i.e. patients who were sick enough to require inpatient care. “Social admissions,” on the other hand, refers to patients whose medical conditions were not so severe, but whose social situation was such that they had no one who was willing or able to care for them (Japanese MHLW 1999).

Of these social admissions, there are two types. The first type are those who suffer not from mental illnesses per se, but from untreatable cognitive defects such as mental retardation or Alzheimer’s disease. Allowing these individuals admission to a hospital is not as much a medical service as it is a form of social service to exhausted care-givers. And this is especially the case in rural areas that have no other forms of assistance. In this light then, this first type of “social admission” is not a matter of medical treatment, but of a hospital’s being called upon to provide a social service for families in communities in which no alternative social service providers of this sort exist.

After all, in many cases of mental illness in Japan, a single individual, most often the mother, will become the sole care-giver. Ideally, of course, there will be several care-givers. But if there is only one, then the pressure of providing care can become an exhausting 24-hour-a-day routine. Doctors in Japan are well aware of this; and when they see cases in which the providing

of care is destroying the care-giver, or when the care-giver is simply no longer able – perhaps because of financial reasons, for medical reasons of her own, or because she dies, etc. – to provide care, then doctors, and the state, will allow that patient to be admitted to a long-term facility even if the patient’s condition is not so severe, medically speaking.

Most often, this type of social admission is short-term, designed to give a temporary reprieve to the exhausted care-giver. I saw this during my fieldwork, in which a mentally-retarded young man was admitted to the psychiatric ward even though he had no mental illness per se. The admission was designed to grant a reprieve to his widowed mother, his sole care-giver, who had become worn down as a result of the constant demands on her time and energy. After two weeks, he was released. He took no medication while in the ward and received no therapy. It was merely an example of the state’s allowing an unwritten rule to serve as a form of assistance to the care-givers, i.e. usually the family members, of a patient.

The second type of social admission concerns those patients who were admitted decades ago during Japan’s rush to hospitalize as many patients as possible. Most of these patients are now over 65 years of age, and most, if not all, are unable to function outside of a comprehensive treatment facility. Most either have no family left, or else their family has simply abandoned them. In his report on Japanese mental health care, Lecount labels these individuals as the “lost generation” (Lecount 2002). In spite of international pressure to cut the number of psychiatric beds and reduce the long hospitalization periods, doctors and national policy-makers are struggling to come up with an alternative solution for these patients (Asahi Shinbun 2002d; Shinfuku 1998). Would it be more humane, more medically efficacious, more fiscally prudent to spend the years necessary to try to train these patients to function on the outside? Or, is it best to

maintain their current facilities, offering them the care and community that has become the only way of life they know? If these patients were lobbying for release, the situation would be different. But this is not the case. Most are merely living away their final years within the confines of an institution that has become their world.

Though calls for de-institutionalization certainly have merit, doctors sensitive to the plight of these social admissions patients recognize that de-institutionalization has to be conceptualized with these differing patient populations in mind. In other words, critics of blanket calls for de-institutionalization emphasize that de-institutionalization must be targeted to those patients who need it, want it, and can function, preferably better, as a result of it. As of 2000, these elderly patients comprised a full 29% of all of Japan's psychiatric inpatients (Lecount 2002; personal communication from MHLW representative).

If we view their hospitalization as a form of welfare, a form of humane care-giving for those who have no other family members to care for them, then it becomes clear that any discussion of de-institutionalization must have a two-tier system to it: a movement toward community care for medical admissions, but a continuing system of providing care for social admissions, as opposed to dumping patients onto the streets.

The point of this detour through the institutionalization issue is to suggest that there are multiple sides to it, and that what looks on its surface to be an example of the "Dark Ages" may, upon a deeper examination, may have some redeeming features. This is not to deny that the mental health system in Japan has reason for garnering criticism, but it is to say that at least part of the hesitancy to overhaul the system may be stemming from humane considerations. The bad rap that Japanese mental health care often gets, especially in the English-language press, rarely

presents these more nuanced aspects of the situation. Indeed, it has become almost cliché to trot out more stories about the problems infecting Japan's mental health care system. Perhaps taking a closer look at the subtleties of institutionalization as well as at those who are indeed working, successfully, to improve the situation for patients would be a welcome contribution to the literature.

I. IN THE SHADOW OF KANPO – PATTERNS IN JAPANESE PHARMACOLOGY

To complete this review of the history of Japanese mental health care as it relates to the current questions about depression and SSRIs, there is one issue that must be included, and that is the issue of medications. Currently, Japan is the second largest market for pharmaceuticals, second only to the United States (Thomas 2001:3). Therefore, given Japan's interest in pharmaceuticals, it is especially interesting that SSRIs took so long to arrive there.

Indeed, timing is one of the factors that makes the current depression boom in Japan so interesting. Whereas SSRIs came on the American market in 1987 and earned almost overnight success, they did not enter the Japanese market until 1999. In the meantime, Japanese doctors were well-aware of the impact the drugs were making in the United States and also in Europe, and drug companies were also aware that Japan was the second largest pharmaceutical market in the world. So, why the delay?

There is no simple answer to the question, though there are two theories that are especially strong. The first one is cultural; the second one is more specifically administrative. The first theory suggests that drug companies did not view Japan as a potential market for SSRIs

because the rates of diagnoses there were so low, with the theory as to why the rates were so low being that in Japan, depression as a medical concept simply did not resonate.⁹

The second theory – one proffered by doctors and others close to the pharmaceutical industry – suggests that culture did not matter nearly as much as internal factors in the pharmaceutical industry. This theory suggests that drug companies did indeed target Japan as a potential market for SSRIs, but that mistakes in the management of the clinical trial process resulted in delays in obtaining federal approval (personal communication from pharmaceutical company representative).

The problem with the first theory is that, as we are seeing now, the drugs are selling so well that obviously “culture” did not present such an obstacle after all, thereby leading one to question the assertions put forth about the cultural inappropriateness of SSRIs. The problem with the second theory is that though one or two companies may have had difficulties in their clinical trials, there were at least five major manufacturers of SSRIs,¹⁰ and none of them entered the Japanese market until over a decade after America’s Prozac Revolution began.

The question as to exactly why there was such a delay in getting SSRIs to Japan, therefore, is still unclear. Both the cultural argument and the logistics argument may contain truths. Given the tendency and legal right of drug companies to keep their marketing plans and management decisions confidential, it is unlikely that the extent of management miscalculations, if they are to blame at all for the delay, will become known. All that we can be certain about is that

⁹ Solvay (maker of Luvox) made the following assertion on its investor relations website: “Japan is very hesitant about anti-depressant drugs. That is mainly because of the culture” (Solvay SA 1998). (See also Kirmayer 2002.)

¹⁰ Eli Lilly (fluoxetine - Prozac), GlaxoSmithKline (paroxetine - Paxil), Pfizer (fluvoxamine - Zoloft), Solvay (setraline - Luvox), Wyeth (venlafaxine - Efexor)

rates of diagnosis for depression were indeed low until the late 1990s. But pinpointing why any rate of diagnosis is low is a perennial problem for psychiatric epidemiologists. Do low rates reflect diagnostic traditions and conventions, or do they reflect actual rates of prevalence? It is difficult to tell. Therefore, the next questions are those of 1) what traditional patterns of drug use may have influenced the delay in SSRI's entry into the Japanese market and 2) are those traditional patterns affecting the use of SSRIs and/or other psychiatric drugs today? To explore those questions, a brief review of "traditional" medicines is necessary.

J. KANPO

The term *kanpo* is composed of two characters: "*kan*" meaning "Chinese," and "*po*" meaning "way, method." *Kanpo*, therefore, refers to the traditional method of treating illnesses that was imported from China starting as far back as the sixth century. *Kanpo* comprises three main modes of treatment: moxibustion (the burning of mugwort on the skin), acupuncture, and herbal concoctions. The use of herbal concoctions (I will use the term herbal "medicines," with caveats explained below) is the most commonly-used of the three treatment modalities, and often the medicines themselves are glossed as "*kanpo*." Though the three modalities differ in form, they share a single ideology about illness causation and health maintenance.

Briefly summarized, the *kanpo* tradition rests on the claim that the body's organs, blood, and animating energy (*ki*) must operate in synch with each other and with the individual's lifestyle in order for the individual to function well. However, the difficulties of daily living prevent perfectly synchronized operation from occurring such that imbalances inevitably develop. "Imbalance," therefore, is the dominant concern of *kanpo*, and the various treatment modalities

each strive to restore balance to the system. As Margaret Lock explains,

The *kanpo* doctors believe that the Taoist approach to nature is basically correct and that man should aim to keep his body in balance by trying to sustain a state of adaptation to the environment. Avoiding excesses, eating a largely traditional diet, and exercising regularly are all considered important. There is no such state as perfect health, because the model of man's body and its relation to the environment is a dynamic one, and though small fluctuations occur constantly, they are not regarded as ill health. Large fluctuations must be treated therapeutically, and the principal aim of all therapy is to restore balance, or a state of dynamic equilibrium (Lock 1980:127-8).

The goal of *kanpo* treatment, then, is to help the body do what it tries to do naturally: operate in balance with itself and its environment. Therefore, *kanpo* emphasizes non-invasive, minimalistic therapies, and each therapy is viewed as "natural" by its practitioners and patients. As Lock adds,

Therapy, that is, intervention by man, should therefore be as light as possible, for it is simply a boost or a catalyst to help nature take its course. Wherever possible therapy should also be as "natural" as possible – that is, simply correcting the diet is the ideal therapy, whereas introducing strong drugs, which are not normally metabolized in large quantities by man, is not held in high regard (Lock 1980:128).

Though *kanpo* practitioners strive for as light and natural a therapy as possible, this is not to say that practitioners are necessarily hostile toward what Lock calls "cosmopolitan" medicine and what others call "Western" medicine or "biomedicine" (Lock 1980:2). For more acute illnesses and injuries, most contemporary *kanpo* practitioners in Japan are willing to give biomedicine its due. But *kanpo* steps in where biomedicine tends to step out, i.e. with issues relating to preventative care and chronic conditions. As a result, an individual would not come to a *kanpo* clinician seeking a surgical procedure, a penicillin injection, or treatment for many of the other more standard biomedical ailments. However, one would come to a *kanpo* clinician for assistance with digestive, cardiovascular, urinary and respiratory problems, and also for pain management and stress-related problems, among others (Murata Kanpo 2004).

This division of duties and specialization accounts for why most of the individuals that use *kanpo* treatments also use biomedical treatments when they consider it necessary. The two systems generally operate alongside each other, as opposed to in opposition to each other, resulting in a state of pluralism in which most patients use both systems, with the assumption being that each has its own strengths and weaknesses.

One issue that needs clarifying, however, is that of causation: pathogen (biomedicine) vs. imbalance (*kanpo*). *Kanpo* operates on the assumption that imbalance and weakness makes the body susceptible to a pathogen or other condition for which, if the body had been balanced, it would not have become susceptible. In this light, then, it is not that biomedicine and *kanpo* have categorical differences in terms of etiological theories, but that there is a proximal-distal difference. A biomedical physician may see the pathogen as the cause of the illness, whereas the *kanpo* practitioner may view a particular imbalance as that which made the body weak enough to become susceptible to the pathogen. One can see how the biomedical approach would favor intervention after the onset, whereas the *kanpo* approach would lend itself to prevention. It is this preventative approach that makes some commentators view *kanpo* as more of an overall wellness strategy than a “treatment” (Matsuda 2004).

But in terms of medications, *kanpo* encapsulates a particular mode of thinking. *Kanpo* concoctions are composed of a mixture of natural substances, mostly plant materials, but occasionally animal materials. Mixtures are viewed not as “medicines” per se, but as natural substances very closely related to food. In fact, there is a very fine line between *kanpo*’s herbal mixtures and food (Oshima 2001). *Kanpo* is most often made into a tea, and it is taken on a daily basis, oftentimes for months or years (Ito 2003). Taking *kanpo* is thought of as a component of a

healthy lifestyle as much as it is a targeted treatment for a particular condition. Therefore, applying the term “medicine” to a *kanpo* mixture is problematic, for *kanpo* practitioners oftentimes differentiate the natural herbs used in *kanpo* from the “unnatural” substances used in biomedicine.

One of the main benefits derived from *kanpo* mixtures is a minimizing of the risk of side effects (Ito 2003). Because of the minute quantities of active ingredients found in herbal mixtures, there are very few side effects reported with *kanpo*. *Kanpo* is also taken in small quantities over an extended period, under the assumption that the effect takes time to begin. Mildness and gradualness of effect, therefore, are considered positive aspects of *kanpo*. These attributes stand in contrast to biomedicine, at least in the minds of many Japanese. They view biomedicines as strong, unnatural, prone to side effects, and designed more to kill pathogens than help the body do what it already does naturally (Lock 1980:254). Granted, this type of medicine has its place, and Japan is indeed the second largest pharmaceutical market in the world. But there are some aspects of the Japanese market that do not seem to mesh with its position as the second largest drug market. First is the fact that average dosages across the board are lower than those in the United States and Europe (Lock 1980:238). For some drugs, the average dose is as low as half of that in other countries. Second is the fact that it is common for a Japanese doctor to prescribe several medications for an illness that would require perhaps one or two drugs in the West (Lock 1980:239). It is well-noted in the literature written by American observers that they often leave a Japanese doctor’s office with a handful of different medications, even for simple problems like colds and allergies.¹¹

¹¹ “Doctors in Japan are rather prone to pumping you full of prescriptions without trying to understand the real problem.” Quoted from webpage offering advice to new JET (Japan Exchange

The standard explanation for the small dosages is that Japanese physiological make-up is simply “weaker” than that of Westerners and that, as a result, smaller dosages suffice. As one doctor told me,

Westerners are bigger and have more muscle. They need more medicine. But Japanese are smaller. Also, we don’t like side effects. We prefer a safer approach with fewer side effects and fewer risks.

The standard explanation for the use of multiple drugs is the fact that doctors in Japan are allowed by law to sell medications themselves, a practice illegal in most other industrialized nations (Thomas 2001:17-20). Doctors, therefore, have a personal financial incentive to prescribe as many drugs as possible, and given that drugs are covered under national insurance programs, there is no incentive to limit such prescribing.

I suggest that these practices are accepted by many Japanese patients, however, because such practices resonate with the most basic ideologies underlying the *kanpo* tradition. *Kanpo* has been in Japan for over a thousand years; biomedicine for a little over a hundred. It should come as no surprise, then, that the approach to medicines supported by *kanpo* can infuse into the culture of biomedicine. As Margaret Lock states,

Attitudes toward medication also reflect traditional beliefs. First, the doses of medicine tend to be milder than in the United States, and the patient is often directed to take the medicine four or even five times a day. In *kanpo* and in East Asian medicine in general, frequent mild treatments are thought to be less harmful to the body, to stimulate the body to heal itself, and to eventually bring about a more long-lasting effect than do strong treatments carried out less frequently. Second, family-style doctors in Japan do indeed prescribe a lot of medicine compared with the amount prescribed in the United States, but they feel it is necessary because they are concerned about the side effects of the medicine on other parts of the body. Compared with American doctors, Japanese doctors apparently think much more holistically. One doctor informed me that for all cases of bronchitis, for example, he would give an antibiotic, and he would also prescribe

and Teaching Program) participants (Mojo Japan Ltd. 2005).

a stomach settler and a diuretic because both the stomach and the kidneys would be affected by the antibiotic. He would also recommend vitamins to build up the body in general and give aspirin to induce perspiration (Lock 1980:238).

Japanese doctors and patients, then, apply to pharmaceutical treatment a series of attitudes that derive from principles underlying the *kanpo* tradition. In spite of signs to the contrary, the new is not so different from the old.

Traditions do not operate of their own volition, however. Historical events and circumstances often contribute to the “reinvention,” the maintenance and/or the altering of those traditions (Hobsbawm 1992). As far as tempering and modulating the use of biomedicines goes, scandal is one the recurring factors that has helped keep the *kanpo* tradition alive (Thomas 2001:9). Over a thousand Japanese babies were born with birth defects because of their mothers using thalidomide in the 1960s, and in the 1970s over 10,000 individuals developed the crippling neurological problem called SMON because of using a prescription drug for stomach ailments (Nakae et al. 1991; Konagaya et al. 2002; Kitahira et al. 2000). Pharmaceutical scandals have been a recurring issue in the post-war history of Japanese medicine, and references to thalidomide and SMON are often included in news reports on the various scandals (Yomiuri Shinbun 2002b). With a media and a public tuned into the history of pharmaceutical scandals, it comes as no surprise that there is a cautionary stance taken toward drugs in general.

This cautionary stance is echoed in the fact that Japan has been in what economist L. G. Thomas, III calls a “drug lag.” Since 1985, Japan has lagged behind most of the rest of the world in terms of its approving for importation drugs that have already received widespread international approval (Thomas 2001:7). Though Thomas argues that the causes of the lag are complex, one issue that factors therein is the fear of side-effects that is shared by Japanese

consumers and doctors across the board. The Japanese simply have a lower tolerance of side effects than what most American and European drug manufacturers would prefer, and as a result, the Ministry of Health, Labor and Welfare is comfortable in adopting a conservative attitude toward the importation of novel medications. They are also comfortable in not considering America's Food and Drug Association as the final arbiter of effectiveness and safety. As a result, Japan has its own drug approval process, complete with its own clinical trial system (Thomas 2001:7-16).

In terms of psychiatry, the shadow of *kanpo* – with its small dosages, multiple ingredients, and long-term usage – is visible. Though national data on the drug-prescribing habits of individual doctors does not exist, my observations and conversations with doctors suggest that the norms outlined above by Lock and Ohnuki-Tierney apply to psychiatric medications as well.¹² I, therefore, suggest that the *kanpo* tradition that is affecting people's attitudes toward psychiatric medications is doing so not because of anything particular about psychiatric drugs, but as part of the more widespread influence that *kanpo* exerts over popular attitudes toward drug-taking in general. Patients and clinicians prefer to use medications in a particular way, and, as I will discuss in chapters seven and eight, these patterns are influencing the way that SSRIs are currently being used.

K. CONCLUSION

When we look back on history of mental health care in Japan, several themes come to the fore. The first is that Japanese political leaders began legislating leniency and charity for the

¹² Details will be presented in chapters 7 and 8.

mentally ill over a millennium ago. Mental illness was on the political radar, and there were efforts to make sure that sufferers were treated humanely. At the same time, medical texts were both describing forms of mental illness as well as putting forth treatments. There seems to be no history of victimization at the hands of those in power; nor does there seem to be any history of romanticizing. It does not seem likely, therefore, that anything comparable to Foucault's *Madness and Civilization* could be written regarding Japan's history of mental health care.

The second theme concerns the fact that efforts to treat mental illness and protect sufferers by way of legislation became less of a priority with the arrival of German medicine in the Meiji era, resulting in a drive to shield the public from the potential dangers posed by disordered individuals. Spurred on in great part by the national effort to present an orderly and "civilized" society to Western observers, the drive to promote public safety and order by confining the mentally ill resulted in a pattern of home confinement, by which families would build cages for their mentally ill members and keep them hidden away there. Though, looking back, the response seems cruel, it nevertheless fit in with broader efforts to create as smoothly-running a society, or at least the illusion of such, as possible.

The trend toward institutionalization, therefore, must be seen in light of that which it replaced. Institutionalization was the dominant mode of treatment for psychotic individuals in the West until the advent of modern pharmaceuticals in the late 1950s. Therefore, Japan's early efforts to institutionalize patients followed in the West's sincere efforts to improve the quality of life for sufferers. Japan's divergence from international standards, however, came about because of a convergence of two factors: the growth in power of the private hospitals and international embarrassment as caused by the Reischauer incident. However, the response to the Reischauer

incident was what it was in large part because Japan had already bought into the idea that social order was something that could not easily be outweighed by notions of individual rights. From the Edo period onward, the stability of social life had been a virtue unto itself, as indeed it is in all societies. But each society has to wrestle, in one way or another, with the question of how to balance individual freedoms with social order and public safety. For most of Japan's history since the early 17th century, the scales have tipped in favor of order. It is easy to see then, how the response to the Reischauer incident and how the hesitancy to experiment with treatments that aim precisely to put disordered people "back on the streets," so to say, each fit in with longstanding expectations regarding the importance of stability and predictability of public behavior.

One perspective on this shift that is particularly interesting is the somewhat nationalistic claim that the entire movement toward institutionalization represented a historical detour along a Western pathway for Japan's otherwise honorable and charitable treatment of the mentally ill. As suggested by Hiruta (Hiruta 2001) and by Yagi and Tanabe (Yagi and Tanabe 2002) in their respective histories of Japanese psychiatry, the current task for Japan is to reverse the trend that it started as a result of its desire to follow the West's example. In these writers' analyses, there was no documented effort to remove sufferers from society before the start of the Meiji era. They see Japanese communities as traditionally exhibiting a generosity of spirit toward their mentally ill residents. What Japan needs to do now, so these writers suggest, is get back on track as far as mental health care is concerned and return to the charity and flexibility displayed in its pre-Western eras. Such theories mark an interesting nationalistic take on the ethics of psychiatric treatment.

The third theme that comes to the fore in the history of Japanese psychiatry is the fact that Japan is currently undergoing significant changes. Many of its social and economic institutions are in the midst either of dissolution or reform, and citizens are looking in new directions for new answers. One group of people who are increasing their advocacy activities are those in the mental health care community. They are trying, as quickly as possible, to come up with solutions for how to deal with the new problems including child abuse, domestic violence, truancy, adolescent crime, drug abuse, death-by-overwork, depression, and suicide. Dealing with these problems marks a significant shift for the mental health community. As the above history shows, the dominant concern of Japanese mental health care for centuries has been the condition we now call “schizophrenia.” In the modern era in particular, the other, less severe, conditions have not been part of the psychiatric purview. Traditionally, therefore, when people in Japan think of psychiatry, they have thought mainly of severe illnesses for which people are placed into institutions for the rest of their lives. Haunted by memories of the Souma, Reischauer, and Utsunomiya incidents among others, Japanese psychiatry now faces a new challenge of revamping both its image as well as its treatment modalities. Its challenge is to overcome this image of a “dark” and somewhat frightening field and replace it with an image of expertise, accessibility, and compassion. I suggest that it is indeed trying to do that and that the recent emphasis on depression is having a significant impact in that regard. The following chapters will highlight arenas in which clinicians, with the help of patients, are attacking the new problems with dedication, compassion, and with a certain amount success.

The fourth theme is that there are multiple patterns regarding the use of medications in Japan, with a primary one being the tendency to prescribe medicines in small dosages, yet to

prescribe multiple medicines simultaneously. Alongside that pattern operates a caution against using “Western” medicines, a caution encouraged by a series of high-profile scandals regarding the use of dangerous drugs. The attitudes toward medication, as will become clearer in subsequent chapters, contribute to the particular way in which SSRIs are now being used in Japan.

IV. STOICISM AND SADNESS

Life is suffering.
Buddha

In contemporary newspaper articles on depression, Japan is sometimes referred to as a “stoic” country, where individuals following centuries of tradition suppress their own personal desires and devote themselves to their tasks, their families, and/or their companies, all without complaining or challenging the norms. As Howard French of the New York Times explained, “When Japanese experience depression, doctors say, they prefer to imagine something is wrong with their character rather than their heads, and a cultural impulse known as ‘gaman,’ or the will to endure, takes precedence over medical care” (French 2002).

Grounding this “will to endure” variously in Zen’s philosophy of overcoming personal desires, in the samurai ethic of devoting oneself to one’s lord, or in the peasant ethic of devoting oneself to home and village, commentators are quick to characterize Japanese culture as one in which stoicism has a long history (Sparknotes; Nitobe 1969). French’s article was entitled “Depression Simmers in Japan’s Culture of Stoicism.”

But to what degree, if any, is such a generalization useful? Is there indeed a “tradition” of stoicism in Japan? And, if so, does it influence factors relating to mental health? This section aims to examine these questions.

A. KEY WORDS

As with other generalizations regarding archetypal cultural characteristics – Japanese as stoic, Americans as individualistic, British as rational, Latins as expressive, etc. – the era of “national character” studies ended for good reason, for such generalizations oftentimes do more to promote stereotypes than explain behavior. But it is nevertheless true that generalizations need not lead to stereotypes. Some generalizations are more inaccurate than others, and sometimes it is not that the generalization is inaccurate, but that the explanation given for the behavior being generalized is that which is inaccurate. Therefore, we should not cast aside generalizing merely because negative stereotypes have sometimes arisen from the endeavor. Without generalizations, we are unable to apply theme to episode; and given the diversity of episodes to which the social scientist is exposed, applying a coherent theme to that diversity of episodes is precisely the goal of most, if not all, social science.

In this chapter, I will make a few generalizations about stoicism and the expression of sadness in Japan. I will suggest that there are three concepts that, taken together, serve as a lens through which we can recognize a tradition of stoicism. Each concept is an everyday word in Japanese, and each concept represents a mixture of emotional, behavioral, and moral elements. They are “culture bearing” concepts,¹³ for they each serve as a nexus for attitudes and values that have been around for centuries and that resonate with feelings of “Japaneseness.” In other words, there are undertones of “Yes, *in Japan*, that concept is important” to each of these terms. They are terms that, on the one hand, are so commonly used by Japanese individuals that the defining of them by native speakers is sometimes difficult. Their meanings are so understood as to render the

¹³ Robert Pirsig wrote that “a culture-bearing book, like a mule, bears the culture on its back” (Pirsig 1985:xii). Perhaps concepts, objects, or events can do the same.

conscious consideration of the terms unnecessary. But, for an outside observer, defining such terms requires extended analyses. Especially regarding concepts rich in emotionality, this type of extended analysis is necessary.

The three terms are *gaman*, *seishin*, and *aware*. Each term carries moral guidance within it, for it not only describes emotional states and behavioral patterns as they are, but as they should be. Each term conveys moral injunctions for people to feel and act in certain ways in the face of difficult, painful, or saddening events and circumstances. And each moral injunction has, at its heart, notions of quiet acceptance, of the futility of expressing one's negative emotions verbally, and of the idea that "stoically" doing what needs to be done is the right thing to do.

B. GAMAN

Gaman [pronounced "gah-mahn"] typically translates as "endurance," "perseverance," "patience," and "self-control" (Sanseido 1999:96). As such, it seems to represent a rather unproblematic and easily-understood phenomenon. But the term has associations that reach beyond its standard definition. Perhaps the key difference between *gaman* and its English translations is that *gaman* entails a social element: it emphasizes a sense of self-sacrifice to the well-being of the group that the English terms do not. *Gaman* encompasses the ability to put one's own desires aside and work for the good of others, along the lines of "pull your own weight so others won't have to." There is, therefore, an assumed team context to which the term applies. The lone worker too can have *gaman*, but most often it is the "good team player" who uses *gaman* for the success of the collective effort. This is when *gaman* shows its real value. As

Japanese literature specialist Naomi Fukumori¹⁴ explains,

NF: *Gaman* means to hold back one's complaints in order to preserve harmony, not to ruffle feathers, not to cause problems for others, but to preserve the balance of a particular situation. There's a social element to *gaman*. The "ga" means "self"; and the "man" has two meanings: "arrogant" and "sluggish." So though the word parses as "self-restraint," there are some interesting complexities here about being both full of oneself and being slow, unenergetic, and lazy as a result of that arrogance. So, there's this idea that being self-absorbed makes you lazy, that getting beyond yourself, sacrificing yourself, working with other people, gives you energy. This notion doesn't work in a society of one. English translations are generally internal, self-oriented, about self improvement, about polishing the self, whereas *gaman* is about socialization. As a child growing up in Japan, I may want to eat, but the proper time to eat is when other people are ready to eat. I can't eat just when I'm hungry. Children are socialized to understand this, to act this way, to assimilate with the group to which they belong. But on other hand, if you want to drag in Buddhism, then it becomes a more internally-oriented term, where it's about asceticism. But asceticism is also about overcoming the self, and there's a social element – compassion – that's in there too. So even there, it's still about restraining the self and placing others first.

KV: How often do people hear the term?

NF: It's one of those terms that a parent uses a lot with children. But a boss doesn't use it with employees. You rarely say it to other adults, not even a senior person towards a junior person. An adult would not say to another "*gaman shite kudasai*" ["Please *gaman*"]. But adults don't have to use it because it's so universally understood as a social code of behavior. Adults know that *gaman* is expected of them. It has a positive tenor. It's something you do for the sake of others, and everybody's expected to do it. There's a self-sacrificing element to it – putting others before yourself – putting situations outside of yourself ahead of your own interests.

KV: How important of a concept is it?

NF: I think it's a central concept. All people are expected to act with *gaman*, as a matter of being Japanese, of being human. It's a fundamental aspect of conduct. It's restraint, and restraint is very important.

KV: Is this just a Japanese thing, or do Americans have *gaman* too?

NF: No, I don't think it's just a Japanese thing. I imagine that American children learn about this in kindergarten, don't they? I'm not sure. But the Japanese are very clear about it, very up front in teaching children about it, very clear about expecting *gaman* from people at every stage in life. I'm not sure if in English there's a single term for it the way there is in Japanese. But I think that the word in Japanese has some history built into it. Japan, under the imperial system, in

¹⁴ Naomi Fukumori, Asst. Professor of Japanese Literature, Ohio State University (personal communication).

which there was this figurehead that was not replaced every four or eight years, in that system there developed this notion of sacrificing – a cult of sacrifice to a single symbolic figure. Japan has a particular history of imperialism, war, defeat, in which people were expected to sacrifice themselves. So I think my mother and members of her generation think that *gaman* was a very central ethic. I'm not in that generation, but I'm still very aware of it. It was part of my upbringing. There's an institutional use of the term, because of particularities of Japanese history and institutions: national mentality, company mentality, group mentality. There are diluted forms that resemble it in American and other societies, but it is very much emphasized by these group entities in Japan.

In short, *gaman* represents the self-restraint that an individual should assert whenever his desires run the risk of going against those of the group. *Gaman* is a marker of strength and good character, with the assumption being that character is a social undertaking. But, as David Plath so eloquently explains, this mode of putting the group first is not a matter of self-oppression, but instead operates on the assumption that people, being social creatures, find their greatest fulfillment and greatest opportunity for self-development in the social context. As Plath states, “the mature person is one of the most remarkable products that any society can bring forth. He or she is a living cathedral, the handiwork of many individuals over many years” (Plath 1980:3). Plath goes on to say that the “American archetype, in short, seems more attuned to cultivating a self that knows it is unique in the cosmos, the Japanese archetype to a self that can feel human in the company of others” (Plath 1980:218). Recognition of humans as both “living cathedrals” and as desirous of feeling “human in the company of others” is part of the virtue of *gaman*. As such, one who strives to support the well being of the group is not acting against his own interest, but is precisely acting in his own best interest given that the social context is the structure upon which his own self can thrive.

In *The Chrysanthemum and the Sword*, Ruth Benedict recognized the importance of this notion of strengthening the self through the mechanism of restraining the self in support of the

group. In that book, Benedict put forth one of the most eloquent articulations of *gaman*'s importance. As she states,

The Japanese, however, as we have seen, define the supreme task of life as fulfilling one's obligations. They fully accept the fact that repaying *on* [an obligation] means sacrificing one's personal desires and pleasures. The idea that the pursuit of happiness is a serious goal of life is to them an amazing and immoral doctrine. Happiness is a relaxation in which one indulges when one can, but to dignify it as something by which the State and family should be judged is quite unthinkable. The fact that a man often suffers intensely in living up to his obligations of *chu* and *ko* and *giri* [duty] is no more than they expect. It makes life hard but they are prepared for that. They constantly give up pleasures which they consider in no way evil. *That requires strength of will. But such strength is the most admired virtue in Japan* (Benedict 1974:192)[italics mine].

This "strength of will" of which Benedict speaks is *gaman*. In keeping with her description, it is the connection between social obligation, self-restraint, and self-development that gives *gaman* its particular resonance. The ability to overcome one's desires – to endure without complaining or causing trouble for anyone else – is an appropriate response to any number of difficult situations.

C. SEISHIN

Closely related to *gaman*, *seishin* [pronounced "say-ee-sheen"] is a second term that factors into the discussion of key concepts underlying the expression of negative emotions. *Seishin* is also an important concept within Japanese mental health care more specifically because the term for "psychiatry" – *seishin-igaku* – has *seishin* as its root. By its very label, psychiatry in Japan is the field dedicated to studying *seishin*.

At its most basic, *seishin* translates as "mind," "spirit" or "soul" and, as such, the term refers to that metaphysical essence that makes a human being a human being. Both the Japanese term and its English glosses appear comparable. But there are overtones to the term that come to

light when we examine some of its other definitions, and in these definitions we can begin to see the differences between the Japanese *seishin* and the English “mind/spirit/soul.”

Providing a longer list of translations, Sanseido’s New Crown Japanese-English Dictionary defines *seishin* as “spirit, mind, soul, will, motivation, discipline, inner life, training the mind, throwing one’s whole soul into something” (Sanseido 1999:419). *Seishin*, then, represents a constellation of values, ideas, and perspectives that sets it slightly apart from its English equivalents. Not representing merely a metaphysical thing, *seishin* encompasses an attitude, an activity, a way of doing something, and, ultimately, a way of living and being. It is something that, on the one hand, all human beings are endowed with, but on the other hand is an essence that can change, and indeed should change, over time. It is something that needs to be developed. One’s *seishin* is not something that just *is*; it is something that must be earned, along the lines of skill, maturity, or understanding. *Seishin* is an achieved essence.

Brian Moeran calls *seishin* one of the “keywords” that permeates many aspects of Japanese life (Moeran 1986:77). Frager and Rohlen observe that “teaching it is a major goal of all traditional arts; parents and schools worry about the spiritual development of today’s youth; and in fact, virtually all aspects of life and behavior are grist for the *seishin* perspective” (Frager and Rohlen 1976:256). Robert Smith adds that

the study of calligraphy, flower arranging, tea ceremony, dance, musical instruments, and of course the martial arts are but a few of the undertakings to which principles of *seishin* training apply... The person who has mastered a skill that requires the perfection of *seishin* is believed to have acquired as well a general competence and self-discipline that will enable him or her to undertake new and quite unrelated tasks (Smith 1983:100).

Through these statements, we can see that *seishin* represents not a mere a psychological or physical essence, but a tool, a methodology, and an approach to life that has a wide variety of applications.

Seishin cannot be understood without reference to dualism, for *seishin*, as a concept, bridges two different realms. The duality, however, contrasts with the Cartesian system that underlies so many of the English-language concepts regarding things psychological and physical. In short, a critical divide permeating Japanese conceptions of self is that between inside and outside [*uchi* and *soto*]. The inside is the experienced, the hidden, the clearly defined, the sacred, the self, the known, and the controlled. The outside is the observed, the revealed, the less-clearly defined, the other, the unknown, and the detached (Quinn 1994:64). There are many words in Japanese that represent different aspects of the *uchi*, the inner realm, and *seishin* is one of those.

However, the goal of self-development is not to act in accord with one's inner nature, as if it were innate or a given reality. The goal is to *develop* one's inner nature. The assumption, therefore, is that one's inner nature is a work in progress. As Takie Lebra suggests, “[p]otency of the self is not something that emerges overnight. One must train, improve, and polish oneself in order to develop a strong, mature character. The Japanese are interested in this developmental, maturational process” (Lebra 1976:164). Frager and Rohlen add to this by suggesting that “the stricter and more painful the discipline, the better for character development. Like fine steel, character is forged and tempered by the heat of adversity. A smooth, easy life does not afford much opportunity for such strengthening” (Frager and Rohlen 1976:259). If we combined this emphasis on the dynamic, developmental component of *seishin* with the notion that it comprises

the metaphysical core of an individual, then a more pointed translation of *seishin* might be “a well-disciplined inner-spirit.”

Dorinne Kondo provides us with a particularly visceral account of *seishin* training in action. In her account of a so-called “ethics retreat,” she explains that companies in Japan often send their employees to such retreats for the purpose of instilling within those employees the ability to devote themselves to their tasks without complaining, to work for the good of the company, to view the company with feelings of filial piety, and to see their ability to overcome obstacles as a marker of their own self-development and goodness. In essence, these ethics retreats teach participants how to use *gaman* to develop their *seishin* (Kondo 1987).

Kondo’s training at the ethics retreat entails a variety of physical tasks including cleaning of the floors, cold water ablutions, walking on gravel, conducting seated meditation on gravel, and long-distance running. Participants performed each activity collectively, and each activity came with specific instructions as to the state of mind that was to be adopted in the conducting of that activity. In short, it was a state of mind, as opposed to any particular skill or substantive knowledge, that the retreat was dedicated to producing in the participants. And it did so through the assumption that as a participant performed an activity in the right way, then that way, as an external structure, would infuse into the individual with the result being that the external would become the internal. As one mastered a particular “Form,” one’s internal state would change in keeping with that Form. In short, one should not be concerned with one’s own internal state, especially when in the midst of something painful or challenging. Instead, one should find the right way to complete the task at hand, and in the process of completing the task in that right way, one’s internal self – one’s emotional state - will naturally right itself, thereby leading to happiness.

It is a doctrine of discipline, with the understanding that right action begets right emotion. Emotion is derivative, not elemental. Negative emotions in particular are temporary, and they are changeable via the proper doing of tasks and the proper fulfillment of one's responsibilities. If one is suffering, one should press on and fulfill the task at hand in the right way. In so doing, the suffering will end and the individual will end up all the happier. As Kondo explains,

In such a theory of selfhood, the outer form may become an index of the disposition of the inner self. This, some would argue, is true not only for programs such as the ethics school, but for Japanese society in general... Physical action can in fact be perceived as isomorphic with spiritual change. For example, polishing the floor was explicitly equated with polishing the *kokoro* [heart]: "If you polish the floor, your heart too will shine." At mealtimes and before every lecture, and especially during the exercises of *misogi* [water ablutions] and *seiza* [seated meditation], we were told to adjust our posture, for having the proper posture was the equivalent to having the proper attitude; "fixing" (*naosu tadasu*) the posture was equivalent to adjusting the *kokoro*...

The ethics center recognizes that adhering to all these forms – physical and social – can be exceedingly difficult. Conforming to social roles, submitting to strict discipline, arising early in the morning, sitting on rocks, running marathons are fully acknowledged to be demanding tasks. Yet *kuro*, hardship, has a paradoxically salutary effect. Hardship draws on the inner reserves of energy, allowing one to tap their potential to the fullest. At the center, in fact, one of the central doctrines was "Hardship is the gateway to happiness"...

In Japanese society generally, hardship is considered one pathway to mature selfhood... You must also see things through to the end, and, as a result, endurance and perseverance are among the most frequently cited virtues in Japanese society (Kondo 1987:264-5).

Kondo's observations and analysis of the ethics retreat demonstrate the importance of *gaman* and *seishin* as principle components of the work ethic and of selfhood more broadly speaking. The rhetoric of *gaman* and *seishin* imposes a way of enduring personal difficulties, a way that includes neither complaint nor the assumption that difficulties are negative experiences. Under the light of *gaman* and *seishin*, suffering takes on a moral sheen. It is a means to a better end. Suffering yields self-discovery and strength.

D. *AWARE*

The third concept, *aware* [ah-**wah**-ray], links with *gaman* and *seishin* in terms of providing a conceptual frame for, and a guideline for responding to, suffering. *Aware* translates loosely as “sadness,” “pathos,” or “misery” (Sanseido 1999:18), but these standard dictionary translations are somewhat superficial for they fail to capture the essence of *aware* as an emotion that stems from a recognition of the impermanent nature of the world. As Thomas J. Rimer explains,

[*A*]ware is a difficult one to find a match for in English. Some have suggested the rather awkward phrase, the “ahness of things,” meant to suggest a sudden deep and intuitive understanding of life and its transience that can come on someone unawares and move him or her tremendously. In the Heian period, *aware* sometimes included a sense of joy, but in the medieval period, it came to represent primarily a sudden consciousness of the sad, even tragic nature of one’s feelings and of the world itself (Rimer forthcoming).

In keeping with this combination of emotionality and awareness, Naomi Fukumori adds the following,

NF: “*Aware*” refers to something that’s frail, that draws one’s sympathy. It’s the realization that something is ephemeral. It’s an observation of someone else’s situation that resonates emotionally in the heart of the observer. The sadness is generated by observing something external to oneself – it’s about sympathizing with something or someone else.

“Melancholy” in English describes an emotional state within and about oneself, but in Japan, people would not describe *themselves* as being “*aware*.” *Aware* describes *other* things, *other* people, animals, nature, helpless things, powerless things. *Aware* is the word we apply to what those others are experiencing, and we are saddened and moved by their experience. But it’s not dramatic or vivid, really. *Aware* moments are not big tear-jerker moments. They’re quiet, almost peaceful moments. They’re moments when you just look at something dying, going away, or pitiful in some way. You say “Ahhh” in a sad way because you know there’s nothing to be done about the situation. In fact, this “ahh” is what the “a” in *aware* actually means. It’s an onomatopoeic word. It’s like “*ahhh-ware*” – with the “a” being the “ahh” of recognition, and the “*ware*” meaning what “*ware*” normally means: “we.”

KV: Can you give me an example of one of those *aware* moments?

NF: Watching cherry blossoms scatter. It's an aesthetic experience tinged with sadness. It's a melancholic scene. Responding to it means that the feeling resonates within yourself. Seeing out there what you feel deep down. So, yeah, I don't want to overemphasize this third-person aspect of it, because the feeling that the observer gets from seeing whatever it is that he's seeing tells something about his own character. It's about his sensitivity. Watching and feeling is really a projection of the observer's state of mind. It seems one step removed, but it's really not. It's like reading a novel or just experiencing art in general. The creator's point isn't just to explain what happened; it's to create a feeling in the reader or the observer. It's not about the distance between observer and observed. It's about connection, sympathy: sadness out there, and sadness inside.

From Rimer's and Fukumori's descriptions, one can see that there are several elements to *aware*. First, there is the notion of sadness – sadness felt in response to an event or circumstance. Second, there is the element of observation and sympathy. The event in question affected some third party, yet the observer is moved by the event. Third, there is the recognition that nothing can be done to remedy the situation. There is a degree of hopelessness that lies at the heart of the matter. Fourth, the situation is not seen so much as tragic, but as natural. There is often no good-guy/bad-guy dichotomy, i.e. no one to blame for what has happened. It has merely happened, and there is nothing to be done in terms of attributing blame, investigating it further, or resolving it. It has merely to be accepted for what it is. There is a “that's the way of nature” sensibility to it. Fifth, the observation links the observer and the observed, for the observer recognizes that the sadness just witnessed is in some way universal, an inescapable part of living. To use a Western analogy, there is an “It tolls for thee” element to it. Sixth, *aware* is not only sad, but beautiful, and its beauty stems from its being a universal aspect of life. It describes something foundational about the experience of all living things. *Aware* puts us in touch with a deeper truth.

In short, then, *aware* steers observers to respond in a particular way to painful events: to accept them rather than fight them or try to correct them. Buddhism's first tenet – that life is suffering – is an expression of *aware* par excellence. *Aware* asserts that sadness is natural, inescapable, unresolvable, outside the realms of morality and justice, and something that gives us insights into the way of the world. *Aware* is the beautiful sadness that reminds us of something elemental.

Donald Keene asserts that *aware* is one of the four main principles of Japanese aesthetics. In *Source of Japanese Tradition*, he and de Bary et al. discuss the words that comprise the “vocabulary of Japanese aesthetics.” As they explain,

The most famous of these words, and one that has had whole volumes of serious research devoted to it, is *aware*... [*Aware*] came to be tinged with sadness... It bespoke the sensitive poet's awareness of a sight or a sound, its beauty and its perishability... (de Bary et al. 2002:197-8).

In terms of the history of Japanese aesthetics, it is interesting to note that in the Japanese literary and historical traditions, there is an abundance of heroic characters who, to put it bluntly, fail. Their stories are stories of sadness, of individuals working diligently and doing nothing wrong, yet meeting sorrowful ends. Examples include the 47 Ronin (the 18th century warriors who avenged their lord's death knowing that they themselves would have to die as a result), Minamoto no Yoshitsune (the great 12th century general who, after winning splendid battles to help bring his older half-brother to power, was eventually hounded by that brother and forced to commit ritual suicide), and, in an example closer to home, the kamikaze pilots of World War II. The fact that these stories are so revered by audiences speaks to something about the intersection of morality, aesthetics, and worldview. As Ivan Morris explains,

This predilection for heroes who were unable to achieve their concrete objectives can teach us much about Japanese values and sensibility – and indirectly about our own as well. In a predominantly conformist society, whose members are overawed by authority and precedent, rash, defiant emotionally honest men like Yoshitsune and Takamori have a particular appeal. The submissive majority, while bearing its discontent *in safe silence* [italics mine], can find vicarious satisfaction in identifying itself emotionally with these individuals who waged their forlorn struggle against overwhelming odds; and the fact that all their efforts are crowned with failure lends them a pathos which characterizes the general vanity of human endeavor and makes them the most loved and evocative of heroes (Morris 1975:xxii).

Such characters truly represent failure, sadness, and loss; and unlike so many “tragic” figures, especially martyrs, in the various Western traditions, the legacy of Japan’s heroic losers is not one of inspiring a call to continue the fight, but, quite the contrary, to recognizing that goodness often comes to sad ends. As Morris continues,

Faced with defeat, the hero will typically take his own life in order to avoid the indignity of capture, vindicate his honor, and make a final assertion of his sincerity. His death is no temporary setback which will be redeemed by his followers, but represents an irrevocable collapse of the cause he has championed; in practical terms the struggle has been useless and, in many instances, counter-productive (Morris 1975:xxii).

In this elevation of the loser to heroic status, achieved through the process of sympathetic recognition of futility, i.e. *aware*, we can see that there is an emotional identification with the person who dedicates himself completely to his duty, but who either fails or experiences a miserable end in the process. Duty and sadness, therefore, oftentimes operate hand in hand within this moral sensibility.

E. CONCLUSION

Gaman, *seishin*, and *aware* form a conceptual backdrop, a set of cultural values, that informs the interpretation of suffering and ideas about how to respond to life’s difficulties. Of the

three, *gaman* and *seishin* are the ones most directly related to assertions of Japan's having a tradition of stoicism. Though such a generality can indeed lead to stereotypes, it is nonetheless true that *gaman* and *seishin* have garnered attention from both Japanese and foreign scholars who together assert that the words embody longstanding moral sensibilities. This is not to say that all Japanese people are stoic, but it is to say that there is a strain of discourse focusing on *gaman* and *seishin* as principles for approaching life in all its difficulties, that this discourse begins in the lives of many Japanese children as their parents and teachers encourage them to merge their individual desires with those of the group, and that the discourse is visible in the way that companies train their employees and in the way that employees view their workplace responsibilities.

With the virtues of *gaman* and *seishin* operating in the background of everyday life, then, we can see how a discourse on depression might have difficulty finding a foothold. Indeed, I suggest that the emphasis placed on *gaman*, *seishin*, and related notions of duty, responsibility, self-development, loyalty, working in harmony with one's in-group, and so forth, have together formed a morality of character that sees the individual's experience of pain as secondary, albeit integral, to the pursuit of larger goals. A recognition of depression, on the other hand, requires that the individual decide that his/her personal sufferings are abnormal, that they have gone far enough, and that further suffering is not warranted. But in a society that, since 1868, has had great success in mobilizing its populace to work toward national goals, philosophies of individualism as well as discourses emphasizing the individual pursuit of happiness have had difficulty taking root. Instead, collectivist goals have taken center stage for much of Japan's modern history.

In the post-war era, these goals have taken the form of economic development, and Japan's effort to achieve the so-called "economic miracle" of the late 1950s and 60s was based, at least in part, on the ability of individual workers to dedicate themselves almost exclusively to corporate productivity.

With that era coming to a close, however, one might think that the promises and expectations that supported such a work ethic would be dissipating. But this has taken place very slowly, for as we will see in the next chapter, working under the risk of losing one's job, an employee will often dedicate himself all the more to that job and work all the more diligently in hopes that the pink slip will go to the next person.

In short, *gaman*, *seishin*, and the overall rhetoric of fulfilling one's duty even at the cost of one's personal happiness is one that has had resonance in Japan for centuries. The 47 *ronin* still capture the love and sympathy of Japanese audiences not merely because of their demonstration of loyalty, but because of their awareness that in acting in keeping with that loyalty, they would meet a sad end. Duty and sadness, effort and pain, commitment without reward – these are combinations that appear again and again in Japanese discourses on both morality and suffering.

Though *aware* seems, at least on the surface, rather separate from issues relating to *gaman* and *seishin*, I suggest that the three are related in the sense that each encapsulates something of the cultural sanctions that influence the way that individuals experience and are expected to deal with difficulty, stress, loss, and sadness. In one way or another, each term provides both a description of an emotional state as well as a guideline for framing and dealing with negative emotions. Whereas the values placed on *gaman* and *seishin* prime an individual for how to approach difficulties, *aware* relates to how to view those difficulties once they have taken

their toll. *Gaman* and *seishin* are about persevering through stress; *aware* is about recognizing that few of life's real stresses are truly overcome, and that instead of maintaining unrealistic expectations, there is a need to accept the fact that some things cannot be helped.

Granted, there is a tension operating between the aesthetic sensibility of *aware* and the injunction toward effort, work, and perseverance of *gaman* and *seishin*. The difference is a matter of acceptance versus vigor. However, the tension need not produce a contradiction, for the two sensibilities can easily operate in tandem, and I think that the result is something translatable as "stoicism": quiet endurance, with the understanding that the overall situation is something that may never change, but that obligations are what they are, and as such, continuing effort is required. This mode of thinking is one that stems from the combined sensibilities of *gaman*, *seishin*, and *aware*.

Ultimately, perseverance and raw will power are virtuous, no doubt. But expectations should be tempered with the mature awareness that sadness, especially in the lives of virtuous people, is inevitable. Work hard, but don't be fooled by shallow promises of happily-ever-after.

Prozac is the "happy pill" (Sigroth-Lambe and Lambe 1994; Healthyplace.com 2004), at least in the words of certain Western commentators. In Japan, however, no articles refer to it so glibly. This reflects the fact that reframing sadness and suffering from a character and life issue to a medical issue is something that has taken some time in Japan. Indeed, with injunctions suggesting that the proper way of dealing with major stresses in life is to work hard, be patient, and persevere till the end, it is easy to see how making a shift from viewing stress and hardship as an inherent aspect of living to viewing it as medical problem for which a pill can help would

require some conceptual reconfiguring.

In terms of asking why this shift is so long in coming, I think it is safe to suggest that values embodied in such words as *gaman*, *seishin*, and *aware* have helped forge a way of thinking – a mode of stoicism – that permeates the way that many Japanese view the problems for which the term “depression” supposedly represents. Many articles on depression in Japan have repeated the claim that the Japanese view these kinds of problems as “character” problems (Kirmayer 2002), and I think that through language we can see some of the manifestations of the reality underlying that assessment.

V. STRESS SOCIETY

*“30,000 Japanese a year have been killing themselves:
Inside a problem the country is only beginning to talk about.”*
Newsweek cover story title (August 20, 2001)

A. POSTWAR SECURITY AND ITS DEMISE

For most of the post-war period, from the mid-1950s to the late 1980s, Japan enjoyed a sense of both economic and political security. Industrial productivity increased so dramatically that the late 1950s and early '60s witnessed the “economic miracle,” and the next 20 years saw incomes and standards of living continue to rise. Japan maintained what historian Kenneth Pyle calls an “astonishing rate of growth” for the entire period from 1955 to 1970 (Pyle 1996:244); and the unemployment during most of this time averaged no more than mere 2%, with the best years averaging about 1.1% (Taira 1983).

Security was indeed one of the primary goals and the realities of the post-war period up until the early 1990s. Japanese families saved at a rate higher than most other industrialized nations (Pyle 1996:255), and many did so through low-yielding yet safe postal service savings accounts. Companies, the majority of which had raised their capital more through bank loans than stock offerings, aimed more for long term stability and incremental growth and less for short term profits. Students aimed to get into the best colleges for the purpose of getting into the best companies, which would then guarantee them a steadily rising income for the rest of their lives. Neither the maverick entrepreneur nor the “get rich quick” mindset captured the attention of

mainstream society. Individuals and companies were seeking to maximize their well-being and productivity over the long haul. Security was a dominant goal.

One feature of this period, one that promoted security both within corporate culture and within the lives of individual workers and their families, was the “lifetime employment system,” in which young workers would enter a company right out of high school or college, then work for that same company until retirement, with promotions and raises granted according to seniority. Though this system did not apply to everyone, it was common among mid- and large-size corporations such that it characterized the employment of many, if not most, white-collar workers, i.e., those called “salarymen” (Aoki 1988; Dore 1973). In terms of security, salarymen had it good during Japan’s boom years. Salaries were so high that spouses rarely had to work during their child-rearing years (Ochiai 1994), and layoffs were rare (Abegglen and Stalk 1985). The lifetime employment system and Japan’s surging economy combined to create a large and stable middle class that exemplified Japan’s transformation from the class-based society it was before the war. With such a strong middle class, an expanding economy, and a stable government, Ezra Vogel felt safe entitling his 1979 book, *Japan as Number One* (Vogel 1979).

The security of Japan’s boom years is reflected in other structural elements. The education system, for example, operated in almost perfect synch with the needs of Japanese industry. Companies often recruited only from particular universities, thereby establishing a school-company pedigree system that almost guaranteed that the university a person entered determined a great deal about that person’s later career and life path. If one performed well on university entrance exams, he could enter a certain university. If he entered that university, then upon graduation he could select from among X family of corporations, which in turn would grant

him Y standard of living and prestige for the rest of his career. It was a system that for the most part played by the book: the rules were transparent and institutionalized, and the results were predictable. For those middle-class and above, it was a system that generated a sense of safety and stability – a sense that was supported socially, politically, and economically. Many parts of Japan were running smoothly, and Japan’s citizens could rest securely in the benefits that such smoothness offered.

But much of this started to unravel with the so-called “bursting” of the economic bubble in 1990-91. This is when Japan’s stock market crashed, triggering a devaluing of debt and initiating a series of recessions. Inflated property values, once deflated, became unpayable debts; corporate profits in certain sectors (especially manufacturing, transportation, communications, finance, and construction)(Akama and Nagai 2001) began to plummet; and worst of all, companies started laying off workers.

The lifetime employment system had originated back in the 1920s, but it became solidly institutionalized after World War II (Gordon 1985). Since World War II, most companies had abhorred the prospect of layoffs, such that Sony’s founder and CEO Akio Morita was quoted in 1989 as saying,

If we face a recession, we should not lay off employees; the companies should sacrifice a profit. It’s management’s risk and management’s responsibility. Employees are not guilty; why should they suffer (Morita 1989).

For the Japanese, layoffs symbolized something un-Japanese – it represented American corporate culture’s cavalier attitude toward workers. In Japan, the familial sensibility – the “industrial familism” – that allegedly characterized worker-company relationships had become part of the national discourse, as represented in the national railroad’s referring to itself as the “One Railroad

Family” (Noguchi 1990). Japan was a nation of workers more than a nation of consumers, and the long-term commitment that workers and companies had toward each other, as well as the expectations that each had regarding the other, provided a synecdoche for the “we’re in this together for the long term” mindset that motivated workers to work such notoriously long hours ever since World War II. Layoffs did not fit with Japanese corporate culture’s view of itself; and, as long as productivity and profits were strong, layoffs were rarely a major issue.

But in the early 1990s, a new euphemism became popular: *risutora*, the Japanese transliteration of “restructuring,” which simply meant layoffs. In 1990, 505 companies announced layoffs. In 1994, 5,324 did so (Ahmadjian and Robinson 2001). In 2001, the number of corporate bankruptcies alone totaled 18,926 (Yumiko Ono 2001).

If lateral moves were possible, then layoffs would not have been so painful for these workers. But a seniority system inhibits workers from moving to different companies after becoming established in their initial companies; and for a middle aged or older employee to lose his job, the prospects of finding another job at another company with a comparable salary and benefits were negligible. The layoff, Japanese style, was therefore more catastrophic than one in the United States, where a merit-based system of advancement as used in most companies made switching companies not only possible, but part and parcel of most employees’ career paths.

Japanese workers had come up through a system predicated on the assumption that if one studied hard during childhood, scored well on university entrance exams, graduated from a good university, then entered a good company, then the company would reciprocate those years of effort by granting job security until retirement (Cole 1979:11; Kariya 1988). But layoffs destroyed that picture, and with it these workers’ primary sense of stability and purpose.

It is this breakdown of security that made some Japanese workers particularly ripe for mental health problems as the period of stagnation and economic restructuring dragged on. By the early 2000s, many Japanese commentators and journalists were starting to use the phrase “Stress Society” to characterize the state of Japanese affairs. They did not use the phrase “Stress World” or “Stress Economy,” but instead used that phrase which referenced a domestic situation that encompassed many aspects of daily life. It was Japan that was at issue, not the world, and the stress in question was one that cast a wide net: companies were struggling, workers were struggling, the economy was stagnant, families were exhausting their savings, the education system was demonstrating its inability to keep up with the times, the nationalistic pride that had been stoked by the “economic miracle” and its subsequent two decades of international success had been called into question, and there were few alternative visions in sight. As workers worked all the harder to prevent the pink slip coming their way, and as companies demanded even more from their employees in order to maximize productivity without taking on new hires, the stress started taking its toll.

B. THE LAYOFF

From the perspective of workers, *risutora* [restructuring] is the dagger of Japan’s economic crisis. Though low by international standards, Japan’s current unemployment rate of around 5% is the highest it has been since World War II. Facing the prospect of unemployment is one of the worst fears for any Japanese worker, especially those middle aged and above who know that their potential to find a comparable income elsewhere is minimal.

The impact of layoffs on contemporary attitudes toward work have been significant. In essence, many people are operating under the fear of being laid off, and it is this fear that is triggering the breakdown of security and a host of mental health problems separate from the actual financial problems that accompany a layoff itself.

In a 2002 news article entitled “Bitter legacy as Japanese firms lay off thousands,” Robert Whyment of the *Times Online* captured the personal side of the situation well:

After 11 months on the dole, Shizuka Aida, 59, has advice for the thousands of Japanese school-leavers who begin their working lives this spring: “Don’t give your life to one company, as I did. Look around, see what’s best for you, and don’t become a cog in the organisation.

Mr. Aida’s bitter experience of redundancy underscores how soaring unemployment is changing the way that the Japanese work, and even reshaping personal values. Loyalty and dedication to the workplace, qualities for which the Japanese are famed, are being eroded increasingly as unemployment soars and firms abandon jobs for life...

“I feel as if everything I did came to nothing,” the quiet-spoken father of two said. We’ve all been made to feel this (the company’s failure) happened because we employees didn’t give enough of ourselves, because we didn’t work hard enough...

Losing a job in Japan is more of a tragedy than in most parts of the industrialized world. A job provides a worker’s identity and his tightknit relationship with the company is the basis of social harmony...

Mr. Aida receives £1,047 a month, but his benefits run out in May. He has tried to find a job, without much hope. “They (employers) won’t look at you when you’re over 40,” he said...

Anger at how the company treated him has faded. Bitterness remains. “I told my younger son not to become a company slave like me, but do something he really likes,” Mr. Aida said. “He’s well-aware that a company won’t keep you on for life anymore. He’s seen what happened to his father” (Whyment 2002).

Mr. Aida’s story, as well as his bitterness, is typical of hundreds of thousands of workers who have lost their jobs since the recession began. For these workers and their families, real wages go down (Japan Labor Bulletin 2001b), and the prospects of finding comparable work are negligible. As one newspaper entitled “Japan says sayonara to lifetime employment” put it,

Once those mid-lifers are pushed out, however, they may discover that finding a new job is tough. Many employers have an age limit of 35 for new hires. Even intensive retraining may not help the middle-aged find a new position (Hara 1999).

One cannot but notice that the Japanese government in 2001 merged the Ministry of Labor with the Ministry of Health and Welfare to form a new Ministry of Health, Labor, and Welfare (Japan Labor Bulletin 2001a). As the Japan Labor Bulletin explains the merger,

The newly-launched Ministry of Health, Labor and Welfare will supervise a vast range of administrative policies related to all stages of people's lives: from childbirth and child-care to employment; work-related issues, from initial recruitment to retirement; together with general health and welfare concerns, including pensions, and other policy issues affecting the elderly. It will aim to evolve comprehensive policies taking full advantage of the merger, setting as its specific policy targets: the promotion of comprehensive policies to deal with a shrinking population; the realization of vitality within an aging society; the enactment of social welfare measures combined with employment measures for the disadvantaged and others; and measures to encourage people to be aware of their own health throughout their lives at the workplace and in the local community (Japan Labor Bulletin 2001a).

Given that the labor situation, especially its layoffs and bankruptcies, had by then demonstrated its impact on the well-being of a significant portion of the populace, it should not be surprising that the government found it conceptually appropriate to combine the goals of promoting health and well-being, on the one hand, with the goals of figuring out how to managing the worsening labor situation, on the other. Indeed, several studies by then were examining the relationship between workplace factors, stress, and health on Japanese workers.¹⁵

¹⁵ Organization of Work in a Global Economy: Work, Stress, and Health 1999 - international conference hosted by the American Psychological Association and the National Institute for Occupational Safety and Health. Baltimore, MD. March 11-13, 1999. (See APA Online 1999). Presentations included: "Job Stress and Health in Japan: Baseline Findings from Japan's Work, Stress, and Stress Cohort Study Group"; "Study Design: Job Stress Patterns and Implications for Policy Development"; "Job Stress, Depressive Symptoms, and Sick Absence in Japan"; "Job Stress and Coronary Heart Disease Risk Factors in Japan"; and "The Association Between Psychosocial Job Conditions and Chronic Atrophic Gastritis."

There is such an abundance of literature on the importance of, and particular characteristics of, work in Japan that I will not review that literature here (Arai 1991; Atsumi 1979; Creighton 1995; Dore and Sako 1989; Kondo 1990; Lo 1990; Nakane 1970; Plath 1983). In short, a mountain of literature by anthropologists, sociologists, psychologists, and political scientists suggests that the Japanese sense of self operates via a model of interdependency that holds group affiliations, especially those among workers, workgroups and companies, as a primary foundation of personal identity (Lebra 2005). An interdependency model of worker identity differs from the individualistic model considered predominant in most of the United States, with the result being, as is sometimes made cliché, that Japanese employees will most often introduce themselves with something along the lines of “Hello, I am Watanabe; I work for Sony,” whereas I, following the American norm, introduce myself with “Hello, I’m Ken Vickery; I’m an anthropologist.” My skill-based identity is one that can follow me to whatever organization I end up working at. A company-based identity, however, cannot be transferred. It is more like a marriage than a skill. It is a marker of commitment and affiliation – a social identity, not an individuated one.

As the literature mentioned above explains, there is a long history of using these group models for identity-construction in Japan, leading at least as far back as the early Meiji years, when the national government began promoting the ideology of a single national “family” that was connected through a shared culture, history, geography, and blood (Gluck 1987). Though that nationalistic ideology came to an official end in 1945, it is arguable that citizens, rather than forsaking completely their models of interdependency and their reliance on group affiliations, merely moderated those sensibilities and transferred them from nation to company.

Whatever the ideological or structural foundations, it is nevertheless agreed upon by most observers that, in the post-war era, the company as the center of social life and personal identity has become the dominant model for company-worker relations for most of the middle class. It is not surprising, then, that in an era of layoffs and corporate bankruptcies, workers stand to lose more than just their incomes. They risk losing a foundation of their identities, and they risk losing virtually all sense of social stature as well as social life. Without the companies of which they have been a part for so long, there is oftentimes little left but a sense of shame.

Demonstrating the severity of these risks and losses, one article in the New York Times provides a poignant insight into the shame and quiet misery suffered by those who, having been laid off, cannot seem to get back on their feet. The article, written in 2000 by Howard French and entitled “The Pretenders,” tells the story of a group of visitors to a small public library in downtown Tokyo. The visitors look just like millions of other salarymen who walk the streets of Japan’s cities. They are dressed in suit and tie and carry briefcases at their side. Perhaps they appear to be visiting the library on their lunch break. But in actuality, they are unemployed, and they are there only to hide and pass the time. As French explains,

These men – and they are all men – are the newly unemployed. They are as elusive as body snatchers, rising early every day, donning white shirts and knotting their ties before setting out for jobs they no longer have. Some have not yet found a way to tell their wives and families the bad news. Others are afraid their neighbors will find out. Nearly all have given up hope of a better future: they are middle-aged in a country that hires young and, until recently, for life. This is not the land of second chances (French 2000).

It was not easy for French to gain access to these men, but eventually a few agreed to tell him their stories. They had all lost their jobs to restructuring, but the fear of admitting their situations to acquaintances and neighbors, and sometimes even to family members, was so strong that they

opted to live this lie rather than succumb to the condemnations that would surely follow their confessions. An equally painful component was the sense of confusion and hopelessness left by the layoff. These men had most of their lives and identities wrapped up in their companies, but that had all disintegrated, and they had not yet achieved anything close to a plan B. There were in limbo, with no exit in sight. French relates the story of one man who had been doing this for two years now:

He stayed at home, where his mother cooked and cleaned for him. But the uneasiness began to mount. He was 48. He had no wife and no children. He had no hobbies and played no sports. He had few friends outside work, and no friends, like him, who were unemployed. Career and company had been everything. “Suddenly, I couldn’t imagine what I would do next,” he says, running his fingers through his thinning hair. “Income was not the problem. The question was, What could a company man like me in his 40’s do with the rest of his life?” (French 2000).

At his mother’s insistence, he had sworn not to tell anyone of his situation and to not give any of the neighbors any reason to think anything was wrong. So, he has continued dressing up every morning, and coming to places like this library, so he could pretend, mainly for the neighbors, that he was still everything he used to be.

The main reason that men like this can even survive is two-fold: personal savings and family support. Governmental safety nets are not very helpful (Ostrum 1997). By international standards, the savings rate in Japan has been high throughout the entire post-war era, and as a result many families have enough cash on hand to get them through periods of difficulty. Also, as L. Keith Brown has demonstrated, three-generation households are still common, and in that tradition lies a survival mechanism for many laid-off men and their families (Brown 2003). With neither savings nor family support, however, prospects grow drastically slim, and this possibility is contributing to the stress levels that many families are experiencing.

Worst of all, these trends – layoffs, bankruptcies, unemployment, declining earnings, disintegration of identities, etc. – shows little signs of waning. Quite the contrary, Moody's Investor's Service downgraded Japan's bonds in 2002 to "junk bond" status, on a par with those of Latvia and Poland, and few Japanese or international experts see any immediate way out of the crisis (BBC News 2002; New York Times News Service 2004:11).

Additionally, there is another trend at work here, and it is one that is virtually impossible to change: Japan's demographic situation. With the most quickly-graying society on the planet, caused by record life expectancies combined with low birth rates, it seems a mathematical certainty that, from here on out, fewer and fewer workers will have to devote more and more of their resources to taking care of an increasingly large number of elderly citizens.

With expectations of continuing economic decline, combined with a rapidly-aging population and an aggressive China determined to take over as Asia's main economic player, many in Japan see little reason for optimism. Indeed, the malaise is quantifiable; and the Pew Charitable Trust, in its 2002 report entitled "What the World Thinks in 2002" – an international survey of public opinions about health, economics, and other quality-of-life issues – measured the degree to which this sense of pessimism had permeated Japanese thinking. As the report summarizes, "Japanese tend to take a dim view of their lives and their futures, as might be expected in a country where the economy has been stagnant for a decade" (Pew Research Center 2002:18).

I should add that much of this talk about pessimism, stress, and economic vulnerability may seem quite implausible to the visitor to Japan given that Japanese shopping areas are bustling, that new construction continues to alter the skylines of Tokyo and other major cities, and that

Japanese industries such as automobiles and electronics continue to have such a dominant presence in the international economy. However, perhaps in keeping with John Edward's observations during the last American Presidential campaign that there are "two Americas," I would suggest, in keeping with James Robeson's (Roberson 1998) and others' work examining lifestyles of the working class and the poor, that there are at least two Japans. One is the more visible – comprised of those who are shopping, enjoying secure jobs, and thriving. But the other (one of the others), comprises a small yet growing group of people, most middle-aged and older, whose lives are now poised somewhere between stressed out and being desperate. Most of them have either lost their jobs or are working under the fear of losing their jobs. In the best of cases, these individuals seek out help – from social service programs, friends, government aid programs, or, in an increasing number of cases, psychiatrists and counselors – before it is too late. However, there are many who do not. They decide that they have had enough. With over 30,000 Japanese citizens killing themselves each year – a suicide rate that now ranks among the highest in the world – the most painful symbol of Japan's becoming "Stress Society" has become a public health priority.

C. SUICIDE

In the American popular media, Japanese suicide is often discussed, and often romanticized.¹⁶ There are numerous commentaries on suicide's allegedly being "honorable" in

¹⁶ A particularly flippant, though not atypical, representation of the claim that suicide is not particularly tragic in Japan is found in the last sentence of this excerpt from a section entitled "Kamikaze" on rotten.com:

"Suicide has always been a much larger component of Japanese culture (which has a lot of issues) than in Western civilization, which never really embraced the idea of "death with honor." Samurai code allowed for the practice of "seppuku," which was a ritual self-

Japan: that it carries moral sanction as a noble way to demonstrate one's convictions, that it evidences the continuing presence of samurai notions of loyalty and self-sacrifice, and that it serves as an appropriate mode of dealing with a situation that would otherwise bring shame to one's in-group (Hurst 1990).

These claims also appear in the scholarly literature. As Ruth Benedict stated back in 1946, "American condemnation of suicide makes self-destruction only a desperate submission to despair, but the Japanese respect for it allows it to be an honorable and purposeful act" (Benedict 1974:166). Mamoru Iga, a sociologist, continued in this vein by claiming that in Japan, "suicide has traditionally been an accepted, if not welcomed, way of solving a serious problem" (Iga 1993:301).

It is true that there are numerous stories throughout Japanese history and literature of individuals killing themselves to uphold their honor, to save their in-group from shame, to win victory for one's side, or to demonstrate love in a situation, like that of Romeo and Juliet's, in which a marriage was impossible (Benedict 1974:166). As a result of these heroic and mythologized examples of suicide in literature and the popular imagination, it is true that some types of suicides are memorialized, at least in theory.

There are two "however's," however. First, the existence of suicide in literature and national mythology should not suggest that actual suicide in Japan is more common than it is in other countries. In fact, there have been several international studies of suicide rates, and, until recently, Japan's rate has been no more dramatic than others (Takahashi et al. 1998:277). Second,

disembowelment, popularly known in the West as harakiri. Seppuku was generally used to absolve one's self of some disgrace or defeat. The suicide mindset continues in Japan today, where failed businessmen opt for the "honorable" way out and deranged teenagers take part in Internet suicide pacts for no special reason" (Soylent Communications 2005).

the reasons for suicide among samurai or among forlorn lovers in ancient novels are rarely the reasons for today's suicides (Takahashi et al. 1998:275). So, a good starting place for the study of suicide is to recognize that the overwhelming majority of suicides in Japan do not fit any of the classic stereotypes.

Psychiatrist Yoshitomo Takahashi is one of Japan's foremost experts on suicide, and he asserts that there are many misunderstandings about suicide, not so much among Japanese themselves, but among non-Japanese who may find a romantic escape in Japanese notions of honor and loyalty. As Takahashi explains,

[T]he widely believed view that "suicide is extremely common in Japan" is a myth, probably due to overemphasis of *hara-kiri* (self-disembowelment by feudal warriors), kamikaze pilots, and suicides of novelists... [I]n contemporary Japanese society, suicidal people often consider that death is the only way of resolving a desperate situation, being neither an honorable form of behavior nor a tradition condoned by society. In fact, there is a strong stigma against suicide and intense prejudice toward the mental disorders related to it... Intense social stigma toward suicide is one of the reasons why there have been few biological researches or psychological autopsy studies on suicide in Japan... If suicide does occur, those left behind have to bear a lifelong stigma that a family member took his or her own life... It is generally believed that people should behave as if nothing has happened, never touching upon the subject, and that time is the only panacea for healing their wound (Takahashi 1997:137-9).

Indeed, if the romanticized notions of suicide were the reality, then why does suicide bring such shame and misery to the suicide victim's survivors?¹⁷ Why aren't suicide victims praised or bragged about? Why do obituaries leave out the actual cause of death? Why are there now organizations devoted solely to helping survivors deal with the experience? And why is

¹⁷ A popular book published about the shame of suicide is *Jisatsu te ienakatta* (We Couldn't Talk About the Suicide)(Ashinaga Foundation 2002). The book was written by children whose father had committed suicide. Two of my informants (both clinicians) said that they had difficulty reading the book because it was so tragic.

government, at local and national levels, working with the mental health community to help curb a tide of suicides that some refer to as an “epidemic”?

The reality is that there is a world of difference separating those samurai warriors of yesterday who committed *hara-kiri* [ritual suicide] in service to their lord and those everyday citizens of today who hang themselves in their bedrooms because of any number of personal struggles.¹⁸ The Japanese realize that there is little that is “noble” about having so many people choosing these days to kill themselves. For those left behind, there is more shame than honor. As one newspaper reported,

Yuuki Saito, now 22, said it took him six years to talk to his mother about his father's suicide, and almost four years to admit to members of an orphans' support group that his father had taken his own life, not died in a car accident. "In Japan, to openly discuss something like suicide is never appreciated," Saito said. "We have been raised not to whimper" (Knight-Ridder 2002).

Yuuki Saito is not alone. Though the suicide rate during the entire period from 1945 to the early 1990s was comparable to that of other peacetime industrialized nations, the situation started changing in the mid 1990s. In 1995, Japan's suicide rate ranked about 21st internationally (International Academy for Suicide Research). But by 2000, according to some sources, that rank had jumped close to the top (Political Affairs Magazine 2005). Among OECD nations, Japan moved into the top two (New Zealand Health Information Service 2004). For the first time since such data had been collected, 1998 saw the number of people committing suicide exceed 30,000 (Newsweek Asia 2001), and that level has continued each year since (Japan Times 2005).

Given the recency of this rise in the rankings and the speed with which it took place, one would be hard pressed to find a “cultural” explanation for the shift. Rather, a more promising line

¹⁸ With laws forbidding hand-gun ownership nationwide and with a minimal influx of recreational drugs and rigid control over prescription drugs, hanging is the most common mode of committing suicide in Japan (See Watanabe et al. 1995).

of inquiry would target those socio-economic changes whose timing and trajectory parallels that of the suicide rate. Indeed, one promising variable in this regard is household economics, particularly the number of personal bankruptcies and the number of layoffs. As these have increased in the past decade, so have suicides; and psychological autopsies have suggested that a significant percentage of those killing themselves have been burdened by either bankruptcy, being laid off, or other personal financial problem (Asahi Shinbun 2002a; Asahi Shinbun 2002g).

According to an Asahi Shinbun editorial,

Wage earners and self-employed people in the prime of their lives are killing themselves because of joblessness, failure in business or hardships in daily life. The number of suicides began to increase markedly around 1998, and the trend continues unabated.

According to the National Police Agency, the death toll from suicide exceeded 30,000 for each of the four years since 1998. A breakdown of the statistics according to motive and age group shows that the increase can be attributed largely to a rise in the number of people in their 40s and 50s taking their own lives to escape problems related to work or daily life. The number of suicides therefore increases as unemployment and bankruptcies rise (Asahi Shinbun 2002b).

There is a lot of blame being laid at the feet of the economy generating such a high suicide rate (Oda 2000). However, this blame must be tempered by the fact that suicides differ. Several recent studies have brought into relief the complexities underlying suicide in Japan today and have shown that there exist a host of reasons as to why individuals may be killing themselves. Yutaka Ono's work in particular has examined the reasons for elder suicide (Ono 2004; Ono et al. 2001). S. Rajagopal and others have examined the suicide pacts being formed over the internet by young people (Rajagopaal 2004; Hoffman 2003; Japan Times 2003c), and several experts have examined suicide among middle-aged salarymen (Tomakoshi et al. 2000; Takei et al. 2000). Though each and every case of suicide is specific, there are nevertheless patterns that seem to be emerging from

these studies. Researchers are trying to establish relationships between demographic variables and suicide rates so as to predict who is at greatest risk and understand why they are at greatest risk.

Though the picture is multifaceted, and though the causes of suicide are often myriad, vague and impossible to verify, one of the clear patterns that has emerged is that middle-aged men comprise the group showing the greatest increase in suicide since the rate began increasing back in the 1990s (Asahi Shinbun 2002b; Kawahito and Takahashi 1999). Additionally, evidence from police investigations suggests that the majority of these men had been laid off, had declared bankruptcies, or had experienced some other form of financial crisis during the period leading up to the suicide (Yomiuri Shinbun 2002c).

But middle-aged men experiencing financial and work-related crises, though they have been the fastest-growing group, are not the only group with high suicide rates. Another high-risk group is that of elderly women, especially those living in multi-generation households (Hu 1995; Takahashi et al. 1995; Traphagen 2003).

But regardless of the actual causes of the increase in suicides, the fact is that the suicide rate has surged dramatically in Japan in the past decade, and policy-makers see the increase as a national problem. The increase has garnered close scrutiny by newspapers and television, and it has become a symbol of the fact that “something” is very wrong in Japan these days.

In terms of depression, the relationship between suicide and depression is assumed to be a direct one. Most of the mental health community agrees that severely depressed individuals run a higher-than-average risk of committing suicide and that depression factors heavily in these individuals’ decisions to kill themselves.

However, we are back to the question of just what depression actually “is.” If the arguments suggesting that suicides are, in many cases, prompted by layoffs or financial crises and the concomitant loss of identity, purpose, security, and hope for the future that accompanies such losses, then to what extent is it productive to insert an intermediate criterion? In other words, if the assumption is that there is a connection between suicide and the sense of loss generated by either a layoff or a hopeless financial situation, then why can we not diagnose the problem as “a sense of loss generated by a layoff or a hopeless financial situation”? What does characterizing the situation as “depression” contribute to our efforts to understand the situation and/or help the sufferer? An “idiom of distress” approach would suggest that actually very little is illuminated by reframing the problem as one of “depression.” If layoffs are causing the problem, then perhaps layoffs *are* the problem. If the fear of being a burden on the family is causing the problem, perhaps “fear of being a burden on the family” *is* the problem. The same goes for hopelessness, helplessness, unresolvable loss, guilt, sense of failure, alienation, aloneness, or any of the other myriad reasons that lead people to kill themselves.

What is undeniable, however, is that suicide has become a symbol of the Stress Society and that numerous individuals in government and mental health care are struggling to understand why the rate is so high and how people at risk can be helped (Asahi Shinbun 2002f). Contrary to the romantic notions of “honorable suicide,” few in Japan today are applauding the fact that so many of their fellow citizens are choosing to kill themselves. Instead, there is a growing discourse on the links between stress, depression and suicide, with the primary goal being to encourage those who are struggling to seek professional help. Such prevention messages are prevalent in

newspaper articles, television shows, and public awareness campaigns sponsored by the Ministry of Health, Labor, and Welfare (Ono 2004).¹⁹

Discourses about the high suicide rate, stress, and depression, then, cannot be separated. Each concern intertwines through the others in most media presentations. Though SSRIs are not central to these presentations, they nevertheless are factoring in. They are being offered up as an example of the fact that help *is* available to those who merely ask for it. Therefore, there is a message that SSRIs are helping deliver, and it is targeting not just an individual problem, but a national problem (Chorlton 2001). Suicide is now considered a public health problem in Japan, and most mainstream and professional voices are arguing that socio-economic factors are highly culpable. Assertions of chemical imbalances and genetic predispositions rarely factor into the discussions; instead, there exists a widespread assumption that Japan is experiencing a series of disruptions right now and that three of the consequences of those disruptions are becoming increasingly visible: 1) an increase in the number of people who are depressed, 2) the increase in the number of people who are suffering from stress, and 3) an increase in the number of people who are committing suicide. Therefore, the prevailing “common sense” in Japan is that depression, stress, and suicide are three interrelated consequences of Japan’s current socio-economic realities.

¹⁹ In February 2002, the Ministry of Health, Labor and Welfare began a series of monthly meetings to bring together leaders in the field of suicide prevention to help prepare a coordinated federal policy (Japanese MHLW 2002).

D. KAROUSHI

Operating hand-in-hand with the high suicide rate, few health-related phenomena exemplify the stress of the times in Japan more than *karoushi*. *Karoushi* translates as “death by overwork,” and it is a household word now in Japan. It refers to those employees, almost all of them male, who work so hard that their bodies simply give out, with no other natural or health-related factors reportedly involved. Though there are tales as well as actual incidents around the world of isolated individuals working so strenuously at something that they die (the tale of John Henry in the U.S., for example), Japan actually has a special word dedicated to the phenomenon, with the added recognition that such deaths are not so isolated but instead have become commonplace enough to warrant national attention. Therefore, death-by-overwork is not the stuff of morality tales and lore, but instead is recognized as a not-so-uncommon workplace problem, for which companies are being sued, successfully, and for which the national government is seeking solutions.

The legal impact of *karoushi* cases became especially visible in 2000 when Dentsu, Inc, Japan’s largest advertising agency, agreed to an out-of-court settlement with the parents of a Dentsu employee who had killed himself, allegedly because of overwork, back in 1991 (Japan Times 2000). Following the case, the Ministry of Health, Labor and Welfare began urging companies to take seriously the increasing suicide rate and develop policies to ensure their employees’ mental health. Since the Dentsu case, several other suits have been filed, and several of those have resulted in rewards or out-of-court settlements given to the survivors’ families (Impoco 2002). There is now an organization called the National Defense Council for Victims of Karoushi, which provides legal assistance to survivors as well as pressures government and

corporations to alter the workplace norms that contribute to poor health among employees (Tamaki 1998).

To prevent employees from working too hard and to prevent lawsuits from being filed, corporate management in Japan has had to recognize the need for in-house *karoushi*-prevention measures, and several psychiatrists have been brought on board to assist in this regard.

Occupational psychiatry, therefore, has emerged as a useful tool in this capacity, with clinicians working with managers to establish workplace policies that prevent individuals from becoming burdened with unbearable responsibilities (Shima and Hasegawa 2000; Shima 2002; Shimomitsu 2000). In an article in the *Mainichi Shinbun*, Mark Schreiber presented the case of a man who had died from overwork, as described by his widow, Yukari Kawamoto (pseudonym):

A section manager at Martek, a Kobe-based machinery sales firm, Kawamoto died in April 2002 at age 52. He'd been preparing to leave for the office when he suddenly squatted on his haunches in the living room.

"Cold... I'm so cold," he murmured.

"Maybe you should go to the hospital," said Yukari, worried.

"Too tired..." came the weak reply. Aside from the occasional sniffles, he'd never once been seriously ill. The night before, he'd been unable to eat. Sleepless, he made repeated trips to the kitchen to drink water. And later, when sleep finally came, he never awakened.

"His death, from acute cardiac arrest, was almost spontaneous," says Yukari. "I saw it on my husband's face as he lay there dead; those long working hours killed him."

Toiling weekdays, Saturdays and holidays, Kawamoto had been putting in an average of 120 hours overtime per month without remuneration, a widespread practice known as "service overtime."

Hiroshi Kinoshita, Martek's president, tells Sunday *Mainichi* his company does not coerce staff to perform unpaid overtime.

"We reviewed Kawamoto's time sheet, but there was no record he put in the hours that's being claimed," he insists.

Martek, however, does not use time cards to register employee work hours.

Cases like Kawamoto's are by no means uncommon (Schreiber 2003).

To provide some hard data to go along with Kawamoto's case, the Japan Labor Bulletin reports that the number of "service overtime" has been increasing since 1999. As the Bulletin explains,

According to the results of the Labour Force Survey, the percent of male employees who worked 80 or more hours of overtime a month – the yardstick for judging *karoushi* – hovered around 18 percent between 1993 and 1999, but exceeded 20 percent in 2000, and has increased for the three consecutive years since. By age group, it is workers aged 30 to 34, followed by 35 to 39 year olds and then those aged 40 to 44 who are hit the hardest (Japan Labor Bulletin 2003).

The message from *karoushi* cases, then, is that the strained economy is bringing about a greater workload for those lucky enough to still have jobs. There is nothing special here regarding Japan, for one sees this trend elsewhere. What is special, however, is that this habit of working unpaid overtime hours has become an occupational safety issue. In other words, the long-lauded dedication of employees to their companies – considered a marker of cultural pride – has now crossed a line, and some employees are paying for it with their lives.

The head of the National Defense Council for Victims of *Karoushi*, Hiroshi Kawahito, is one of the most vocal critics of Japanese corporate culture, but he sees that the reasons for *karoushi* are just that – cultural – as opposed to being a matter of bad bosses merely abusing their employees. In an interview with the Daily Yomiuri, Kawahito explained the situation as follows:

Yomiuri: Why has the situation become so extreme?

Kawahito: In our culture, there are no internal factors that restrict us from working. There is no religious custom that prevents us from working on certain days. Our whole society is controlled by a single value. Our society believes that greater efficiency, superior services and more competition are better and, therefore, continues to seek them. There is no final goal in raising productivity (Redford 2000).

What was the pride of the economic miracle – productivity – has now veered slightly out of control, and Kawahito bemoans the fact that there are few culturally-sanctioned wellsprings of resistance, i.e. few alternative values, with which to counter the problem.

Correcting the problem is, therefore, difficult given that struggling companies are trying to survive without hiring more workers and workers are struggling to do anything they can to prevent themselves from being laid off. So, *karoushi* represents a vicious cycle for which there are no easy solutions. Kawahito's organization is trying to help bereaved families mount court cases, and he is also encouraging the government to strengthen and enforce its occupational health and safety laws, especially those regarding overtime. But given that overtime hours do not appear to be diminishing, one result is that the mental health community is stepping in both to help workers deal with their workplace stresses and also to help companies develop policies to maintain productivity without endangering the health of their employees. As the narratives in the following chapters demonstrate, workplace stress is perhaps the common denominator linking the recession, the suicide rate, the increase in *karoushi* cases, and the depression boom.

VI. WARD AND CLINIC

Things are OK. I can get some rest here.

inpatient diagnosed with depression
talking about being in the hospital

This dissertation aims to present as multifaceted a picture as possible of the changing status of depression in Japan. Chapter two introduced the theoretical issues underlying the basic questions, and chapters three and four suggested that historical and literary sources can shed light on the current situation. This chapter, however, introduces the ethnographic component of the project. Based on 18 months of fieldwork in the Japanese mental health community, this chapter will present two main forms of data. The first will be my direct observations in a locked psychiatric ward and a busy outpatient clinic. The second will be narratives from patients whom I met in the ward and clinic. My goal is to show a little of what psychiatric treatments – from daily life on the ward for severely depressed patients to the short sessions in the out-patient clinic for more stable patients – are like. Part of that will be based on my own observations and ruminations; while the bulk will come from patients' own narratives.

The chapter begins, therefore, with a recounting of some of my experiences on the ward. I was particularly interested in the modalities of care, i.e. the use of antidepressant medications, support groups, one-on-one sessions with doctors, recreational activities, and so forth. I was also interested in the doctor-patient relationship, medical training, and some of the more implicit ideas that might permeate care.

Following my observations about the issues, the chapter segues into the narratives of patients. Though I approached my conversations with patients with a questionnaire, I nevertheless wanted the interviews to be as open-ended as possible. I wanted to learn about issues I had not even considered yet. Therefore, the trajectories of the conversations with the different patients were never the same. Some spoke more about family life, some about their struggles at work. Some were philosophical and indulged in heavy social commentary, while others spoke only of their own experiences narrowly prescribed. I hope that the result, however, contributes to a richer, albeit less structured, summation of the diversity of voices from those with the most at stake in terms of depression and its treatment.

A. CASE STUDY INTERVIEW

My first day at Hospital Seishin (pseudonym) began with a case evaluation. Sixteen doctors and trainees had assembled in the ward's tiny, narrow conference room. I had arrived fifteen minutes early, wanting to avoid the possibility of arriving late for my first meeting with the doctors and trainees with whom I would be working over the next few months.

The department had granted me permission to accompany the doctors on their bi-weekly rounds, participate in follow-up conversations, participate in recreation periods with patients, sit in on case study reviews and counseling sessions, and in general just “hang out” with patients on the ward.

The doctors entered one by one and seated themselves on the long, narrow benches that lined the walls. The room was cluttered with boxes of old case records and books. An ancient typewriter sat dusty on a dilapidated desk in the corner. This was a functional room,

unpretentious, not intended for guests or public display.

Hospital Seishin was a private university teaching hospital, and it was located in one of the blue-collar sections of Tokyo. Relative to other private hospitals, Seishin was large, and as a general hospital it offered treatment for almost all major illness and injuries. Though some of its departments were well-known for research and top-quality care, in general, the hospital was considered a mid-level hospital, and it catered mainly to the working-class patients who lived nearby. The layout and decor of the ward and its offices seconded the hospital's reputation as a mid-level institution. Walls appeared not to have been painted in years; floors were worn; some of the chairs and other furnishings were old.

As more doctors entered the conference room, we all squeezed closer and closer together until finally there was not even room to cross our legs. Like finding a seat on a crowded train in rush hour, however, we managed to squeeze in even those who arrived late.

As we waited for the department chairman to arrive, I introduced myself in whispering tones to the doctors sitting around me and nodded knowingly to those few whom I had already met. I had talked to enough doctors in Japan already to know that "medical anthropology" was not a term that most were familiar with, so I had become accustomed to including in my self-introductions a brief description of my field along with particular emphasis on the fact that I was not a clinician. I wanted to clarify that I was not a doctor and that I was looking at the "cultural" aspects of medicine from the perspective of a social scientist.

The chairman of the department arrived precisely on the hour. I had not seen him since my initial interview with him almost a year before. Through a friend of a friend of a friend, I had made contact with a doctor at Hospital Seishin, and while I was in Japan learning language and

conducting preliminary fieldwork, I went to the hospital to meet him and the chairman. It was on the basis on that meeting and the permission granted by the chairman and the hospital administration that I was now sitting there. He nodded to me and began the meeting.

Given that this was a weekly meeting, it had the feel of routine. Until the chairman arrived, some doctors had been discussing their weekends, other patients, the morning's activities, etc., while other doctors were getting in a few minutes of sleep. However, conversations and naps ended when the chairman entered, and the meeting started immediately. He began by acknowledging that there was a guest present (me) and that he would have introductions later. He then invited the doctor in charge of Ms. Tanaka [pseudonym], the patient for today's case study, to review her file. The doctor, one of the senior physicians on staff, then presented the basics: name, age, diagnosis, admissions summary, chief complaints, medical history, job, living situation, family history, and current medications.

Given that over half of the doctors present were trainees, the chair asked if there were any questions so far. No one responded. The chair then invited one of the younger clinicians to summon the patient and escort her in.

In just a few seconds, the two entered and took seats at the head of the room. In a calm, gentle, yet matter-of-fact voice, the young clinician introduced himself, thanked the patient for coming, and explained to her that she had no obligation to answer any questions she did not want to and indeed could leave at any time she wanted to. He then clarified that the purpose of the meeting was merely to benefit the medical trainees, to help them learn about her symptoms and experience. He then asked if she understood. She said "yes." He asked if she had any questions for him or for anyone else there. "No." He then asked if she could answer a few questions about

herself. “Yes.”

He then started asking basic questions about her life. How old are you? Where do you live? What is your job? When did you arrive at the hospital? Are things going well at the hospital so far? Is the food OK? Have you been sleeping OK?

After she gave one-word answers for each of those questions, he then started on more substantive questions: Tell us about the few days before you entered the hospital. How were you feeling on those days?

I was impressed with the calm and sensitivity of the interviewer. English-language descriptions of the Japanese doctor-patient relationship sometimes present Japanese doctors as authoritarian, demonstrating little of the “human touch” and compassion associated with a good bedside manner (Konner 1994:26). But this interviewer was nothing like that. He knew how to communicate with a troubled patient. He established rapport with her immediately, made sure she was comfortable, started with easy questions that required only one-word answers, then slowly transitioned to more complex questions. All along, he used a supportive voice, nodded approvingly whenever she answered, and gave her as much time as she needed to think about her answer. And in those instances when she couldn’t answer or when she answered with “I don’t know,” he just moved onto the next question without pressuring her to come up with an answer.

After twenty minutes, the patient started staring blankly ahead and stopped answering questions. She looked tired. The interviewer stopped asking questions, thanked her for her participation, and asked her if she needed anything. She said “no,” and so he escorted her back to her room.

I thought it was a delicate and sensitive interview, conducted by a clinician who was tuned into the condition of the patient. Though the encounter was ostensibly about her, I was focusing mainly on him and the interaction between him and her. The authoritarian doctor was not what I saw.

I learned later that day that the interviewer was not a psychiatrist, nor even a doctor at all. He was a master's level clinical psychologist in training. I wondered why the doctors chose not to have one of their own conduct the interview. In my journal I wrote: "Ask why a clinical psychologist is conducting case study interviews."

I had been looking forward to observing the conversation to follow the case-study interview. I was curious not only about doctor-patient relationships, but about doctor training. In the rounds that I had participated in at the University of Pittsburgh's psychiatric hospital, the Western Psychiatric Institute and Clinic, attending physicians adopted a Socratic mode of teaching: following a patient interview, doctors would drill residents on the interview, demanding that the residents demonstrate a thorough mastery not only of that particular patient's condition, but of the condition more broadly speaking, with the goal being the resident's ability to write an order based on what he/she observed during the interview. This mode of Socratic pedagogy, with some medical schools being more notoriously aggressive in their training than others, is the norm for American medical education.

The conversation following the patient's exit from this case conference, however, contrasted with the Socratic method with which I was familiar. It was a casual conversation, in which those who wanted to participate did so, and those who didn't did not. The attending physician invited questions from the trainees, but he did not ask any directly to them. No one was

put on the spot. When there was a question from a trainee, either the chairman or the doctor in charge of that particular patient's case answered. The direction of the question-answer session was just the opposite of what I had seen at the University of Pittsburgh.

Later, I asked the chairman about the discussion and its representativeness as far as Japanese medical education went. Specifically, I asked why he asked so few direct questions and demanded so few answers. He answered merely that perhaps Americans were simply more aggressive and that medical education merely reflected this trait. In Japan, however, that type of aggressive exchange just was not the norm, he continued. Another doctor, however, one who had trained outside of Japan and who was critical of many aspects of Japanese medical education and care, offered a different theory, suggesting that the Socratic method has never been part of mainstream pedagogical theory in Japanese higher education, and not in medicine particularly. Instead, he said "We've been taught to watch and learn through watching. To mimic without saying anything. To assume that the Master has all the answers. Instead of asking questions and analyzing, we learn by observing." Perhaps this apprenticeship approach to learning accounted for the conversation following the case conference.

Another doctor added to this, saying "I've seen how doctors treat residents in American medical schools. They like to make them feel stupid, to embarrass them. I don't see the need for this, and most other Japanese doctors don't see the need for this either. It's aggressive and embarrassing."

I responded, "So you think that *not* aggressively asking questions and *not* demanding answers on the spot is a good way to train doctors?" "Hmm, I think so, if it's done right," he answered. "There are many ways to learn, don't you think?"

The next day, I participated in my first rounds. The psychiatric ward at Seishin had rounds twice each week, in which the attending physician, along with most of the physicians on staff and the trainees, would all walk down the corridor, visiting patients – half of the patients on one day, half on the other day. Sometimes there were as few as eight doctors and trainees; at other times there were as many as twenty.

We met in the small conference room before rounds and briefly reviewed each patient's file. Afterwards, we started down the hall.

On today's agenda were fifteen patients, ranging in age from 18 to 70, about half male, half female, and with diagnoses including schizophrenia, depression, bipolar disorder, eating disorder, and many others.

Seishin's was a 40-person ward, with no segregation by illness. Schizophrenics shared rooms with patients with other conditions, with the only exception being the patient who was so delusional, violent, or in other ways troublesome such that he or she had to be moved to an isolation room. This was not uncommon.

There was segregation by gender, however. Rooms on one corridor were for males, those on the other corridor for females. The corridors ran parallel, and each branched off from the central meeting area which doubled as the recreation area and dining area. Behind a glass wall and looking over this central room was the main nursing station.

This week, about half of the patients on the ward were diagnosed with depression. The staff all agreed that this percentage was typical for Seishin. They also agreed, however, that the numbers of depressed patients had been slowly rising over the last few years. As one older doctor said, "When I started here nine years ago, there weren't so many patients with depression. But

times have changed. People have more to be depressed about. Especially poorer people. We see a lot of people here who don't have jobs anymore.”

We entered the first room. It contained four beds, and beside each bed was a small night stand with a cabinet and drawer. A curtain could be pulled around the bed for privacy, but the space between the beds just barely allowed for a person to walk, and each bed was pushed against the wall. Space was at a premium.

The first patient sat up straight on the edge of the bed when we arrived. It was almost as if he were sitting at attention. The chairman spoke first:

Doc: How are things?

Pt: OK.

Doc: How are you sleeping?

Pt: Well.

Doc: Appetite?

Pt: Good.

Doc: Anything else bothering you?

Pt: I think I'm OK.

Doc: Well, take care.

The patient answered crisply, nodding affirmatively as if to ensure the doctor that he was doing well.

The entire exchange took less than a minute. The chairman and the doctor in charge of the patient exchanged a few whispered words, then it was on to the next patient. There were no questions by trainees or other doctors. The only person to say anything was the chairman himself. The trainees stood quietly, watched, and listened.

This patient had been hospitalized for depression.

The next patient, however, was mildly schizophrenic. When we steered attention toward him, he too sat up on the side of his bed, virtually at attention, and awaited the doctor's questions.

Doc: How are things?
Pt: OK.
Doc: How are you sleeping?
Pt: I'm a little tired.
Doc: Appetite?
Pt: Good.
Doc: Anything else bothering you?
Pt: No, I'm OK I think.
Doc: Well, take care.

The attending and the patient's doctor – a different doctor from that of the last patient – consulted quietly for a few seconds, then we all exited the room. Again, no discussion.

Our next patient was asleep when we entered the room. His diagnosis was depression, and he had been at the hospital for four weeks now. The attending nudged him on the shoulder to wake him up. "It's time for rounds." The patient slowly came to, then sat up for his questions. He was still groggy.

Doc: How are things?
Pt: Umm, OK
Doc: I guess you're sleeping OK.
Pt: Yes (laughing a little).
Doc: How's your appetite?
Pt: Not so good.
Doc: Anything else bothering you?
Pt: I'm OK.
Doc: Well, take care.

By this third patient, the pattern seemed clear: these doctor-patient "discussions" were perfunctory and concerned almost exclusively with eating and sleeping. In all of my experience at the University of Pittsburgh, I never witnessed a dialogue during rounds as short and as seemingly meaningless as these. Discussions that I had seen went into greater depth regarding the patient's conditions, dealt with issues far beyond mere sleeping and eating, and entailed the attending's

explaining significant points to residents after each patient. What, then, was the purpose of these odd little conversations? I wrote in my notebook: “Questions: Why so short? Purpose?”

When I posed these questions to various doctors afterwards, I received a variety of answers. Almost all of the senior doctors suggested that the questions were sufficient for engaging the patient in conversation. If patients wanted to talk more, they could. These doctors agreed that the rounds were a useful component of patient care because they allowed the chairman to check in on each patient and allowed the patient to talk one-on-one with the chairman.

Another young resident, however, one known to be somewhat critical of many treatment strategies prevalent both at this hospital and throughout Japan, stated that he could not find any justification for rounds. “It’s the way we’ve done things in the past, so it’s the way we do things now. Rounds – they’re useless.”

But if they are so useless, then why did so many patients adopt the particular mode of body language and speech that they did when the chairman entered the room to talk to them? Many patients sat up straight in their beds, straightened their hair, adopted a respectful manner of speaking, and in general gave the impression that they took the discussion seriously. Many smiled, looked either excited or relieved, and in general seemed to enjoy the encounter. Could it be that what these rounds lacked pedagogically was made up for therapeutically? In other words, is it possible that these rounds were serving the interest of the patients more than those of the trainees, in spite of whatever the “explicit” purpose of the rounds was?

Stanley Tambiah has called attention to the performative component of medical care, arguing that the prestige of the doctor and other aspects of the clinical encounter can actually aid

the healing process (Tambiah 1990). Tambiah calls this “performance efficacy,” and by that he means the ability of the ritualized interaction between patient and healer to induce those positive effects commonly labeled the “placebo effect.” As Ted Kaptchuk elaborates, this effect relies “on the power of belief, imagination, symbols, meaning, expectation, persuasion, and self-relationship” (Kaptchuk 2002:818). Though clinical research often strives to diminish the placebo effect, recent studies have suggested that the placebo is powerful enough so that the medical community should be searching for ways to maximize it rather than ways to diminish it (Crow et al. 1999). In terms of ways that do seem to promote the placebo effect, the status of the physician, the attitude and manner of the physician while talking to the patient, the setting of the encounter, and many other non-biomedical-proper characteristics can have significant impact on recovery rate (Kaptchuk 2002:818-20).

One doctor on the ward supported Tambiah’s notion of performative efficacy by suggesting that the purpose of rounds was to demonstrate prestige – that of the chairman or the attending physician for that day. As he explained:

Doc: The more trainees there are, the more important the attending doctor appears. If there are lots of trainees watching the doctor, then he must be a real expert. Patients are assured by this.

KV: So this is a matter of enhancing the appearance of the doctor, as opposed to teaching the trainees per se?

Doc: Yes. Appearances are important. They’re important for patients. It’s good for patients, I think.

Though it is one thing for a doctor to assert this, it is another for a patient to actually admit it. However, in a discussion I had with a patient several months later, I received clarification that indeed, for this patient at least, just being in the presence of a doctor can have therapeutic effects:

KV: So what did you and he [the doctor] talk about?

Pt: I told him my concerns, about the things I was worried about. But just upon looking at his face, I felt good. I think many people feel this way.

KV: Why is this?

Pt: There's something real about the doctor. We just trust him. If I just meet him, my worries are gone.

KV: Just by meeting him?

Pt: Yes.

KV: So you just walk into his office, see his face, and immediately you feel better?

Pt: Yes.

If the purpose of the rounds, then, is to give the patient the opportunity for the spotlight, for some face-time with a prestigious doctor, then the topic of the discussion is really not all that important. In this light, the chairman's pattern of asking about appetite and sleep takes on greater meaning, for what can be easier for a nervous or distressed person to talk about than food and sleep? The answer, I think, has to do with the conversation and the topics therein serving more as means than as ends.

One of the most popular topics of conversation in Japan, especially among people who have either met for the first time or do not know each other very well, is food. I have personally had the same conversation about food at some point with almost every Japanese person I have met – discussions of favorite foods, favorite restaurants, curiosity about American's ability to eat Japanese foods, assertions about the health-generating aspects of certain foods, bizarre foods, gender and foods (“Only effeminate or depressed men like sweets, you know”), and so forth. At one restaurant, I sat next to two twenty-something women who spent their entire lunch, exactly fifty minutes, talking non-stop about their favorite foods.

This interest in foods is supported by the fact that at almost all hours of the day and night, there are television shows airing that revolve around food, whether the ubiquitous show on food

preparation, the day-time quiz shows that examine the health benefits of particular foods, or the comedy shows that film the stars conversing and making jokes while eating at a restaurant.

One of the tenets of the subfield called the “anthropology of food” is that the act of eating is rich in meaning; and this is no doubt true in Japan. I suggest, however, that one of the hallmarks of food culture in Japan is that food serves as an ice-breaker in conversations precisely because it is something that anyone and everyone can discuss. It can be discussed without reference to controversial issues; and it is an equalizer, i.e., anyone can participate in the discussion. No specialized knowledge is required to talk about one’s favorite foods.

On these weekly rounds, the attending physician seemed to be capitalizing on this aspect of food culture as he asked patients about their appetites. It was a question that they could all answer, and it eased the tension between doctor and patient. He was “on safe ground” so to say. In this way, he could focus on what was the deeper purpose of the exchange, and this was to get a general reading of the patient’s ability to express himself and his general ability to be in touch with his/her own condition. After all, any oddities in the patient’s dietary habits had already been marked on the patient’s chart; therefore, if the patient complained of no appetite yet the chart showed that he was eating normally, then perhaps there was a disconnect that required follow-up inquiry. By the same token, if the patient said his appetite was fine yet the chart showed that he had not eaten very much and that he had lost weight, then again, follow-up inquiry was suggested.

In this light, it was not necessarily the case that the doctor was merely going through the motions of asking superficial questions, but that he was asking a question that virtually all patients, if they were cognitively and emotionally able, would be comfortable answering and even

talking about at length should they feel the need.

Most Japanese are used to talking with strangers about food. Many, however, are not used to revealing to doctors and strange onlookers their deeper emotions. Therefore, “How is your appetite?” operates as a useful code for “How are you feeling?”. And the way a patient answers reveals information how that patient is doing. Can the patient understand the question? Does he know who the doctors are? Does he have insight into his physical state? What do his facial expressions and body language reveal? An astute clinician can assess very quickly whether there are any “red flags” that warrant further examination by asking the simplest of questions, in this case, one about appetite. At times, it is possible to taste the ocean in a single drop.

B. MR. KAN

Mr. Kan (pseudonym) was a new patient on the ward. Diagnosed with depression, he had been admitted just a few days before. He was single, unemployed, lived alone, and had no major health problems. He was 31 years old, but he looked to me to be at least 45. He appeared worn and fragile; but, in a strange way, he was slightly wired. Perhaps he had a mild euphoria from the medications.

Most depressed patients recently admitted to the ward were not interested in talking with me about their conditions, nor about anything for that matter. This was not surprising given the reason for which they had been admitted. Chattiness is not one of depression’s symptoms. But Mr. Kan was an exception. He actually initiated the conversation with me. It was obvious that he was interested in foreigners. He had studied English a few years ago, and he wanted to practice his language skills with me. He, therefore, had struck up a conversation the first day he saw me

as I accompanied the other doctors on rounds, and we had agreed to talk one-on-one later in the week.

At the beginning of our conversation, when I asked him to tell me about himself, he launched into his work history. As he explained (in Japanese, interspersed with a few English words),

Kan: I was trained as an architect and worked in an architectural firm for seven and a half years. I specialized in structural design. Though I enjoyed the work, the job became bad for me. I was working all the time. I arrived at the office at 8:30 every morning, and I couldn't leave before eleven that night. I usually arrived home at 12:30. I went out to dinner sometime between six and eight usually, but I only had 30 minutes to eat. The worst thing, though, was human relations [*ningen kankei*]. I didn't get along with most of my co-workers, and I argued a lot with my boss. He said a lot of things to me – called me an idiot [*ahou*], called me an asshole [*baka yarou*] – and so there was a lot of bullying. This lasted for a year and a half.

We got a new boss finally, and things were fine for a while, but then we got a contract from the Self-Defense Force, and then the pressure started. The stress became intense. I didn't sleep much, and I started suffering from sleep deprivation. My body started to feel like it was breaking. I had “body broke” [in English]. I decided to quit.

KV: What happened then?

Kan: I knew that mentally I was not well. My head hurt, and I wanted to kill myself. I didn't actually try to, but I told my mother and one friend that I wanted to.

KV: Did you consult a doctor?

Kan: No, I didn't go to a doctor until two weeks ago, and all this happened three years ago.

KV: OK.

Kan: So, I found another job working part-time. I did that for a year and a half, then I found a new job about a year ago. But I had no sense of power [*jitsuryoku ga nai*]. I was anxious. My head was confused, and I still wanted to kill myself.

KV: What did you do?

Kan: Two weeks ago I saw a doctor here, and he put me on medicine [antidepressants]. They helped me. I now don't think about killing myself. I think about “work very well” [in English]. I feel that I want to work again.

KV: Tell me about being here in the hospital.

Kan: Yes, the hospital is good for me. The medicine is helping. I trust the doctors. Getting some rest is good. Nurses and other patients are warm. I feel I want to recover now.

KV: What about after the hospital?

Kan: This year, I want to rest [*yasumi*]. But next year, I will look for a job. I want to work.

KV: Why?

Kan: To make a living. Money is necessary. I need to pay rent. I want to find a reason for living [*ikigai ga hoshii*].

KV: A reason for living? [*Ikigai?*]

Kan: Yes, now I am seeking a reason for living. I want to “skill up.” To work well. Also to eat well. For a long time, I haven’t wanted to eat. But now maybe I want to eat.

Mr. Kan’s narrative brought to the fore the associations he had made between work and his current state of mind. During the rest of our conversation, he said very little about his family situation, personality, upbringing, friendships, mood, symptoms, or even about his condition overall. Instead, most of the talk revolved around his work history and his aspirations for future work. In short, work seemed his primary unit of analysis, the mirror into which he viewed himself. I wondered if his mental problems had generated his troubles at work, or if his work troubles had generated his current mental problems.

His final comment about finding a “reason for living” was especially poignant, I thought. Here was a man who, upon admission, was close to the bottom: a failed career, no company, no job, no wife or no friends, no pleasure even in eating, and no sense of direction. But in only two weeks in the hospital, things have already started looking up for him. Though he credits the medicine for helping him improve, he is also tuned into the efficacy of rest [*yasumi*], which he aims to continue for the next year.

C. THE WARD

The ward offered a recreation period one afternoon per week. During that time, patients and nurses would participate in some sort of scaled-down sporting event such as bowling with an

inflatable ball and empty soda bottles, arts and crafts projects, going up on the fenced-in rooftop to play badminton and talk, take a chaperoned walk around the grounds, or, if a holiday were near, participate in a holiday-related activity. The recreation period gave me an opportunity to do something alongside the patients, as opposed to just sitting and talking with them, and so it served as a good vehicle for me to get to know some of them. If the activity of the day was making a calendar out of construction paper and paint, then I too would make one. If we were to sing songs or make origami figures or whatever, I would gladly participate.

Recreation period broke up the routine of life on the ward. After all, the ward was a closed one, which meant that patients were under full-time supervision and were not allowed to venture outside the ward unless formally accompanied by a relative or staff member.

The ward was composed of three main areas: the central meeting area served as dining room, game room, and lounge. On one side were lined up long tables and their chairs, along with a television set, which was almost always on. On the other side of the room was an elevated area, which was carpeted, and which contained a modest collection of books and magazines and a second television, which was also almost always on. The middle of the room was the main thoroughfare from the door to the sleeping areas, and though it was usually cleared for traffic, patients could move their chairs there if they wished.

A large pot of hot tea stood atop one of the tables for most of the day. It lent one of the few pleasures of home to the otherwise institutional atmosphere. The floors were tile, the tables and chairs made of office-style plastic and metal, and the building itself dated from the 1950s and had that boxy, functionalist, concrete feel to it that characterizes so many Japanese buildings built during those years.

On the right side of the central meeting room was a hallway that led back to the men's bedrooms; and on the left side of the central meeting was another hallway, this one leading to the women's bedrooms. Most of the bedrooms slept four people, but the ones at the ends of the corridors were larger and could sleep eight. A single person could barely maneuver between the beds, and beds were pressed against the walls. To my eyes at least, the rooms looked small and cramped. But this was no doubt because of my American sensibilities regarding space. There were curtains, hung from an oval rod, that patients could wrap around their beds so as to approximate "closing the door" so to say and give themselves some privacy. But rarely did I see these closed. Most of the time, patients were either in the central meeting area talking, watching TV or smoking, or else they were in their beds sleeping or reading.

The ward could accommodate forty patients, and there was no segregation by illness category, age, or anything else other than gender. Men had their corridor and women had theirs, but otherwise the ward was mixed: from teenagers to the very old, patients with schizophrenia, depression, eating disorders, bipolar disorder, mental retardation, and any other kind of mental condition.

The socio-economic level of the patients, however, was more consistent. Most were blue collar. Many of the men were unemployed or working part-time. Many of the women came from working class families or had husbands who were unemployed. Though I saw no homeless people during my nine months there, it was equally evident that persons of wealth did not enter this ward. This was in keeping with the clientele of the hospital overall. Hospital Seishin catered to a local clientele, and it was situated in a working class area of Tokyo. Given that, in Japan, the medical system steers people toward making frequent visits to their doctors (for example, most psychiatric

drug prescriptions are for a short term supply – one week, maybe two or three – with refills requiring an in-person visit), most people choose to go to a neighborhood clinic or hospital. Though this hospital is large, most of its patients still operate within this system and therefore come from the surrounding neighborhood for purposes of convenience.

I participated in recreation periods every week, but I also spent a lot of time in the ward outside of recreation periods. I mainly just “hung out,” in the hopes that patients would get used to my presence and eventually feel comfortable talking with me. Given that I was a foreigner, there was certainly a novelty element to my presence. Some patients were obviously curious about my presence there and initiated conversations with me, especially young schizophrenic girls. One girl was convinced that I was the father of Gackt, who was one of the most popular *tarento*²⁰ at the time, so she was always trying to get me to talk about him. (I didn’t). Other patients liked the opportunity to use some of their English words with me. But I wanted to move beyond just the conventional conversations about where I was from, how old I was, if I was married, and which Japanese foods I couldn’t eat. So, I just sat around and talked with whomever would talk with me.

At the direction of the chair of the department, I wore one of the long white coats that other doctors wore. It made me uncomfortable because of the obvious hierarchy that it created between patients and me. Though I told patients that I was not a doctor, I still looked like one. When I talked with one doctor about the possibility to going in without the coat, he cautioned me against it, emphasizing that a locked ward should have only two types of people therein: patients and authorized care-givers. So, to be in a third, liminal, position (that which I, as an

²⁰ *Tarento* is a transliteration of the English word, “talent.” In Japan, a “talent” is sort of a multipurpose artist/actor/singer/comedian/television personality/all-round celebrity.

anthropologist, more-or-less naturally gravitate toward) would confuse the patients. It was best to ally myself with the people entrusted with care-giving so as to legitimize, in patients' eyes, my presence on the ward. So, I continued with the coat.

The pace of life on the ward was relaxed and slow. Patients had a few regularly-scheduled activities such as meals, bi-weekly rounds, weekly recreation periods, and weekly one-on-one meetings with their doctors. But for the most part, the atmosphere was calm and care-free. Patients just "hung out" all day long, doing whatever they felt like doing, or not. Social life consisted mainly of watching TV together or talking in the central meeting room. There was often friendly banter between the nurses and the patients. Indeed, nurses contributed significantly to the activities and feel of the ward. Though the legal ratio of nurses to patients in psychiatric settings was 48:1, this hospital had a much lower ratio than that. Nurses were almost always in sight, and there was usually at least one in the central meeting room at any one time, helping a patient dry her hair, tending to the tea, talking with a patient, or doing something else. The way that nurses interacted with patients was different from the way that doctors did. The hierarchical divide between nurses and patients was much smaller than that regarding doctors; and nurses seemed, to my eyes at least, much friendlier and more accessible to patients. Though their near-constant banter with patients, their casual interactions, assistance with intimate activities like bathing, it seemed to me that nurses were the ones who established the "human" side of care there. It was they to whom patients went with small questions, with requests for this and that, and that they seemed most comfortable interacting with.

All of the nurses on the ward were female, and most were young. They wore white outfits, as well as white bonnets on their heads. When I first saw the attire, I thought I had gone

back to the 19th century. Florence Nightingale came to mind. But such conventions were the norm at Hospital Seishin. It was clear that nurses were to fulfill a role of care-giving that intersected with wider social expectations regarding the good, young female (Long 1996). Care-giving, in terms of the daily rituals and assistance, i.e. the non-medical, non-scientific aspects of care-giving, was gendered here at Seishin. Nurses were the young, cheerful, helpful women who brightened up the routine of daily life on the ward. When I asked patients what they thought about the nurses, they responded positively across the board. Patients liked their nurses. Nurses provided a form of intimacy, personal attention, and accessibility that doctors, on average, did not.

D. THE BOXER

During my nine months at Hospital Seishin, I got to know several patients rather well, talking with them for several weeks on end. I was able to do so only because they stayed in the hospital for so long. At Seishin, the average stay was about 30 days, but some patients stayed as long as three months.

Aki (pseudonym) had been diagnosed with depression and invited to enter the ward just two weeks before. I had seen him during rounds and knew his clinical profile, but, as with most new patients on the ward diagnosed with depression, he was not very talkative. Aki was 26 years old and a professional boxer, or more precisely, an ex-professional boxer. In a tournament last year, he had suffered an injury to the face such that his athletic career had ended there on the spot. Another blow to the face was likely to cause damage to the brain, so he had to conclude what was until then his one-and-only career path. He had loved boxing since childhood, and all he had ever

aspired to was becoming a professional athlete. But now, in a single moment, his aspirations had come to a halt. After last year's surgery to repair his broken cheekbones, he had become distraught, and at the encouragement of his parents and a psychiatrist, he now he sat on the ward, drinking a cup of tea, sitting in front of the television, and staring blankly out the window.

By this time, I was confident that he knew who I was through word of mouth, and we had exchanged greetings on a couple of occasions. Today, I was sitting nearby when he entered the central meeting room, so when he sat down, I turned to him and tried to make conversation. I introduced myself, had some polite chit-chat, and we talked a little about his boxing career.

KV: I hear you're a boxer.

Aki: Yeah.

KV: How long have you boxed?

Aki: Since high school.

KV: How far did you get?

Aki: I won an international tournament in Korea last year.

KV: Wow, that's fantastic. You must've had to train really hard to get that far.

Aki: Yeah, every day. That was my job.

KV: Tell me about it. I know virtually nothing about the life of a boxer. What was your training schedule like?

He then explained his regimen, the morning workouts, the diet, his coach, some of his favorite tournaments, the style of boxing he did, his favorite American boxers... he seemed to enjoy talking about it. We spoke for about twenty minutes. He then offered to have his dad bring in a video of some of his tournaments so I could see him in action. I told him I would definitely look forward to seeing it.

A couple of days later, I returned to the ward, and he gave me the video. I thanked him and told him I looked forward to watching it at home. We then talked some more, but this time the conversation leaned more toward him and his current situation rather than his boxing career.

KV: Why do you think the doctor wanted you to come into the hospital?
Aki: He thought I needed some rest [*yasumi*].
KV: Some rest?
Aki: Yeah.
KV: Why did he think you needed some rest?
Aki: Well, after the surgery,²¹ I worked part-time for a while. But things didn't go so well. I was doing office work, but I couldn't do it well. After two months, there was a lot of stress, so I quit.
KV: You needed some rest after that?
Aki: Yes, the rest will help me.
KV: How much rest do you think would be good for you?
Aki: Maybe a few weeks.
KV: What do you want to do after that?
Aki: Work in my parents' restaurant.
KV: Oh, tell me about it.
Aki: They have a small restaurant. I can help them there.
KV: Is that what you want to do?
Aki: Yeah, that's what I want to do.
KV: Have you tried it already?
Aki: Yeah, right before coming here. But I want to get back to it.

The doctor in charge of Aki said that he was suffering from depression and that he had suicidal thoughts. The doctor, therefore, had prescribed a sleeping pill, an SSRI, an anxiolytic, and an anti-psychotic. He anticipated that the boxer would be in the hospital for a few weeks.

I asked the doctor about Aki's career, if the two of them had talked about what Aki could do from this point onward in terms of career. He answered that the plan was for Aki to continue working at his parents' restaurant.

I wondered what the diagnosis of "depression" had meant here. Did it reveal anything or clear anything up? Did it shed light on what was going on in the mind of this young man who had just had his life's aspirations literally bludgeoned out of him by a single well-placed fist? The doctor seemed to have thought little about the proposition that Aki was suffering not from some

²¹ He refers to the surgery to reinforce the broken bones in his face after the boxing accident.

psychiatric disorder, but simply from loss. But why should such a thought have even crossed the doctor's mind. After all, "loss" is not a psychiatric phenomenon. The DSM does not mention it. No psychiatrist diagnoses anyone with "loss," or even with "loss disorder." Quite the contrary, the DSM has been written quite strategically so as to avoid words that suggest a miscegenation of biomedical phenomena and routine life events. The DSM is about illness, not life struggles. Life struggles are things that psychotherapists deal with; and the DSM has purged itself of language reminiscent of psychiatry's early interactions with psychotherapy. "Losses" are for the therapists, ministers, and friends to deal with. The DSM is concerned with "illnesses" narrowly defined. And depression is among those. So, no, the boxer was not suffering from the "loss" of anything. He was suffering from a mental illness, and the proper treatment was drugs and confinement in this hospital.

It was times like this that I felt the tension between my respect for medical expertise, on the one hand, and my own common sense, on the other. It seemed, to this untrained observer at least, that this young man was exhibiting a perfectly rational response to a major life event, and that what he needed was help in redirecting his life so that he could capitalize on his sports knowledge and expertise without putting himself back in the ring. Surely there were job options out there more in keeping with his talents than that of working at a small family restaurant for the rest of his life. In my mind, he needed career counseling more than anything else.

But to give them credit, psychiatrists in Japan are not called upon, nor have they been trained, to provide career counseling. They are doctors, and every single one that I encountered at this hospital demonstrated a sincere and diehard devotion to the task of healing patients. So, my ruminations are not directed toward individual doctors. Instead, they are directed at the tools

that doctors have to work with and the ideas about life and health that operate implicitly within those tools.

The boxer left a couple of weeks later. One day I arrived at the hospital to find that he had been discharged. I obtained his address to send him back his videotape, and I watched the tape one more time before sending it back. It was a moving experience to watch the person whom I had gotten to know as a sad, slow-moving, lifeless young man, actually fighting in the ring with a swiftness, passion, and full-bodied vitality befitting what he really was, a championship boxer. Was the difference between these two people, only a few months apart, meaningfully encapsulated through the term “depression”? Did the term reveal anything at all?

E. INPATIENT TREATMENT

In keeping with chapter three’s discussion of the relative length of average hospital stays in Japan, those at Seishin were long by international standards. The average stay for a patient diagnosed with depression was about 30 days. Some of the patients I talked with stayed twice that long. Though a cynical response to the question of why these stays are so long may credit national health insurance as the primary reason, I do not think that this is sufficient explanation. Even though it is true that national health insurance reimburses for long hospital stays, such reimbursement does not require that patients consent to the long stays. Almost all of the depressed patients on the ward were there via voluntary admission (i.e., only a very few were involuntarily admitted because of suicidal intentions), which meant that they had chosen to stay there. The hospital had no legal right to keep them there. So, there must be a reason for why patients were choosing to stay so long.

I think that the answer lies in the implicit modalities of care offered by the hospital. By “implicit,” I mean those aspects of care that are not part of the overt regimen. The overt regimen consists mainly of providing a safe and controlled environment, medications, and round-the-clock supervision by medical staff. By being in a safe and controlled environment, it is assumed that the medicines, monitored and regulated daily by doctors and staff, will have the chance to take their fullest effect. This, then, is the biomedical basis of inpatient treatment for depression.

But one word that repeatedly arose in conversations with patients and staff members was *yasumi*, which means simply “rest.” Though rest is important in the recovery process for any number of medical problems, I wondered why so much of it was welcomed by patients and paid for by government. Once medicine dosages were right, could not patients rest at home?

I asked one doctor about this, and he gave me an interesting response. He said:

Yes, the long stays are important. In the outside world, the role is king. One has to do what one has to do. The name of the game is responsibility, duty, task, and so forth. But if one is confined within a hospital, then one is freed from those responsibilities. It’s an opportunity to hang low for a while, to give oneself a break. Emotional recalibration. One can be free to take care of himself and himself only, which goes against the way one should be thinking in the course of regular life. It’s the permissiveness of confinement. Yes, that’s it. The ward gives the opportunity for freedoms that don’t exist elsewhere. It seems like a confining place, and it is. But it’s the permissiveness that matters, I think.

I was struck by his comments because I had never aligned “permissiveness” with “confinement” before. It was as if the locked doors of the hospital were designed not only to keep patients in, but to keep the outside world out. But in remembering the fact that Japan, for about 250 years during the Edo Period, pursued a policy of national isolation, I thought that this theme of self-imposed confinement for purposes of well-being was interesting. I also thought about

hikkikomori, a problem that seems to be particular only to Japan.²² *Hikikomori* is self-imposed confinement in its simplest of forms, and yet it now began to lose its aura of oddity, for it seemed to have something in common both with Japanese history and with the logic of inpatient care. Though these connections might be a little far-fetched, it seems true that something positive regarding confinement finds resonance in Japan.

But regardless of the degree to which the theme of the permissiveness of confinement can be linked and expanded, it is well-established that not only is national health insurance willing to pay for long hospital stays, but companies are willing to grant extended periods off for them. Such stays are predicated, however, on the patient's actually being in the hospital. Home recuperation does not carry the same legitimacy. Therefore, hospitalization seems to operate as a matter of social consensus between the patient and those who otherwise depend on him or her. Being sick does not let one off the hook; but being in the hospital does. Long hospital stays might suggest, therefore, that long recuperations are acceptable, but only if they are carried out in certain scripted ways.

Additionally, the extended periods off granted by companies and the extended hospitalizations paid for by insurance suggests that the Japanese are in touch with the idea that rest is integral to the healing process. Lest this sound all too obvious, it must be remembered that the era of managed care in the United States has done an excellent job of minimizing inpatient recovery time by shifting the primary site of recovery from the hospital to the home. With the hospital seen, in Japan, as the main place in which time can take its course, we can conclude that

²² *Hikikomori* means "social withdrawal," and it affects mainly young men in their twenties. These young men live with their parents, and they shut themselves in their rooms and refuse to leave for years on end. Estimates as to the number of *hikikomori* individuals range up to a million (Rees 2002). The problem is frequently in the news.

the hospital, in spite of its serving as the main site for the application of science and technology to the healing process, is also serving as a site for the application of the most natural of forces – time – to that process.

In terms of these thoughts about the role of rest, along with my observations about the importance of support as provided by young cheerful nurses and the role of physician's high status in the eyes of patients, there have been studies examining the impact of such non-biomedical factors on the healing process. Perhaps Norman Sartorius, the former head of the World Psychiatric Association, summarized it best when he said, "Very few solutions are medical in medicine" (Vedantam 2005).

F. THE OUTPATIENT CLINIC

The outpatient clinic at Seishin opened at 9:00 a.m. sharp Monday through Friday, but by 8:30 the waiting room was usually packed. There were no appointment schedules. Sessions were on a first-come first-served basis, so arriving early was the only way to maximize one's chances of seeing a doctor quickly.

The old adage in Japan regarding medical appointments is "3 & 3," which stands for "three hours of waiting, three minutes of examination." In the case of Seishin, the adage was an exaggeration, most of the time. But on some occasions, especially when one of the doctors was out sick or handling an emergency, the morning's sessions could get a little backed up.

The waiting room was rectangular and contained a set of long benches that could seat about 30 people total. On two sides of the room were five doors, each leading to a small examining room. On a third side were doors to the records area and the doctors' lounge. On the

fourth side was a hallway. The clinic had a compact and self-contained feel to it. From any vantage point, one could either see or hear most of what was going on in the lounge, records area, and even in some of the examining rooms if one listened closely enough. It did not appear that promoting privacy was a major concern of whoever laid out the area.

A patient was called in for an examination when a door opened and either a doctor or a nurse stepped out to call the next patient's name. Until then, patients sat side by side on the benches, sometimes shoulder to shoulder if it was a particularly busy day.

Doctors saw patients from nine until twelve, and many doctors aimed for 25 patients a day. Ideally, this would work out to just over seven minutes per patient, including all paperwork. So, even though patients could not predict how long they would be at the hospital, they could rest assured that all doctors would be seeing patients as quickly as they possibly could. In my entire time there, I did not hear of a single patient complaining about the system or the time spent waiting.

On several days, I sat in the waiting room and just observed what happened there. Most patients came alone, and oftentimes they would sleep while they waited. Others came with family members, and they talked about any number of things until they were called in. The atmosphere was for the most part calm yet busy. Nurses were energetic, friendly with the patients, and continually moving briskly as they transported patients' charts to the appropriate doctor, helped patients sign in, looked up whatever information a doctor had requested, and managed the records. Most of the patients had been there numerous times; indeed most came there every couple of weeks and had done so for months, if not years. Therefore, there seemed to be a ho-hum atmosphere to the waiting room that combined, of course, with the overall sense that most

patients who were there were not feeling very well. Many, in fact, looked quite tired, and most of those were schizophrenic patients who were taking sedatives.

Overall, like so many other hospitals and office buildings in Japan, the waiting area at Seishin was functional, designed to accommodate as many people as possible given the limited space, and therefore not much emphasis had been placed on aesthetics. The benches were black leather and slightly padded, but there were no backs to them. There were some medical guidelines hanging on the walls, but otherwise no art work, flowers, magazines, or television. Getting in and out as expeditiously as possible seemed to be the dominant intent. Waiting in comfort wasn't part of the package.

Most of the examining rooms were small; and to me at least – a 5'10", 160 pound American – the rooms seemed cramped. Each had just enough space for a desk and chair for the doctor, a bed, one or two chairs for patients, and a sink. Boxes were stored under the beds. During my observations, I had to squeeze into a back corner, where it seemed like I was sitting just inches from the doctor.

But from my position in the corner, I was able to observe around 40 days worth of sessions spread out over a six-month period. In total, I observed hundreds of sessions, held by twelve different doctors. Some of the doctors were male, some female; some younger, some older. Overall, I sat in on sessions held by almost every doctor who worked in the clinic, including the chairman of the department.

At the beginning of most sessions, the doctor would introduce me briefly to the patient and ask if he/she minded if I observed. Not once did a patient object to my presence. Though I cannot be sure, I do not think that this willingness on the part of the patients was contingent on

either their intuitive response to my person or to unspoken pressure from their doctor. Instead, I think it stemmed from the fact that this was a university teaching hospital; as such, it was common for medical students and residents to sit in on outpatient clinic sessions as well as on any and all other clinical activities. This was precisely why I was now conducting fieldwork in a university teaching hospital as opposed to a non-educational institution.

In terms of having an observer in their sessions, then, patients at Seishin were used to it. In terms of having a *foreign* observer, however, this was a different story. Fortunately, though, it seemed to be a positive more than a negative, for most patients who ventured to ask about my presence seemed more curious than uncomfortable. When these patients did ask about my activities, the doctors were ever willing to indulge the patient a few extra minutes so that the patient could ask of me whatever he/she wanted to ask.

Pt: Excuse me doctor, but, does he speak Japanese?

Doc: Yes, go ahead [motioning that the patient direct the question to me].

KV: Please forgive me, but my Japanese is not so good.

Pt: Ah! He CAN speak Japanese.

KV: Just a little. Thank you for letting me observe your session today.

Pt: You're welcome. How long have you been in Japan?

KV: About a year and a half now.

Pt: How are things? Can you eat Japanese food?

KV: Oh yes. I love Japanese food.

Pt: Oh really?

Some conversations went beyond this, but given that doctors were forever pressed for time, I did not encourage a longer exchange unless I got a cue from the doctor that it was OK to do so.

When this did happen, there usually followed a light and pleasant conversation between the patient and me about my life in Japan and/or about differences between American and Japanese health care. But most of the time, patients seemed just curious, as if they just wanted to make a brief conversational connection, and doctors were very generous in allowing that to happen.

For reasons of privacy, I am unable to recount the details of any actual cases that I saw during my observations in the outpatient clinic. There was never enough time to explain my project in sufficient detail to validate a request for consent; therefore, privacy laws require that I keep all details confidential. However, I can speak generally about some of the “types” of patients and conditions that I saw, with the understanding, however, that each description represents a generalization based on observations of several comparable cases.

What was clear from my observations was that this was mainly a working-class clientele. As with patients in the ward, patients in the outpatient clinic came predominantly from the surrounding neighborhoods, and these areas were lower middle class. Given that the next hospital I was going to conduct fieldwork in was a more upscale hospital with a reputation for catering to a wealthier, even elite, clientele, I was curious about class differences in the provisioning of care. I, therefore, talked with the doctors routinely about individual patient’s socio-economic status whenever time allowed.

The observation set-up was as follows: The doctor would review the next patient’s file, then tell me the patient’s name, age, and diagnosis.²³ The patient was then called in. The doctor would greet the patient, introduce me, request permission that I observe, then begin the session. Upon the patient’s exit, if there was time (and there usually was), the doctor and I would briefly discuss the patient’s background, treatment history, family situation, work situation, or whatever questions I had. If there was a heavy load of patients that the doctor had to see that day, and/or if

²³ There are two diagnostic systems used in Japan. One is the international standard, as represented by either the DSM or the ICD. The other is what doctors referred to as the “traditional” system, which meant diagnoses based on what had become conventional over the years among Japanese psychiatrists. Given that it was very rare for anyone from an insurance company to step in and challenge a diagnosis or a treatment, the need to apply rigid and consistent standards to diagnoses was not as strong as it has become in the United States.

there were additional questions about the patient that the doctor and I could not cover during the morning sessions, then doctors were usually amenable to discussing such cases later in the day back in the departmental offices.

About a third of the sessions mirrored the short encounters I had observed during rounds on the wards: “Good morning. How are things? How’s your appetite? How are you sleeping? Anything else? How about the same prescription. OK, take care.” I timed most sessions with my watch, and the record for brevity clocked in at just over a minute. This doctor had started his questions just as the patient entered the room, and by the time she sat down he was halfway finished. They had their routine down pat.

But it was also clear that in the midst of the routine meds check, there was often a short exchange about something in the patient’s life. The doctor would ask about the patient’s job, relationship with spouse, child’s progress in school, or some other issue that the two had discussed in the past. The doctor then might nod favorably about what the patient had done recently, “Ahh, yes, that sounds good,” or might utter a short assessment of the situation, “Have your daughter considered cram school?”. Basically, though the brevity of the session would make it appear superficial and only medication-oriented, oftentimes the doctor would indeed give out some little tidbit of either advice or encouragement, which patients seemed to appreciate.

The range of cases I observed was broad: depression, schizophrenia, anxiety, bipolar disorder, panic attacks, personality disorders, eating disorders, obsessive-compulsive disorder, social phobia, substance abuse, adjustment disorder, body dysmorphic disorder, double depression, post-traumatic stress disorder, dementia, somatization disorder (still called “hysteria”

[*histeri*] by most doctors), and virtually all the other conditions that, one, are profiled in the DSM and, two, would be considered “typical” in any American clinic.

There were, however, several cases that one finds almost exclusively in Japan, namely, *hikikomori* and *taijin-kyoufushou*. *Hikikomori* has garnered national attention in the past ten years (NHK 2003a; NHK 2003b). Translated, the terms means “social withdrawal,” and what characterizes *hikikomori* patients is that they are usually young adults in their 20s who refuse to leave their houses even though they exhibit no other signs of mental illness or psychological instability. Therefore, whether or not to consider it a “mental illness” is problematic. *Hikikomori* patients (I use the term “patient” loosely here, given that most of them do not seek treatment) do not exhibit the irrational fears about life outside the protected confines of the house that those diagnosed with “agoraphobia” or “social anxiety” outside of Japan usually do. Instead, these patients seem thoroughly rational in all aspects of their thinking, including their decision to not leave the house. It is not that they are afraid of anything particular on the outside, but just that they refuse, adamantly, to venture out.

Some experts suggest that there are upwards of a million cases of *hikikomori* in Japan right now (Rees 2002), and many clinicians and commentators alike view it not as just a psychiatric problem, but a social one, i.e. one that mirrors something dysfunctional about contemporary Japan. According to Dr. Hidehiko Kuramoto, most *hikikomori* patients are merely “school refusal”²⁴ students who have quit school, are now in their twenties, and have generalized their refusal such that they refuse to join adult society at all (personal communication).²⁵ In

²⁴ Term given to students who simply stop going to school.

²⁵ Dr. Kuramoto explains more about *hikikomori* on the following website: <http://www.nhk.or.jp/fnet/hikikomori/2003/column/col6a.html> (NHK 2003b).

short, they are truants who have grown up, and without schooling have found themselves unable to function in adult society. After all, without educational credentials in Japan, with the least being a high school diploma, it is almost impossible to get a job.

What makes *hikikomori* more than just a “disorder” of the individual is multifaceted. First, many in Japan realize that the education system does not work for everyone. There is sympathy, therefore, with students who refuse to attend school. Students themselves are rarely blamed for the problem, nor are individual schools. Instead, the national school system is often viewed as needing reform. Targeting the school refusal problem has been one of the primary impetuses behind education reform efforts of the last ten years. Second, *hikikomori* implicates the family. After all, the patient himself (not all, but the majority of *hikikomori* patients are male) must be fed and taken care of by someone, and that someone is in almost all circumstances the mother. *Hikikomori* cases, therefore, depend on the participation of the mother in the child’s refusal to leave the house. In essence, the mother must enable the child to act this way. She obtains whatever supplies he needs, and, most importantly, keeps him fed. *Hikikomori* is, therefore, a condition rich in cultural norms about family life, about parental responsibility, and also about problems in the education system. The condition is psycho-social-cultural in the clearest sense, implicating individual, family, and society in the single question, “What is going on here?”.

In the majority of sessions I observed in which *hikikomori* was the problem at hand, it was not the child who came in, but the mother. This appears to be common around the country for many mothers of *hikikomori* patients. Here is how the problem was articulated by one mother, in a letter she submitted to the *Yomiuri Shinbun*, one of Japan’s major daily newspapers:

My child became a “school refusal” child, and at home she became violent. She then became *hikikomori*, and at that time I began to think that my abilities as a parent were nil. People would say the parents were bad and that the whole family was bad.

My daughter started refusing to go to school in seventh grade. She started sleeping during the day and staying awake at night. She would fly into rages and throw everything out of her room. Once, she even grabbed my neck.

I knew that there was no quick solution here. When my daughter was out of control, I couldn't do anything but cry.

At times I thought there must be a bright side somewhere here, and I hoped for a resolution. But not knowing if one could come, I became so anxious. I became hopeless (Yomiuri Shinbun 2002d).

Her letter goes on to explain that they finally found some help when they went to a counselor. But the point is that this woman's story is typical of many that I saw in the clinic, with the only addition being that many of the women I saw were themselves being treated for depression. They carried a sense of failure about their own role as mothers, and they took upon themselves much of the blame for their child's situation. Many of these mothers were also being bullied by their child. Verbal and physical abuse toward the mother is oftentimes a factor in these cases.

These were some of the most difficult cases I saw, and many of the doctors seemed particularly interested in these women's predicaments. Most of these mothers were exhausted, frustrated, and out of answers as to how to turn things around. The sad thing was that doctors were equally baffled as to how to proceed. Indeed, these cases are notoriously difficult to treat precisely because the patient refuses to come in for treatment. Some clinicians, especially clinical psychologists, have had success in coming into the home to try to talk with the patient. But most *hikikomori* patients refuse to cooperate even with this, and so the situation comprises a real dilemma for the family and the clinician. Currently, clinicians are aggressively studying how to

handle the problem, and legislators at every level are being forced to recognize its severity (Ogino 2004).

But, as with many other problems for which there is no solution on the horizon, there is nonetheless a “meantime” to deal with, i.e., in the meantime, there is a mother in need of help. And psychiatrists often provide the last-ditch chance for her to get some help.

I suspect that there are some Americans who would blame the Japanese mothers for enabling their children to behave in such a manipulative manner, i.e. that they would blame the mothers for not simply “kicking the brat out,” so to say. But this does not seem to be an option for the overwhelming majority of Japanese families facing this type of problem. I suspect it is because Japanese families know that there is no place for that child to go. With no money, no income, no job, no friends (most lost their friends when they stopped going to school years before), and no half-way houses or other public facilities to handle such cases, there are literally no other options for food and shelter other than life on the streets. To “get tough” and kick him out would be to watch him become homeless, and the thought of this is more than most mothers can stomach. It goes too deeply against the ideal of the “good wife, wise mother” (see Long 1996).

And so until a solution is found, there will probably be a continuing flow of depressed and frustrated mothers coming into clinics in search of any type of help they can find.

Overall, my observations at Seishin’s outpatient clinic suggest that the primary tension, and one that permeated almost every aspect of care there, was that between compassion and time. On the one hand, the doctors that I observed in action demonstrated a heartfelt concern for

patients and strove to provide as expert care as they could. At the same, institutional constraints prevented many of these doctors from giving patients the one thing that they knew many patients wanted more of: time. According to my calculations, the average time that doctors spent on each patient, including pre- and post-visit paperwork, was about seven minutes. Actual face time was about five minutes. Doctors knew that if they spent an extraordinary amount of time with one patient, then other doctors would have to pick up the slack. Therefore, there was consensus among the doctors, based in their concerns for each others' morning schedules, that they had to move patients as quickly as possible.

Though this resulted in many patients having, at best, a perfunctory discussion with their doctor, it was nevertheless true that many patients treasured what little time they did have. The name of the game was efficiency, and most patients and their doctors had established a working pattern. But it must be remembered that such care was being offered in an ideological context of biomedicine. As explained in chapter three, psychiatry in Japan is very much grounded in the biomedical approach. Psychiatrists saw themselves as doctors treating illnesses, not as counselors talking about life problems. Therefore, much of the care was impersonal. Such impersonality is best represented by the fact that patients would oftentimes not come into the clinic expecting or needing to see "their" doctor, but would instead would see whichever doctor was available first. Additionally, on many days, one of the doctors might be out dealing with a problem on the ward or at a meeting or something, and on those days the other doctors would simply divide up the extra patients. Intimacy seemed not to factor into the majority of doctor-patient encounters here.

That being said, however, several doctors did manage to give support, encouragement, and advice even in the four or five minutes that they had with the patient. With a bi-weekly

schedule being the norm for most patients, it was possible for many doctors to have more or less a running conversation with patients that merely took place in small yet frequent units, but which over time accumulated in something valuable. At least this was the hope. One doctor said that he saw his sessions as like snow: “It falls slowly, but over time it gets higher and firmer.”

VII. PATIENTS: IN THEIR OWN WORDS

Our image is that we [Japanese] are on a conveyor belt. But once you go to a psychiatrist, it means you're off of the conveyor belt.

Mr. Yon (diagnosed with depression)

During my observations in the outpatient clinic, one of my goals was to recruit patients for my own one-on-one interviews. The hospital had given me approval to meet with select patients outside of the hospital, and I had hoped to find some who would be willing to talk with me. Working in association with the chair of the department and the individual doctors, I decided on five criteria regarding patients whom I would invite to participate. First, each was to be diagnosed with depression and each were to be taking antidepressant medications. Second, depression was the major problem for which each was receiving treatment. Third, each was in very stable condition, i.e. had not been hospitalized recently, did not seem suicidal, and was in the midst of no particular crisis. In essence, each was “safe” for being interviewed by a non-clinician. Fourth, each was to appear open to talking about his/her conditions, as evidenced by talkative interactions with their doctors. Fifth, each was to speak Japanese in a manner that I could understand relatively easily.

Based on patients whose sessions I had sat in on, the doctors and I created a list of twelve patients. All were middle or working class, and all lived in one of the neighborhoods surrounding the hospital.

We decided that I would invite patients to participate by writing them a letter which the doctor would hand to them in their next session. We agreed that the doctor would exert no pressure on patients to participate, but would instead merely remind them of who I was (i.e. that they each had met me in previous sessions) and state why I was wanting to talk with them.

The letter clarified my credentials, the purpose of the project, and my desire to talk with them casually about the lives and experiences as someone diagnosed with depression. I also guaranteed anonymity, stating that I would use pseudonyms and would remove or alter any identifying characteristics from the final presentation of the conversation. I also said that there would be no follow-up request and that, therefore, there was no pressure to participate.

Of the twelve people to whom I sent letters, I received positive responses from six. Of those six, one got sick and could not participate. Another one started a new job and said she no longer had time to meet. I, therefore, ended up with four candidates.

I met three of the patients at a well-known family restaurant just a block away from Seishin Hospital. I met the fourth at a coffee shop of his choice in another part of Tokyo.

Three of the interviews lasted about two hours; the one with Mr. Yon lasted almost three. I paid for coffee, and in some cases snacks, for all interviews. At the beginning of each interview, I reiterated what was contained in the letter they had received from me, and once that summary and other introductory matters were completed, I asked each patient if he/she would consent to my tape-recording the interviews. Each consented, and so I tape recorded each interview. Afterwards, a native speaker of Japanese transcribed the interviews.

Doctors had given me permission to interview each patient without the need for a follow-up discussion with the doctors. As such, I was able to promise the patients that none of their

comments to me would be relayed to their doctors. My goal in this regard was for them to speak candidly with me about their doctors.

A fifth patient, Mr. Yon, whose narrative is included in this section, was not a patient at Seishin. He was instead a colleague of one of my friends. I had met him on one occasion prior to my interviewing him, and after his discovering through our mutual friend the nature of my research, he contacted me privately, gave me a little background on himself, and offered to talk with me if I wished. Needless to say, I accepted his offer.

None of the individuals presented below as case studies exhibited either a medical history or a life history that could be considered out of the ordinary. They were all rather normal individuals, and though they all were diagnosed with depression and though each had their own private stresses and sufferings, I do not think that many Japanese would consider their stories to be atypical. They were just living their lives in ways that most Japanese would probably consider to be quite average.

My goals for the interviews were three-fold. I wanted to get as unprompted a depiction as I could of each patient's experience, focusing specifically on the episodes and factors that prompted the seeking of psychiatric treatment. In short, I wanted to obtain patients' own versions – not their doctors' versions – of what their problems really were. This was my primary goal. Second, I wanted to obtain their thoughts about what the term “depression” and other clinical terms meant. Third, I wanted to explore a variety of related issues such as the doctor-patient relationship, the effects and side-effects of the medications, the goals for treatment, and stigma.

At the time, I took a “grounded theory” approach (Dick 2000) to creating the interview schedule. Though a list of ten questions formed the basic framework for my interviews, I wanted to ask open-ended questions in the hopes that I would obtain insights about which I did not even know to ask. After all, one main goal of the project was to elicit patients’ own descriptions and interpretations of their experience, and so I wanted to try as hard as possible not to prompt them, even subtly, with my own understandings of what “depression” meant in the American context and/or in the context of the DSM. Therefore, many of my questions were open-ended, and most were asked in the hope that the patient would take the lead. Additionally, I myself did not like the term “interview,” and so I did not use it. I told patients that I wanted to just “talk” with them. The result, therefore, was indeed more of a conversation than a structured interview.

One consequence of this approach was that conversations were neither predictable nor overtly organized. Though this is what I had wanted, an unaltered presentation of those discussions here would be difficult to follow. Therefore, in the case studies presented below, I have taken a few liberties. I have consolidated some comments that may have been uttered in different parts of the interview. I have also left out certain sections in between comments, choosing instead to connect sections on the basis of their being related, as opposed to presenting them in the actual order in which they were spoken. In my opinion these manipulations do not alter the overall context or the specific points made.

The interview with Mr. Yon was conducted mainly in English. Interviews with the other four were conducted in Japanese.

A. MRS. ICHI

Mrs. Ichi (pseudonym) is a married female in her late early 40s who has one child, a 16 year old daughter. Mrs. Ichi lives with her husband, daughter, and parents. Her husband works for a major company, and he is hardly ever at home, leaving early and returning late on weekdays and most Saturdays. They are lower middle class and live in a working-class neighborhood, though they do not consider finances to be a major problem because her husband works for a major company.

Mrs. Ichi first came to a psychiatrist here at Seishin eight years ago. She saw that psychiatrist for six years, but then he retired. For the past two years, she has been seeing other psychiatrists here.

As she explains, she started having problems eight years ago because of her father. He was starting to develop Alzheimer's Disease, and he was getting harder and harder to control. On most days, he would become violent – throwing things in the house and yelling. He was also suffering with a cervical vertebrae problem, and so he needed help walking and moving about. Mrs. Ichi's mother provided almost no assistance with him. In fact, she preferred to remain out of the house most of the day. The mother and father had had little to do with each other for their entire married lives. They had been brought together through an arranged marriage, and they had never developed feelings of affection for each other. They lived separate lives. He worked virtually all the time until he retired, then he soon developed back problems, then he started becoming senile. The burden of taking care of him had fallen exclusively on Mrs. Ichi's shoulders.

Ichi: When I went to the doctor for the first time, I didn't talk very much. About all I did was cry. My mother was there too, but she got quite angry with me. By that time, I had decided that I wanted to die...

I was spending all of my time trying to take care of my father as well as my daughter. My mother didn't help much. My husband didn't help at all because he was at work all the time...

I used to enjoy teaching piano. That used to be my job. I taught lessons at home. But I had to stop when my father got sick. I couldn't teach with him so violent in the house... It was scary.

I was spending all of my time in my room. When I wasn't having to take care of him, I just spent all my time in my room. I just wanted to get away from him, and this was the only way I could do it.

[Things got so bad that] I couldn't eat any more. I had lost 12 kilograms by the time I went to the doctor... I didn't want to live anymore.

Mrs. Ichi realized that she needed help. So, she decided to see a psychiatrist. Fortunately, she clicked with him from the outset. She could talk with him. They would talk about her life, her daughter, and how to handle her father.

In their first few meetings, the doctor talked with her about her suicidal thoughts. He discouraged her from considering suicide, arguing that she must place her daughter as her priority and start making decisions based on what was best for her. His strategy obviously worked.

KV: How did you feel about that advice [to not commit suicide and to start living for the sake of your daughter]?

Ichi: It was good. I thought he was a really good doctor, that he understood me. I felt comforted.

Mrs. Ichi continued seeing that doctor once every two weeks for the next six years. All during that time, she was taking antidepressant medications.

KV: Tell me about the medicines you started taking. How did they make you feel? What effect did they have?

Ichi: They were effective, I thought. They helped me sleep, helped me breathe better, helped me eat. My heart also stopped pounding.

KV: Did they have an emotional effect? Did your mood change?

Ichi: I don't really remember.

KV: What about your relationships or interactions with other people. Do you think the drugs helped with that?

Ichi: Yes. When things were bad, I wouldn't talk on the phone. I wouldn't talk much with people at all. I also wouldn't participate in activities at my daughter's school. But [after starting treatment] I started to participate again. I also started

meeting with some of the other mothers... Sometimes I would go out to eat with them. We all went to PTA meetings, and there were a lot of them!

KV: How did you feel about these changes?

Ichi: They were good. I felt that I was returning [to normal] a little bit maybe.

Mrs. Ichi's experience with the medications and her psychiatrist were obviously good ones. The medicines were helping her to get out of the house more and take on a more active role at her daughter's school, and they helped with her appetite and sleep problems. But the sessions with the doctor seemed to offer additional benefits from those coming merely from the medications. She simply enjoyed the conversations they were having together.

I noticed that the word she used to characterize her recovery was "returning" [*modoru*]. Several patients that I talked with used this word to characterize their goals for treatment, and several newspaper interviews with patients also pick up on this. In contrast to Peter Kramer's concerns in *Listening to Prozac* about the possibility of American patients taking their culturally-constructed desire for newness to new levels by turning medicines into mechanisms for "cosmetic psychopharmacology," I found very few images of newness being articulated by Japanese patients. At best, they seemed to merely want a return to what they had before.

KV: What all did you talk about with him?

Ichi: His children, my daughter, his hobbies, etc.. We just chatted. He liked cars, and my husband worked at a car company, so we could talk about car things. This felt good. I was able to chat.

KV: This was effective?

Ichi: Yes

KV: Why?

Ichi: It was good to be able to have fun talk.

KV: You talked about children. Did he ever give you advice about your daughter?

Ichi: Yes. At the beginning, I couldn't do what I needed to do for her, so I thought I was a bad influence. But he said that she was seeing what I was doing these days [to try to get better] and that this was good. I started having much more confidence.

In the six years in which she saw that psychiatrist, nothing dramatic took place in terms of her family members, behavior, or feelings about herself. Instead of intense changes positive or negative, she mainly spoke of “returning,” and sometimes specified that she was returning to a normal routine. “I just returned to my regular lifestyle. I also started working.”

All during this time, she continued taking her medications. But after six years, her psychiatrist retired, and she started seeing other doctors at the same hospital.

KV: Tell me about your present doctor, Dr. A.

Ichi: Hmm...

KV: Do you talk with him like you did with the other doctor?

Ichi: Not so much.

KV: Can you elaborate?

Ichi: We don't talk about much of anything.

KV: About how long do you meet with him most of the time.

Ichi: Two or three minutes.

KV: How does the conversation usually go?

Ichi: “Are things OK?” “Yes.” The end.

KV: Wow, that's pretty short.

Ichi: Yes.

KV: Have you gone to another doctor?

Ichi: Yes, I've tried several, but they've all been the same.

KV: So you haven't found any doctor like your first one?

Ichi: No.

KV: Looking back, then, what do you think made him so special?

Ichi: He listened to me.

He listened to her. In my conversations with patients on the wards and in my interviews outside of the hospital, and also in my conversations with various mental health care advocates, the single most commonly-heard complement used to describe “good” doctors was that they listened. Though it appears that good listeners may be in short supply in the psychiatric community, those who do exist certainly receive the praise and affection of their patients.

B. MRS. NI

Mrs. Ni is a 56 year old married female with two grown children, each of whom have their own households. Mrs. Ni lives with her husband, who owns a successful butcher shop.

She started seeing a psychiatrist eight years ago, after she had a few fainting spells. She attributes the fainting to the stress of her work. Just two years before, after spending years assisting her husband at his butcher shop, she decided to open up her own business, a small snack shop. As the owner and sole employee, she was responsible for all aspects of the business. Though she had extensive experience in helping with her husband's business, she did not realize how difficult running her own business would be. She worked hard, however, and the business starting becoming successful.

But after a while, she started hearing a loud ringing in her ears [*mimi-nari*]. At times, it was so deafening that she could not concentrate.

Other than the ear ringing and the fainting, however, she reported having had no other problems or symptoms of any kind. Overall, she asserted that her health was good, that her relationships with her husband and children were fine, and that she had had no psychological or "mental" problems before this episode.

KV: Tell me how it all started. What prompted you to go to a doctor?

Ni: My business started becoming very stressful. I was working hard, and all of a sudden one day I collapsed. It was scary. I was rushed to the hospital in an ambulance. They ran all the tests, but couldn't find anything wrong with me. I went to several doctors after that, but they couldn't find anything wrong with me either. Finally I went to an ENT [ear, nose, throat] specialist, and we talked about the ringing in my ear. For a while, I had had a loud ringing in my ear, and sometimes it was so bad that I couldn't do anything or think about anything. He said that was my problem.

KV: What did it sound like?

Ni: "Gaa, gaa, gaa... jii, jii, jii"

KV: Was it like a voice?

Ni: No, it was like the sound of blood flowing.
KV: Did it hurt?
Ni: It made my head feel heavy.
KV: So what happened next?
Ni: I passed out two more times, and each time I went into the hospital.
KV: How long were the visits?
Ni: One was three weeks, the next was 10 days.
KV: What did they find?
Ni: They still didn't find anything. But my head became heavier, and the ringing continued.

After some additional questions, it came to light that at about that same time, Mrs. Ni's daughter had given birth to a child out of wedlock.²⁶ Because the daughter was living at home at the time, Mrs. Ni took on many of the responsibilities of raising the child. The daughter returned to work as soon as she could after the birth, and having to take care of the child and run the business became too much. So, she decided to sell the business. It had now been two years since her first fainting.

KV: How did you feel when you sold the business?
Ni: I felt nothing.
KV: Were you sad?
Ni: No.
KV: Were you relieved?
Ni: Yes. After I passed out that first time, I thought that I would quickly recover, so I didn't sell the shop. But, I didn't recover, and so I had to sell it.
KV: So this brought some relief?
Ni: Well, not so much. Because I wondered if I would be able to work again. I wondered if I were capable. If I recovered, could I still do anything?
KV: What did you do after you sold the shop?
Ni: That's when I started playing pachinko.
KV: Tell me about it.
Ni: I play pachinko every day.
KV: For how long?
Ni: Usually about seven hours.
KV: Seven hours a day?!

²⁶ It is very rare for an unmarried woman in Japan to have a child. According to Robert Retherford et al, "[i]t is assumed that fertility among the never-married is zero, which is a reasonable assumption in Japan, where out-of-wedlock births are rare" (Retherford et al. 2004).

Ni: Yes.

KV: What does it do for you?

Ni: The pachinko parlor is very loud. The ringing in my head is very loud. The pachinko parlor drowns out the sounds in my head. I can forget about myself. I can get lost in all the sound. So, I feel good when I'm playing pachinko. But, when I return home, I feel bad again.

In the conversation that followed, she explained that with her and her husband's earnings from their shops, they have made enough money so that she can afford to play pachinko all day long. She claims to be an excellent player, such that on most days she makes more money than she loses. But she admits that she does lose sometimes, but that on average this is not a problem. She added that she never gets relief upon returning home, though. The only place that the ear ringing does not bother her is at the pachinko parlor.

I wanted to ask her about her diagnosis. She had been diagnosed with depression, and her doctor had felt confident about the diagnosis. But until this point Mrs. Ni had not mentioned the word "depression," nor did she seem to have had a history of any of the standard symptoms. The ringing in the ears and the passing out had no doubt been severe, but I was curious as to how she herself characterized her condition.

KV: Do you think this is a "psychological" [*shinri-teki*] problem?

Ni: I don't think so.

KV: What kind of problem is it, you think?

Ni: Maybe "mental imbalance" [*seishin-fuantei*]. You see, "psychological illness" in Japan means "lunacy." People think you're crazy.

KV: So there's a stigma.

Ni: Yes, and this is why there's such a big difference between a "psychiatrist" and a "neuropsychiatrist." A psychiatric problem is a problem with being crazy, that your head is really strange. But a neuropsychiatric problem is about nerves. About a slight aberration [*zure*].

KV: So did you agree when they gave you the diagnosis of "depression"?

Ni: Yes, but at another hospital they had diagnosed me with menopause. So I've had many diagnoses.

KV: Menopause? Were you going through menopause then?

Ni: No. And later they said I had a "mild cerebral infarction."

KV: Did you have that?

Ni: I wasn't sure at first. They gave me all the tests – MRI, CAT scan, etc. – but there were no abnormalities. And my blood was fine. So, it didn't seem to be an infarction. We still wondered what was wrong.

KV: So it was a mystery.

Ni: Yes, a mystery.

KV: What did you yourself think the problem was?

Ni: Maybe a slight cerebral infarction. Maybe a tiny nerve just shorted out. But I didn't know. All I knew was that I had this ringing in my ear.

Mrs. Ni, like so many in Japan, then, was well-aware of the stigma associated with seeing a psychiatrist. She did see herself as suffering from a “neuro-psychiatric” problem, and so there was a tension in her attitude toward her own treatment. On the one hand, she had been taking antidepressants for eight years now. But on the other hand, she had never bought into the idea that she was depressed. She characterized her problem as merely a two-fold somatic problem: fainting and having a ringing in her ears.

KV: After you fainted and went to the hospital, how did things change with your husband and daughter?

Ni: They understood. They saw that I was having difficulty. They told me to depend on them.

KV: So they supported you.

Ni: Yes. My husband helped with the chores: washing dishes, cleaning the house, and he started doing the cooking. My daughter started helping too with her daughter.

KV: So things start improving for you.

Ni: Yes.

KV: What about the medicines you were taking. Were they helping?

Ni: I had a lot of side effects from the first medicines they gave me – the ones for menopause and everything. But the medicines I take now are fine.

KV: What are you taking now? [She then showed me her medicines: one anxiolytic, two antidepressants, and one medicine for the ear ringing.]

Ni: I take those three [pointing to the anxiolytic and antidepressants], but not the one for my ear ringing. That one makes my heart race.

KV: What effect do these medicines have?

Ni: Now, they help me calm down. At first, they made me sleep all the time, and my head was unclear. But if I didn't take them, then I couldn't calm down.

KV: What other effects do they have?

Ni: None really.

KV: Physical effects, changes in mood, in social life?
Ni: No, I just improved.
KV: “Improved”?
Ni: Yes, I was able to calm down. When I met with someone, my heart would race. But with the medicines, I could calm down.
KV: Does anyone know that you’re taking these medicines?
Ni: Just my husband and daughter.
KV: Have you talked with anyone else about these medicines?
Ni: There are people who don’t think these medicines are good. They’ve heard rumors that they cause side-effects like senility.
KV: Do any of your friends know that you’re seeing a psychiatrist?
Ni: No.
KV: What else about you factors into all this that you haven’t yet talked about?
Ni: Hmm, I still don’t ride the trains.
KV: Trains?
Ni: Yes, I haven’t ridden the trains for years.
KV: Why not?
Ni: They’re scary. I ride only in cars. My husband’s car, and sometimes a friend’s car. But only for short trips.
KV: When did you stop riding the trains?
Ni: Eight years ago.
KV: You just stopped suddenly?
Ni: Yes, after I passed out and entered the hospital, I just became scared. I stopped the trains totally.
KV: So, eight years ago, you had a lot of stress with your shop, with your daughter and granddaughter, your ear ringing started, you passed out, you went into the hospital, and stopped riding trains. What else?
Ni: I stopped meeting with friends, bowling, going to karaoke, and skiing. I used to do all those things. But I stopped.
KV: Do you do any of them now?
Ni: Not much.
KV: Have you talked with your doctor about all these things?
Ni: No. We don’t talk much.
KV: What do you do, then, when you see him?
Ni: I just tell him “In the morning, my head is a little heavy,” or “Today, my head is particularly heavy.” And that’s about all I ever say to him.
KV: Is this the case with all the doctors you’ve seen?
Ni: At one hospital, I talked about gynecology and menopause, but that was all.
KV: So, looking back over the past eight years, what do you think the problem has been?
Ni: Well, I’ve never wanted to kill myself. It’s all been painful, but never that painful. It’s just that stress is not good. Managing my own shop and having my husband running his own shop, it was very stressful. It was hard physically and mentally.

Mrs. Ni's narrative contains many of the elements that patients diagnosed with depression in Japan often mention: a sudden onset of symptoms, stress at work and/or at home, and fear of being labeled as "crazy." Additionally, Mrs. Ni's narrative mentions anxiety about riding trains and a ringing in the ear, both of which characterized the experiences of many individuals I spoke with.²⁷ I found most poignant, however, the fact that she spends most of her waking hours playing pachinko. But I sensed that something was still missing from our discussion, i.e. that there was a bottom to which we had not reached.

KV: That's about all the questions I have, but is there anything else that I should have asked but didn't? Is there anything I should know that I haven't asked about yet?

Ni: I don't think so.

KV: Do you have any questions for me?

Ni: Mr. Ken, do people like me ever recover?

I was taken aback by the question. It marked a shift in tone from everything that had been spoken before. It was as if, after eight years of seeing a psychiatrist, she had not even broached the issue with him. If she had, she seemed quite unassured by his answer. Had they ever talked about recovery in the broad sense, about what it would mean for her to "recover," or had they just chit-chatted about medicines and headaches for a couple of minutes a week for eight whole years?

How far had she come during that time? And what kind of life was she leading, spending most of her waking hours in a pachinko parlor, alone, trying to drown out the noise in her own head, never looking forward to returning home to her husband. I wondered what the pings and

²⁷ I have not come across any academic literature on ear ringing in Japan, even though there are some websites devoted to it (See *Esu eru iryou guruupu* [SL Treatment Group]). Though there is an almost unlimited number of possible somatic symptoms, doctors told me that ear ringing is a common one among Japanese patients.

dings of the pachinko machines were really drowning out. Was it the failed business – the one and only chance she had had in life to run her own business – that was the problem? Was it having a daughter who had had a child out of wedlock? Was it having to take charge of raising that child at precisely the time she was finally starting her own business? Was it a matter of recognizing that she was unwilling to raise the child? Was this all a matter of resistance, of failure? I never found out. We didn't go that deep. All I can be sure about is that she had a severe ringing in her ear, had passed out a few times, and that the doctors had summed it all up as "depression." No one seemed interested in digging. Just taking the medicine, seeing the doctor, and continuing with that pattern for as long as they continued with it. She had been seeing a doctor for eight years, and yet here she was asking me, an anthropologist, if she could look forward to recovering.

KV: I'm not a clinician. I'm just an anthropologist, so I don't know about those things. I can't give any advice. I can only say that, based on what I have seen, different people seem to recover in different ways. Some respond well to medicines, others to talking with friends or counselors, others to changing their lifestyle, others to spending more time with their children, and so forth. A lot of people succeed in finding what works well for them. I've seen a lot of people who have recovered and are living good lives.

I am not sure if she obtained anything of value from my answer. But it was the only answer I could give. I wished her well, sent her a thank you letter as I did each of the other interviewees, and never saw her again.

C. MR. SAN

Mr. San is a 50 year old married male with two children: a 22 year old daughter and a 20 year old son. He works as a sales representative for a mid-sized company. He reports that he is

secure in his job and has no major problems with either his home life or work life. He claims to have good relationships with his wife and children and that in general he enjoys a “happy” lifestyle.

Last year, however, he started having some problems. He started breaking out in sweats, most often when he rode the train, but also at work. He also started feeling anxious. He was diagnosed as having anemia, for which he started taking medications and vowed to stop drinking alcohol. He claims that before then he had no major health problems.

But after taking the medicine for his anemia, his sweating continued, as did his anxiety. He continued to have difficulty riding trains. His anxiety became so severe and so continual that he started feeling suicidal. When he realized what he was feeling, he decided to consult a psychiatrist.

In the first visit, the psychiatrist diagnosed him with depression and started him on antidepressant medications. Though Mr. San doesn’t necessarily disagree with the diagnosis, he does not think that it is 100% accurate.

KV: Tell me about your life during the time just before you started seeing a psychiatrist. What was going on in your life then?

San: I started sweating severely when I got aboard a train, and I was very anxious. I hyperventilated on the train.

KV: Had you ever experienced these things before?

San: No, this was the first time. It all started suddenly.

KV: What could have brought it on?

San: I don’t know.

KV: What was going on with work at that time?

San: We were very busy. I was getting pressure from the President, and I started losing interest in work. I couldn’t handle the work, and I couldn’t sleep. The pressure from the President was intense.

KV: How were you feeling?

San: I was dizzy. My ears were ringing. I had headaches, and urinating was difficult.

KV: You said the doctors thought it was anemia, what did *you* think?

San: I think it was male menopause.

KV: Male menopause?

San: Yes.

KV: To be honest, I don't know much at all about male menopause.

San: Yes, it happens to men at about my age – 50 – and once it started happening, I started researching it over the internet. I learned a lot about it.

KV: What did you learn?

San: When it happens, you lose energy. It's hard to concentrate. Of course you have little interest in sex.

KV: And this described what you were experiencing?

San: Yes, this was what I was experiencing.

KV: So what did you do?

San: I went to a psychiatrist.

KV: And what did he think?

San: He thought I was depressed.

KV: Did he start you on medication?

San: Yes, Paxil, 10 miligrams.

KV: How did you react to his diagnosis?

San: Well, I thought that what was really going on was that I was just getting old. But I decided to just try the Paxil. Turns out that it had a quick and really good effect. My spirits were no longer low. The hyperventilation on the train ended, and I started having a desire to work again. But sex became impossible.

KV: Yeah?

San: Yeah. But because I was able to control things at work again, things were good. Really good.

KV: Why so good?

San: I now think that things will be different from here on out. I can now concentrate on work, even when I'm driving. When I was depressed, I couldn't think about work at all. But now, to the extent that I can think clearly, I know my spirits [*kokoro*] are OK.

KV: What other effects have the medications had?

San: None.

KV: Any differences in getting along with people?

San: No.

KV: Any other kind of effect?

San: I can sleep better. I used to wake up in the middle of the night a lot, but no more. Paxil helps me sleep.

KV: What else?

San: Other than ED [erectile dysfunction], everything is better. Appetite, sweating, wanting to kill myself, control at work. Things are better.

It was clear from the discussion that Mr. San was pleased with the medication he had been taking. He was informed about the type of drug Paxil was, called it an "SSRI," and had

researched it over the internet. So, in terms of his medical treatment, especially his medication, Mr. San seemed to be a satisfied patient.

But as the conversation continued, he veered away from talking about his treatment and started talking about why he thought depression was becoming so common in Japan. It was clear that he thought there was something “Japanese” about the fact that so many people were becoming depressed.

KV: Any other kind of effect?

San: If I take the medicine away, my worry would return. My worry is now 1/4 what it used to be. I used to always worry about work. Even when reading the paper on the train, always worrying about work. But that’s no longer the case. I can even enjoy time away from work.

KV: That sounds good.

San: Yes, depression happens to those who work too much, who can’t cast off work at all.

KV: What do you mean?

San: Well, we Japanese are all working. We’re all doing the same thing. It’s like fashion – we all copy each other and this gives us a sense of security. It’s like that. When someone builds a house, all his friends build houses. People of the same era and generation want to be average. They want to be the same. So, when Americans look at Japanese, they see no individuality. But for Japanese, when we’re all at the same level, this actually gives us peace of mind. After all, since losing World War II, we haven’t had anything else to guide us. Our religion, Shinto, was totally removed. Americans have religion – they can get their sense of purpose from God. But we don’t have God or religion any more in Japan. So in terms of finding a sense of purpose, that’s a problem. When we’re uneasy or anxious, we don’t have anything – no God to talk to. Without that, we don’t know what we should hold on to. This is why we all just try to do like everyone else is doing. We don’t have other options.

KV: I haven’t heard this before.

San: It’s true. And it’s bad these days because there are lots of people who don’t have any close friends, who don’t have many friends at all, who don’t have many relatives, and who are living in Tokyo all by themselves. They are really uneasy about things. It’s sad. All they can do is work. They work too hard. There are a lot of people like this who now have depression. They’re becoming like discarded shells of themselves [*nukegara*].

KV: Tell me more about this not having God or other source of purpose.

San: It’s often said that we Japanese are like onions. You need to peel away all the different layers to find out what’s really going on. The problem, though, is that

once you peel down to the inside, you find out that it's empty. There's no core. There's nothing there.

I was surprised by Mr. San's rather quick shift toward heavy social commentary. Perhaps he was projecting his own feelings onto "we Japanese," or perhaps he was engaging in a bit of scapegoating. Or, perhaps he was just expressing an honest lament. Either way, his making such generalizations about his fellow Japanese citizens being "empty at the core" seemed to take the common refrain about Japan's national sense of inferiority [*rettoukan*] and move it several steps in the direction of nihilism.

Upon hearing his comments, however, I could not help but wonder if other Japanese shared his sentiments. It was not an issue, however, that I could easily broach. Would many people care to admit that they found their culture and fellow citizens "empty to the core"?

With later reflection, I realized that his comments were actually reminiscent of what I had heard from several Japanese people who were quick to assert that Japan is "not religious," and that they, being Japanese, were personally not interested in religion. Yet, they participated in any number of rituals and ceremonies at any number of shrines and temples on a very regular basis (Kawano 2005). And here we were in a country that had over 80,000 documented holy sites.

I was curious about what was prompting this sentiment against the proposition that Japan was religious. What kind of sentiment was it, and how widespread was it? Though the questions were fascinating, I thought they were slightly over the edge of what I was trying to figure out in terms of the normalization and treatment of depression, and so I did not pursue them much further. I did, however, on one occasion, ask a clinician (Dr. Aka, whom I will introduce in the next chapter) about it. Here is her response:

Aka: Emptiness and nothingness... hmmm... I think it has to do with concepts of self and that maybe the Japanese concept is a little different from the Western concept. The self here is always defined in relation to other people. And several words that deal with the self – words like *aware* and *sunao*²⁸ – are related to this idea of the empty self, of nothingness.

I think that when we use the word *sunao*, I think it means a psychological state in which you put your values and frameworks on the shelf and, by so doing, try to become open to new ideas. But with most Americans, you like to have your own ideas in place and are quick to judge things in keeping with those values. But we like to empty ourselves of ideas for the time being, to withhold judgement, to have a wait and see attitude, to see what happens. Like an incubation period. It's like a temporary nothingness.

It comes down to the question of how do you define self, what is the core of the self. If we Japanese can empty ourselves, to go completely with the flow, we feel that this is a matter of going with the flow of nature. It's a feeling of naturalness.

So, rather than emptiness, maybe there is an uncertain self, a permeable self, only without the negative connotation.

This is the way I see emptiness. But maybe emptiness means different things to different people.

Though Dr. Aka and Mr. San had divergent understandings of emptiness, it is nevertheless true that emptiness and nothingness have a long history as culturally-loaded terms in Japan. A concern with them has permeated many schools of Buddhist and Taoist thought for centuries (Kodansha 1993:1116). Dr. Aka's comments offer a positive reading of how emptiness interacts with sociality in creating a Japanese conception of the "indeterminate self," whereas Mr. San's takes the inside-outside distinctions so often-associated with that conception and asserts their ultimate impotence.

I do not see a possible resolution here, nor for that matter even an argument, really, for there are too many intangibles at play to make an analysis even possible. But Mr. San's comments are useful in that they bring into relief the fact that there exists a multitude of opinions as to why so many people are being diagnosed with depression these days. Whereas one person

²⁸ "gentle, mild, meek, docile, innocent, obedient" (Sanseido's 1999:491).

may see a rise in public awareness about mental illness, another may see a socio-economic malaise (Pew Research Center 2002:18), and yet another may see a psycho-spiritual void that runs to the core of Japanese identity.

D. MR. YON

Mr. Yon is a 31-year old unmarried male who lives alone and works as a salaryman for a mid-size company. He comes from a middle class family, graduated from a reputable university, and is in excellent health. Until last year, he had had no experience with the mental health care system.

Two years ago, Mr. Yon decided that he wanted to change careers. He wanted to become an accountant. So, in secret, he started taking accounting classes in the early mornings and on Saturdays. After a year of study, students in these classes are permitted to take the first of two licensing examinations. If the student passes the first exam, then he/she is able to take the second and final exam, the passing of which qualifies one to become an accountant.

Mr. Yon's classes were held every weekday morning from 7:00 to 8:30, and he was able to leave class and arrive just in time for work to begin at 9:30. His workday usually ended between eight and nine at night, after which time he immediately returned home to begin studying for the next morning's class.

KV: Tell about what was going on just before you decided to see a psychiatrist.

Yon: I was extremely busy at the time. So busy. I went to school before going to the office every morning. Class was from seven to 8:30, and I had to be in my office by 9:30. On weekends, class was all day long. There were lots of tests, and each test gave me more stress. From October to December of the year before last, this schedule continued.

The first test was in May last year, and if I passed, then the second test was in July. Results arrive in October. So, last year, I took the test in May and passed,

then took the second in July. But in October I found out I was not successful. So, I had to restart the school again. So, last year was very tough. I was at a weak stage. In my head, I was always thinking I was not successful, thinking that I was not studying hard enough.

Also, my job at that time was at a weak point too. There were many problems to be solved. So, November and December were especially difficult. That was the situation.

KV: At that time, what did you think the problem was?

Yon: The prime reason I decided that I had to go to the doctor was that sometimes I was very stressed. One time I kicked my desk. I shouted sometimes. I exploded sometimes. My colleagues looked at me like I was not well. It was like another me. That person would just lose it sometimes.

KV: What did you think of yourself? Did you think you were sick?

Yon: I didn't think I was really sick. I just wanted to run away. My bosses were good people, but the job was very serious. There are not many people in my department, so there were so many things to do. I had to do them. There were lots of young people in the company, too, and they didn't know how to do things, so I was the only one who could do my job.

Mr. Yon's account demonstrates a clear-cut interpretation of his situation: he was stressed out because of the double burden of dealing with difficulties at work and studying for his licensing exam. However, further questioning revealed that there was a secondary component of the exam situation. He explained that his father had worked for years as a software engineer when software engineering was a new field, but that later he decided, like Mr. Yon is now, to change careers. As he explained:

Yon: He was a software engineer, which was rare for his generation. He was kind of a pioneer, I think. But his company did not make use of his skills because they thought that advancements with computers would result in restructuring. So, he couldn't do anything with his skills. He got sick. He had a bleeding stomach, and he stayed in the hospital for two years. He had two operations. All because of stress. But he is OK now. The polyp was removed, and it wasn't cancer.

KV: What did he do after getting out of the hospital?

Yon: He didn't retire. He returned to the company. But he felt that he couldn't work there long. So, he started studying to be a tax counselor. He studied very hard – like me – while working at the same time. He got his license after five years, and he quit the company and started his own office.

KV: He sounds a lot like you.

Yon: Yes.

Mr. Yon's situation, at least in part, may have some father-son issues involved, but the immediate problem for him was merely that of how to function adequately at work given that his situation seemed to be quickly deteriorating. His stress and anxiety level were worsening, and he saw no way out.

KV: So how did you first decide to see a psychiatrist?

Yon: A high school friend of mine was now a psychiatrist, and so I called him.

KV: What happened?

Yon: I explained to him my symptoms. He was very objective. He said this was a very serious problem, that I was in a very serious situation. He said that the way I was talking, the way I was using phrases, was abnormal.

KV: In what way?

Yon: He didn't explain. He just said it was abnormal. But I didn't think I was abnormal. I didn't know what to think.

KV: So what did he recommend?

Yon: He said that he could give me medication, but that the best way to deal with it was just to take days off. He said I needed a vacation. Fortunately, Christmas and New Year's holidays were coming up. He also said that I should stop trying to do everything at work, that I should release some of my responsibility. At first, I could not do this. But little by little I became able.

I also went to get massages. My massage therapist said he had never seen a body so hard. My shoulders were really hard.

So, I changed my mind about things at work. The job was not "my" job. It was the company's job. My job was just my own job. The company is the one with the overall responsibility for things. Before last year, I was taking on too much responsibility for someone in my position. I was only one staff member. I didn't delegate any of my work to other people, but my friend [the psychiatrist] said that I should do that.

KV: How did you explain this to your boss?

Yon: Looking back, I'm thinking that a lot of what happened [kicking desk, yelling, exploding, etc.] was just a way to let my bosses know of my situation. When I am angry or frustrated, I am not good at showing that emotion to people. I am not good at showing what [emotional] situation I am in. Maybe I was advertising what my situation was. Maybe if my bosses thought I was insane or crazy, then maybe they would stop pressuring me. I just wanted to run away. But even after doing that [kicking, yelling, etc.], my bosses didn't change. This is my analysis now. At the time, I did not know what I was doing.

KV: Did you tell your bosses at work that you were seeing a psychiatrist?

Yon: No. Not at all. I didn't even want to "officially" meet with my friend because if I did that, then I'd be registered as a "patient," and this is troublesome

in Japan. Maybe in America too. In Japan, to go to a psychiatrist means that he's not normal, that he doesn't have the ability to work for a company. So, if I did that [go to a psychiatrist], then I would lose my job. You may not be fired, but you would lose your job in some other way.

KV: So what did you do?

Yon: I did not meet my friend officially. We just met and talked, and it was for free.

KV: Did he give your condition a name?

Yon: Yes, "depression." He said this was my problem. But he said that my problem was also manic-depression. From high down to low. I am that kind of person. When I am high, I am thinking that I am beautiful and wonderful. But if I do some little thing wrong, then I go down. I am a bad person. Nobody likes me. I don't have a right to live.

KV: When did this start?

Yon: When I am alone, I am OK, in a good condition. But depression starts when I stay a long time with other people. For example, in college, I took a long trip with some people. By the third day, some of them were making fun of me. And so I stopped talking. They were surprised and said that Yon changes so drastically, so they were confused. So I told them that they were right, that I was just like this and that they didn't do anything wrong, that I was just this kind of person. So, that's the kind of tendency I have. It's not a sickness.

KV: It's just your personality?

Yon: Maybe.

Mr. Yon was clearly in touch with the proposition that his problem did not merely begin suddenly, but instead harkened back to issues and/or aspects of his personality that showed themselves at least as far back as college. But even though there was a "history" here, Mr. Yon did not see that history as being the root of the problem. Instead, he saw the immediate stress of his workplace situation, combined with his struggles in the accounting class, as the central issue. In his mind, therefore, this was primarily a stress problem, not a personality problem. His goal was just to get through it, to continue doing a good job at work until he could pass the exam and begin a new job in another company as an accountant. In keeping with this interpretation, he was not interested in reframing the situation psychologically, nor in any type of cognitive or other psychotherapeutic approach. He wanted something more immediate.

KV: So when you talked with your friend, did he tell you to take medications?

Yon: No, he doesn't like medications. He is prejudiced against the drug business and their making lots of money. Drug companies make a lot of money through insurance, the Japanese insurance system. According to him, doctors make more money through prescribing medicines than through anything else. Doctors always take advantage of patients by always making them take medicines. But to him, medicines are sometimes harmful. So, he rarely gives medicines. He just said I should stop working and studying so hard and should take a rest.

KV: Did you?

Yon: Yes. Also, my mother has a heart problem, and she takes some medicine to calm her down. She gave me some of that, and whenever I thought I was about to erupt, I took it. When I was stressful, it helped, but then I stopped it because I read in the newspaper that it harms other parts of the body.

KV: So you got the medicine from your mother?

Yon: Only a little. I then got it from my friend.

KV: So he gave you some?

Yon: Yes. He didn't want me to use it often, but he agreed to give it to me.

So, even though Mr. Yon was amenable to a pharmaceutical treatment, he was respectful of his friend's attitude toward drugs. As stated in chapter three, there are structural (ability of doctors to sell drugs directly) as well as ideological (*kanpo*) supports for Japanese doctors to over-prescribe medications; and Mr. Yon's friend was one of the progressive doctors who was challenging those habits. In essence, Mr. Yon's friend wanted to de-medicalize Mr. Yon's condition to greatest extent that he could, and he did this by asserting that what Mr. Yon needed was not medicine, but merely a reduction in workplace responsibilities and a little rest. He just needed to take it easy, so to say, and the best way to start that was by taking some time off.

His recommendation to Mr. Yon is reflected in a variety of television and billboard advertisements in Japan these days, most of them from companies in the leisure business, encouraging individuals to "pace down," relax, and try not to work so hard. But the fact that billboards are having to exhort people to do so demonstrates that doing so is indeed difficult.

And so Mr. Yon's friend was recognizing in Yon a condition, and a need, that was not uncommon.

KV: Do you think the stress that you suffered around November and December is typical for other people?

Yon: Yes, I think many other people have this stress. Compared to other people, though, I think I am a lazy person. I can give into stress easily. I can recognize it and want to run away. But other people, more industrious people, don't think that way. I have to overcome this situation, without saying anything to anyone else. I'm expressing this to you, but to other people, expressing this is a shame. For most Japanese people, saying that I'm struggling with this hard work, that I am stressful, saying I want to run away, is *haji* [shame]. Very shameful. It means I have lost, that I am a loser. A loser of a human being [*jinsei no ruuzaa*]. A depressed person like this is a loser. This is a Japanese society thing.

It's like the Indy 500 car race. If your car is in trouble, you are out of the race. He leaves the race. That is the situation. Japanese people think American society is favorable for challengers, that if you lose once, you will have another opportunity, another chance. But in Japan, once you lose, that's it. You're out of luck. We agree that once you start talking to a psychiatrist, people think you are out of the race. In America, if you're out of the race once, then see a psychiatrist and find a solution, then you can get back onto the track and get back into a race. But in Japan, this is not the case.

KV: Why can't you get back into the race?

Yon: Commuting to a psychiatrist means that you're out of mainstream society. There's a conveyor belt. Japanese people say we're on a conveyor belt. We get into elementary school, then junior high school, then college, then marry, then children, then age, then cremated. Our image is that we're on a conveyor belt. But once you go to a psychiatrist, it means you're off the conveyor belt.

My friend says that the goal of psychiatry is to get people back into the mainstream. But I think most know that this is impossible. Once people visit a psychiatrist, mainstream people are very skeptical about these people.

KV: What's wrong with being off the conveyor belt?

Yon: For people who work at companies, it's a problem. In Japan, we're educated to think we should do like others do. So, it's risky to be an outsider. Mainstream and outsiders. Japanese people tend to understand the world by categorizing people – by who is in and who is out. Maybe this sounds like textbook talk, but I think it is true. Out or in – this is very important to us.

KV: And psychiatric patients are always out?

Yon: Yes. But maybe in ten years the situation will change. Because it's different in America, maybe it will become that way in Japan. Every time it happens that way.

KV: Are you still going to accounting school?

Yon: Yes.

KV: Is it still a secret?

Yon: Yes. My friends know, but they know it's a secret. My number one stress comes from this – that I have told no one at work about my commuting to license school. Once I tell people, then they will expect me to get out of the company, so this would be very negative for me. So, I don't say anything about it.

By keeping such a secret, Mr. Yon is living a lie. He is a *shain*, which means he is a full-time permanent employee, and given that this is a well-known and successful company, there is an implicit assumption that, barring economic disaster, *shains* will work there for the rest of their careers. But Mr. Yon does not intend to do that. He wants to leave the company as quickly as he can. This alone keeps him on edge. He knows the risks if he is found out.

There are several issues that compound the fact that he is living with a secret. First, his prospects for moving on are not at all guaranteed, for they depend on his ability to pass an exam that he has already failed once. Without passing the exam, there is zero chance of his becoming an accountant. And if he doesn't become an accountant, there are no prospects for him on the horizon outside of his current company. Second, it may be that he has already destroyed, or at least diminished, his prospects for advancement at this company given his bizarre behavior of last year. Third, there may be feelings of inferiority vis-a-vis his father given that his father was in a similar position years ago and managed to follow through in his efforts to pass the exam he needed to begin a new career. Fourth, Mr. Yon knows that time is not on his side. The older a man is in Japan, the less likely it is that other companies will hire him. This becomes especially important after he turns thirty. So, putting all these factors together, Mr. Yon has several reasons for becoming stressed-out.

Mr. Yon's case speaks to those who question the company-employee relationship in contemporary Japan – in particular the question of loyalties, or more precisely, the lack thereof.

Mr. Yon started with this company immediately after graduating from college, and he has done well there, being promoted in keeping with his seniority. He makes a good living. If the stereotype about “company filiality” were true, then, we would expect him to value the security of his position with his company more than almost anything else, certainly more than concerns about personal fulfillment. But Mr. Yon is not loyal to this company, and he is interested in fulfillment. And he is willing to tolerate a great amount of stress in the short run in order to find that fulfillment in the long run.

Mr. Yon’s example calls attention to the studies over the past ten years that question the validity of the salaryman stereotype and challenge the claim that most middle class male workers are industrious, cooperative with their colleagues, and loyal to their companies. James Roberson’s work in particular has broken down the image, common outside of Japan, of the Japanese as workers who are exclusively white-collar, employed by large corporations, fiercely loyal to those corporations, and consider their company to be a big family in which everyone cooperates, participates in collective decision-making, and takes care of everyone else (Roberson 1998).

In keeping with Roberson’s work, Paul Noguchi examined career trajectories and attitudes about company-employee relationships in the Japanese railroad industry and found that many employees do not view the company with filial affection, but instead maintain a somewhat antagonistic stance that accepts as reality the fact that employees are often competing against each other for raises and promotions, that employees as a group are competing with management, and that any future with the company is contingent on a variety of factors such that lifetime

employment is neither guaranteed nor desirable in all cases (Noguchi 1990). Mr. Yon's case, therefore, resonates with both Noguchi's and Roberson's findings.

But Noguchi and Roberson did not examine the extent to which the stresses of workplace conditions and career-related issues could trigger, or comprise, mental health problems. This is not to say that their research overlooked something. Quite the contrary, it is merely to suggest that the mental health component is a relatively new arrival on the scene. It is at least a new arrival to the part of the scene that the public is talking about.

If we take the salaryman image as our norm, then, Mr. Yon may be exceptional in his determination to make a fresh start for himself. But if we recognize that in this era of increased layoffs, corporate insecurity and continuing economic malaise, more workers than ever are choosing and having to choose to retrain, then Mr. Yon's decision to seek a new beginning may not be so exceptional after all.

But whether or not his ambitions are typical, the fact remains that in the white collar world of corporate Japan, changing companies in mid career without suffering a loss in salary is still difficult, even for those who have not been laid off; and Mr. Yon's struggles in achieving that change is proof of that difficulty. It should come as no surprise, then, that he is stressed out. Though the official diagnosis of his condition as "depression" may resonate in medical circles, it is clear that Mr. Yon himself does not medicalize the situation but instead views it as one for which there is only one solution, and it is not a medical one. He just wants to pass his exam and start a new career. Until then, he works, studies, and waits.

It should be noted that Mr. Yon's friend was an effective therapist in this regard, at least in the sense that Mr. Yon himself was satisfied with the treatment he received. What makes Mr.

Yon's experience interesting is how the clinician was able to assess the situation and deal with it to the patient's satisfaction so quickly. Mr. Yon met with his friend only a few times, the first time being a diagnostic interview and the subsequent times being just for getting medicines prescribed. But because of those brief encounters, Mr. Yon became stable. The psychiatrist told him that the situation was serious, that he was not acting normally, but that the situation was treatable. Rest was the main prescription. This resonated with Mr. Yon, and so he spoke of his clinical encounter with praise and gratitude. It is as if Mr. Yon just needed a slight navigational change, a nudge in the right direction. The psychiatrist was able to do this immediately, without the need for drastic measures or long-term care. With the clinician's distrust of pharmacological treatment – the foundation of much of Japanese and international psychiatry – one can argue that he was challenging the norms of his profession. By the same token, if the goal of any healing profession is to treat the problem as quickly and effectively as possible, then it appears as though this clinician succeeded.

At the time of my interview with him, Mr. Yon was continuing with his classes, was now calmer at work, and was hoping to pass the exam coming up in a few months. He thinks the worst is over and is looking ahead.

E. MR. GO

Mr. Go is a 36 year old married male with two children. He lives with his wife and children and reports no major medical problems. He works as a magazine editor for a publishing company. He has been seeing one of the psychiatrists at Seishin for almost a year now.

KV: Tell me about your life about a year ago. What were you doing? What made you decide to go to a psychiatrist?

Go: It had to do with the magazines. Three years ago, I started as the main editor for this line of magazines. But you know the IT bubble burst in 2000, so our sales had started to go down. So, this particular line had to be revamped – the content had to change. When I contacted Dr. Z at about that time, a feeling had suddenly started – that I just didn’t want to make the magazines any more. But I couldn’t take any time off of work. I didn’t have any vacation time, so I had to keep working. We had to shift the kind of magazine we were making. But I couldn’t make the switch. I didn’t correspond any with other staff members. We then started having budget problems, and that’s when things got really bad.

KV: Was this a budget problem regarding the whole company?

Go: Yes. The whole budget got really low. On the magazine I was working on, we went from eight people to two people. So, I was having to be the photographer, the writer, do all the negotiations with the printer, and other new tasks. I was also put on commission. Japan is becoming more like America in this regard. We used to have the seniority system, but more and more it’s a meritocracy. So, if my magazines sold, I made a salary. If they did not, then I had no salary. So, my condition started going down.

Looking back, it was depression, I think. I became really strange. At night, I couldn’t sleep at all. For an entire week, I didn’t sleep at all. I still went to work, but I was getting so agitated there that it reached the point that I lost my sense of judgement.

KV: So you couldn’t even think?

Go: Yes. But there was a wonderful [*erai*] person at work, so I consulted with him. I asked him to help me. He said that things had gone too far and that I needed to go to the doctor.

KV: So you went to a doctor?

Go: Yes, but for the two or three days before I saw him, I was thinking about suicide.

KV: Suicide?

Go: Yes, actually I had strung a belt out on the veranda of our mansion²⁹ and had tied it tight. I was ready to hang myself. But ultimately, I failed. I couldn’t do it. But I still wanted to die. I told the doctor about it.

KV: Do you think he understood?

Go: Yes. He said I was depressed.

KV: Did you really intend to kill yourself?

Go: Yes. I was just lucky. You see, I had not slept for six days by this time. At that time, my wife was pregnant. She was in her tenth month, so she had before then returned to her hometown to be with her family.³⁰ But the very next day, she unexpectedly returned from her family’s home so she could get our son vaccinated

²⁹ “Mansion” is a synonym for a “apartment,” although it connotes an apartment large enough for a small family to live in.

³⁰ It is common in Japan for an expecting mother to live at her natal house for the couple of months immediately preceding and/or following the birth.

here. In the meantime, I had been doing everything by myself. It was all too much. When I saw my wife's face, though, I came to my senses [*shouki ni modotta*]. If she had not returned soon, I probably would have gone ahead and killed myself.

KV: Did you talk with your wife about all this?

Go: No. I talked with her about not being able to sleep, but nothing about the suicide. But she knew about the depression.

KV: When was this exactly?

Go: August.

KV: And when did the baby arrive?

Go: October.

KV: So, you had financial crises at your work as well as a new baby coming, so you had a lot of pressure and worries, huh. Becoming depressed doesn't seem so surprising. When you first met with the doctor, did you talk about all this?

Go: We talked about my not sleeping, and to my surprise I did end up talking about wanting to kill myself.

KV: Did you go into detail?

Go: We didn't spend much time talking. The vice president for general affairs [Mr. Go's boss] had come to the session with me. So, Dr. Z just suggested that I take some time off. He never even said the word "depression." He didn't even write up a written diagnosis, thinking that other superiors would look at it.

KV: Were you also dealing with the threat of being laid off?

Go: No. As a manager here, I wasn't at risk of being laid off. But many others had already been laid off, so that's how I ended up with no staff. Also, my company had had experience with suicide, so their attitude toward suicide had changed. For people with this kind of problem, they just got moved to another section or were given time off. This is what happened with me. I was moved to another section eventually.

Mr. Go's story brings up many of the stresses for which people are increasingly turning to the mental health care system for help. In his case, though the threat of being laid off was not hanging over his head, the consequences of his company's already having laid off so many of its workforce had increased his responsibilities and difficulties significantly. Given that his section's staff had been reduced from eight to two without any corresponding reduction in workload, he was, at the time he sought professional help, trying to do the work of four.

Additionally, his wife was pregnant with their second child. To have a child due at precisely the time all these work-related changes were underway seems to have contributed to his

unease. Eventually, he became suicidal.

Mr. Go mentioned nothing about chemical imbalances in his narrative. For him, there were clear environmental and psychological reasons for his difficulties.

Fortunately, the surprise return of his wife and his subsequent decision to see a psychiatrist averted his plans for killing himself. But I was curious about the treatment he received, especially his experience with SSRIs.

KV: Tell me about the effect that Paxil has had on you.

Go: At first, it hardly had any effect at all. I was only taking one pill a day. But now I'm taking three. I take them every night. Once I started doing that, I started calming down. They're like vitamins to me now.

KV: Can you elaborate? What effects did it have on your body, on your mood, and so forth?

Go: It helps me sleep. When I get up in the morning, when I'm eating breakfast, my mood is immensely better than it was before. Before, when I was just on anxiolytics, I couldn't eat breakfast. And later, when I got on the train, I would start to feel dizzy.³¹ This stopped after I started taking Paxil. Especially when the trains were crowded, I would feel dizzy, but Paxil stopped this. It's the number one thing that has helped me.

With depression, I don't want to leave my room, and I just want to live under my futon. When I get dizzy, there's a feeling of uneasiness. It's like a panic attack is coming.

KV: Panic?

Go: Yes, especially when I ride the trains.

KV: What kind of feeling is it?

³¹ Several patients that I observed in the outpatient clinics spoke of the panic they experienced upon riding crowded trains. I, also, actually witnessed a case of this first hand once. A boy who looked to be around 11 or 12 entered the train with his mother and stood beside me. Soon after the train left the station, the boy slowly dropped to the floor, where he laid down as if he had become ill. I asked the mother if he was OK, and she responded saying that on occasion he has this kind of panic attack [*panikku*] when he gets on a train. Once the doors opened at the next station, the boy slowly rose to his feet, and she helped him off.

Transportation-related problems may have societal variation to them depending on the dominant modes of travel. Whereas much has been written about "road rage" in the United States, perhaps "train panic" is a common experience in Japan.

Go: My heart races. If I sit down, it's OK. But if I have to stand, then I get dizzy. But because of the Paxil, this isn't a problem anymore. The effect of the antidepressant is very good. It's been a huge difference.

KV: What's your relationship with Dr. Z like?

Go: Well, our time together is very short. It would be nice to have more time to talk with him, but the system doesn't work that way. So, there's nothing to be done about it.

KV: If you had more time to talk with him, what would you want to talk about?

Go: This year, half of our company has been laid off. I don't ever talk about it, but feelings of nothingness and melancholy have come, so maybe we would talk about that. You know, a 34 year old relative of mine died from overwork, so...

Mr. Go has had a good experience with Paxil, and he is tuned into the changes that he has experienced as a result. In terms of sleep and appetite, he credits the drug with having a positive impact. But in terms of behavioral and psychological factors as well – panic on the trains and the desire to crawl under his futon – Paxil has also proven helpful. SSRIs are working so well with Mr. Go that he has reached a level of stability that he is pleased with. He is also sufficiently pleased with his sessions with Dr. Z. I think it would be safe to consider Mr. Go, therefore, as a psychiatric success story.

But Mr. Go's last statement suggests that all is not resolved in his mind. Knowing that a relative of his died from overwork, and wanting to ensure that "feelings of nothingness" do not start again to get the best of him, he knows that there are still issues operating just under the surface.

I was curious as to Mr. Go's interest in psychologizing about his experience. Many patients seem uninterested in associating their current situations with their childhoods, but in each of my interviews with patients I at least tried to broach the topic:

KV: These feelings of depression that you've had, did they begin just last year, or did you ever have them earlier in life?

Go: Truthfully, last year was the first time I ever wanted to kill myself. But in childhood, I do think I was melancholic [*meronkorikku*]. Or more specifically, I was angry [*angurii*].

KV: What were you angry about?

Go: As a child, I fought a lot, so I became melancholic. I even injured a friend once.

KV: Why did you fight a lot?

Go: I was teased a lot. I made the highest grades in my classes, so other kids teased me. It was like this for the last half of middle school. There was always a hostile relationship between the other students and me.

KV: Were you bullied?

Go: Yes. Once, students even set me up. I was sleeping by the pool, and they stole some bakery bread from a store, ate it, then said I had stolen it. The police came. Afterwards, everyone's parents told their children to stay away from me. So, I had no friends at all.

KV: How long did this last?

Go: About a year.

KV: Did you have any other problems like this when you were younger?

Go: Actually, when I was young, a cousin killed himself. He was 27 years old. It was the most dramatic event in my childhood. And just three years ago, my uncle killed himself. He was a painter, but as he got older, he could hardly see at all. He couldn't paint any more. He was living alone, and he just killed himself. So, I've been thinking about mental illness for a long time. It appears to be in my family.

In broaching the topic of possible childhood origins of his current struggles, I opened a series of doors about his early emotional state (melancholic), experiences at school (bullying), and his experience with his cousin's and uncle's suicides. Mr. Go's "history," therefore, went way back.

Mr. Go's willingness to talk about these events in his life and his finding a link between them and his adult depression demonstrates that it is difficult to generalize about Japanese tendencies regarding psychologizing. Even though he was raised at a time and place in which psychotherapy enjoyed little popularity, his propensity for grounding his current emotional state in his developmental experiences suggests that the "emotional digging" at the heart of many psychoanalytic therapies is not necessarily alien to Japanese individuals. Though talk therapies

may not have been widely used during most of the 20th century, this should not suggest that they will not become widely used. It may be that many Japanese are very interested in discussing their lives in a psychotherapeutic setting, but merely that they have until recently not had the opportunity or encouragement to do so. As the current growth in the popularity of clinical psychology and counseling (examined in the next chapter) evidences, there is indeed diversity in the ways that Japanese are expressing their feelings about themselves. Though patterns exist, it is perhaps becoming increasingly difficult to discuss those patterns without emphasizing the range of alternatives existing around them.

F. CONCLUSION

Given the diversity of symptoms, backgrounds, experiences, and attitudes of the five patients featured here, the safest conclusion to draw from their narratives is that there is no single dominant paradigm for depression that rises to the surface. Instead, there is a plurality of interpretations such that making generalizations about what depression means to sufferers, what symptoms prompt a diagnosis, how patients feel about their treatment, and other questions is a risky undertaking. Patients have constructed their situations in diverse ways, and yet the diagnosis of depression links all of these individuals, summarizes their conditions, and funnels them all into a single pathway as far as official classification and treatment goes.

That being said, however, there are a few patterns that run through the narratives such that we can say something about the meanings of depression, at least in the comments and experiences of these five patients.

First, contrary to the bulk of the medical discourse on depression in the West, no patients spoke of anything approximating a “chemical imbalance.” Though this phrase has earned almost household-word status in the United States, not a single patient mentioned it. Nor, for that matter, was the phrase emphasized in any of the sessions I observed in the outpatient clinic. As I will discuss in chapter nine, the phrase was also not used in Japan’s first television commercial for depression. One can surmise, then, that the idea of depression’s signifying an imbalance of chemicals in the brain does not resonate in the minds of these patients. This is not to say that it wouldn’t resonate if it were emphasized to them. But, for whatever reason, this process has not happened. I suspect that it is because there are other understandings of depression that are resonating and finding consensus, which brings me to my next point.

Second, in each of these narratives, depression is associated with stress. Patients speak of stress, either at work, at home, or, in some cases, both. None of the five presented their conditions as something that was purely endogenous, i.e. with no connection to environmental factors. This suggests that patients, then, were not adopting a purely biomedical model to explain their conditions. A psycho-social or idiom of distress model better characterizes the model with which patients were interpreting their problems.

Third, somatic complaints were included in each of the narratives, and in some cases comprised the dominant complaint for which the patient had sought treatment. Mrs. Ni is the best example of this. Though she was struggling with running her new business and taking care of her daughter’s illegitimate infant, her explicit focus was on her ear-ringing. As well, Mrs. Ichi spoke of losing weight and feeling her heart race; Mr. San spoke of dizziness, headaches, and urination problems; and Mr. Go spoke of insomnia, loss of appetite, and dizziness. This emphasis on

somatic symptoms is in keeping with several studies regarding idioms of complaint in other Asian countries (Kleinman 1990). The issue is important in that it makes the question of what depression “is” all the more difficult to answer. Is it a physical problem? A psychological one? Something else?

Additionally, there are two somatic complaints that appeared repeatedly in these narratives and in the doctor-patient conversations I observed in the outpatient clinic. These complaints were ear-ringing and panic on the trains. At this point, I am not sure what to make of the ear ringing other than merely to note its prevalence as well as its seeming lack of association with depression in the United States. As for the trains, given the presence of trains in Japanese life, it is not surprising that they would factor into patient’s narratives. I find their presence interesting, however, because of the possibility that the trains may be symbolizing a conflated amalgamation of some of the down-sides of urban Japanese living: crowdedness, rigidity of time schedules, lack of escape, high speed, anonymity, collectivization, pressure, and so forth. Given that trains have been such a marker of national pride in the post-war era, it is interesting that patients would view them as being so stressful. At this point, I am not sure how far to go with this other than to merely note that many patients include trains in their narratives.

Fourth, most patients spoke highly of their medications. This is no doubt in large part a matter of sample bias given that I could only interview patients who were in very stable conditions. But the narratives do show that at least some patients credit SSRIs with playing a significant role in the recovery process. As Mr. Go said about Paxil, “It’s the number one thing that has helped me.”

Fifth, most patients wanted to talk more about their conditions. Mrs. Ichi in particular lamented the loss of her first doctor, the one who “listened to me.” Patient desires in this regard relate to the fact that counseling and clinical psychology are growing fields in Japan and that psychiatrists are urging the Ministry of Health, Labor, and Welfare to authorize clinical psychologists to work in the hospital environment. Doctors know that patients with depression and other of the milder mental health conditions want someone to talk to, but with time constraints on psychiatrists being what they are, there is little that can be done within current institutional constraints. However, the main point is that though there is a long tradition in Japan of Japanese not seeking out the opportunity to engage in the various forms of “talk therapy,” and though there are cultural factors that help explain that tradition, it is true that times are changing.

Sixth, in terms of issues about which patients did want to talk with their doctors, matters of self-discovery were not included. In other words, there was little interest suggested in these narratives about discovering anything “psychological” at the core of the patient’s problem. Patients displayed little interest in what we might gloss as “emotional digging.” In general, then, psychologizing did not seem to be an important theme. Granted, Mr. Go’s discussion of his melancholic childhood and his experiences of being bullied at school, as well as his hinting that he would like to have deeper discussions with his doctor, suggests that psychoanalytical perspectives are not totally alien to Japan. However, in general, most patients focused more on somatic complaints and environmental stress (thereby presenting a socio-somatic model of their conditions) rather than memories of childhood or unresolved issues from childhood. Instead of a language of newness or resolution, most spoke merely of “returning,” of “getting back” to something they had gotten away from.

In summary, then, we have a few patterns arising from these narratives. But those patterns must be placed in the context of diversity. Patients' experiences vary, in spite of the fact that a shared diagnosis lumps those differing experiences together. Though this brief ethnographic analysis of five patient narratives suggests a few themes operating therein, it is difficult to conclude that depression means X in Japan and Y in other places. What it does support, however, is the observation by critics of biomedicine that it is difficult to establish with certainty exactly what "depression" means here, there, or anywhere.

VIII. PROGRESSIVE CLINICIANS

*With the major changes taking place in society, there is
no doubt that our feelings of stress are increasing.*

opening line of *Notes to Refresh the Heart*
by Dr. Yutaka Ono (Ono 2003)

This chapter explores the commentaries of four progressive clinicians who share a concern with the social context in which the depression boom is taking place. Two of the clinicians are psychiatrists. Of those, one works rather quietly in a general hospital, whereas the other is one of the most famous psychiatrists in the country. The other two clinicians are clinical psychologists. Each of the four has his/her own perspective on the changes taking place in the Japanese mental health care system. However, they all agree that mental health care is more important in the public realm today than it has ever been in their lifetimes, and they all agree that there are good reasons as to why depression is at the center of attention.

In keeping with Gay Becker's writings on disruption, all four clinicians talk about the disruptions facing those individuals who are seeking, in ever greater numbers, professional help with problems defined, at least on the surface, as depression, anxiety, and stress. These disruptions stem, at least in part, from the ongoing economic situation, with layoffs and bankruptcies being among the chief issues. But the disruptions are not merely economic. They comprise broader concerns about the demise of the sources of security upon which two post-war generations have been raised, and they reach into the stability of families, the decisions to enter the workforce or not, and the ability of people to maintain some sort of hope in a situation that,

according to many experts, will probably get worse.

Psychiatrists and clinical psychologists are increasingly being sought after for answers on how to deal with these disruptions. And each of the clinicians included in this chapter displays a nuanced understanding as to the type and depth of these disruptions, about how mental health care professionals can help sufferers deal with those disruptions, and about what the entire shift underway can tell us about life in Japan in the new millennium.

Though patients and clients are operating independently when they come in for treatment, together, they are representing a problem that is increasingly being seen as a societal problem, one for which policy-level decisions are required. And the government is indeed responding. As of this writing, the Ministry of Health, Labor, and Welfare is poised to inaugurate a first-ever medical license for clinical psychologists (Yomiuri Shinbun 2005a). In so doing, the government will be inviting clinical psychologists into the medical care system and will start allowing insurance to pay for their services. Putting its money where its mouth is, then, the Japanese government has recognized calls for new alternatives in the mental health care arena, and it is responding.

But there are a host of issues involved in making sense of the shifts underway: the call to license clinical psychologists, the increase in the use of SSRIs, the air of discovery about depression, the determination to reduce stigma, and many others. In this chapter, four clinicians who are each seeing patients/clients regularly and who each have a “big picture” perspective on the current situation talk about their experiences and perceptions.

I will start with Dr. Uta, a psychiatrist who is critical of the overuse of medications in Japan and concerned about the influx of SSRIs making matters worse. Next will be Dr. Yutaka Ono (real name), who is one of Japan’s most visible and respected experts on depression. A

writer of several books and a weekly column in one of the major newspapers, Dr. Ono has dedicated himself to raising public awareness about depression and about medical and non-medical methods for dealing with it. I will then introduce Dr. Aka, a clinical psychologist who is tuned into questions about the impact of communication strategies and culturally-sanctioned modes of expression on the therapeutic process. I will conclude with conversations with Mr. Andrew Grimes (real name). Grimes is one of the very few Westerners to, one, be providing counseling services in Japan and, two, to have received his training and certification in Japan. He, therefore, contributes a rather unique perspective on the cross-cultural aspects of mental health care.

A. DR. UTA - PSYCHIATRIST

Dr. Uta works at a large general hospital, where he treats both in-patients and out-patients. He is in his late 30s, married, and lives in Tokyo. He, like many Japanese psychiatrists, reads English and keeps abreast of the English-language psychiatric literature. He, therefore, is knowledgeable of international differences in mental health care and is particularly interested in comparing Japanese care with that found in Europe and the United States.

Dr. Uta is also a bit of a renegade. He goes against the grain of many practices in mainstream psychiatry, in particular, overmedication. In his mind, psychiatrists prescribe far more medicines than are necessary. Many, he says, do so because they are not up-to-date on the state of international research, whereas others do so out of the profit motive. Either way, he blames psychiatrists for adopting an approach to care that relies too much on pharmaceutical treatment.

He is also critical of the hierarchical doctor-patient relationship and sees that relationship as inhibiting a shift toward greater informed consent.

Most importantly for this study, however, he thinks that depression is a new trend that is on the verge of becoming overly-medicalized. He thinks that Americans have gone too far in their embracing of the medical model of depression, and he fears that drug companies are succeeding in doing the same thing in Japan. He displays a cynical attitude overall toward drug companies, attributing to them little other than the desire for profits.

In his thinking, many Japanese these days have good reason to be depressed, precisely because so many of the socio-economic supports that have undergirded their lifestyles and identities over the past two generations are slowly being dismantled by the various economic shifts Japan is currently experiencing. Though pills can make suffering people feel a little better, they certainly will not fix the source of the problem. He fears, therefore, that medicalization and the increasing use of SSRIs will divert attention away from the real sources of these problems.

The following narrative is comprised of excerpts from several conversations I had with Dr. Uta. [All interviews were conducted in English, and all were tape recorded.]

KV: How has the arrival of SSRIs changed the way doctors, patients, and society in general are feeling about depression?

Uta: Depression – it's becoming over-diagnosed here. There's a lot of despair, dejection, and so forth in Japan right now, but this is not depression! This is just dejection. Depression may be caused by the dejection, but dejection can't be cured with medicine. But people look only at depression and think the problem can be healed by this new drug. I am quite against this. Dejection and despair and personal exasperation – they are not the same thing as depression, are they.

I had a patient this morning who came in and said "I can't work as much as my colleagues." He said that his colleagues stay up all through the night and have given up their family lives to devote themselves to the company. He said "I can't do that. It's too much for me. So I must acquire more brain stamina. It must be depression." That's the mode of thinking. You have to conform to other people as much as possible.

SSRIs are now one way to help do this. They're allowing people to conform better. They tame you, make you less harassing, less mumbling, that sort of thing – rather than making you more edgy or more outgoing. People believe that once you take antidepressants you feel you can lift yourself up; but oddly enough, but really it ties you up, like a straightjacket. Like a chemical lobotomy. I think antidepressants are being used like tranquilizers. They're meant to make people calmer rather than more animated. Now, they are good drugs to treat patients with because they don't have many side effects. And I myself treat patients with them. But not so much necessarily for the efficacy. Usually for just the reason that they cause fewer unwanted side effects. So, it's not about the efficacy itself. SSRIs aren't any more effective than imipramine or the older antidepressants.

But how well a drug works depends of what the patient wants to believe, right? For example, recently I was seeing a 60-something year old woman who was having a hard time with her husband. She was abused physically by him, and she had been seen by many doctors here and there, complaining of all sorts of pains. I, as a psychiatrist, was the last person she came to see. I thought she was depressed to some degree, but the major issue wasn't that. I sorted out all the things she was telling me and finally said "So what you're telling me is that you can't make your brain work as much as you believe it should be working." She said "Yes, that's what I'm saying."

So, she started seeing me, and in time we started talking about her home life and her husband. In one of her later sessions, she came in and was in pretty good shape, and we both acknowledged that there had been some improvement in her mood and so forth. She said "How is it that there are drugs as good as this – these antidepressants?" She believed that she had been improved by the drug I chose for her. But my belief is that she had sorted out her problems and had come to see the core of the issue, which was her forcing herself to do things and believing that she had to conform to her husband's wishes and expectations, her social role and so forth.

KV: How did she arrive at this new understanding?

Uta: Mainly through coming to see the issues, seeing the hardship that she had been through and the impossibility of her carrying on like that.

KV: Did she work this out through therapy sessions with you?

Uta: Yes, that's my belief. But it happened unconsciously. Consciously, she isn't aware of these realizations. She believes, she wants to believe, that these changes have been caused by the drug.

KV: What were your sessions with her like?

Uta: I saw her about twice a month, for probably five minutes at a time. Professionals don't call that "psychotherapy." But I believe you can generate some sort of understanding through psycho-dynamic, psycho-analytical ways even if it's only five or ten minutes.

Dr. Uta raises many of the issues that are involved in the medicalization of depression: overdiagnosis, overmedication, variation in the interpretation of effect, and the difficulty of identifying the actual mechanism – talking or drugs – by which psychiatric treatment works. He also makes clear that there are at least some doctors in Japan who are poised to resist a Japanese-style Prozac Revolution. Given that overmedication is one of the accusations included in the debates over the Prozac Revolution in the United States, I wanted to hear Dr. Uta speak further about that particular issue.

KV: So why is it that [Japanese] psychiatrists prescribe so many medicines?

Uta: To reduce anxiety of the doctors and the patients. Patients like to go home with something in their hands to signify that they indeed had something legitimately wrong with them. And doctors don't think that they've done anything unless they've prescribed something.

But in many cases, I've seen patients who have been to other doctors and who have been taking many types of medications, and so I tell them that they're on too many drugs. I recommend that we decrease the dosages gradually. Most of them agree, and some of them have even told me that they're relieved to hear that, saying that the medicine was too much and was making them drowsy. They say that doctors have told them to take the drugs for a little bit longer, always a little bit longer, just for sure, just to prevent a relapse, that it's not good to stop it so abruptly, and so forth. I think this is very common, and patients don't want to go against their doctors. It's such a pity. Many of these patients could stop all of their medications for good in only two or three months. They're not really depressed at all. But they're still taking drugs.

But overmedication – it's a universal phenomenon. I'm sure of it.

KV: Do you think it's more serious here than in the States?

Uta: Of course. No comparison. You will be hard pressed to find a psychiatrist here who actually prefers monotherapy, who prescribes just one sort of medicine at one time. I have seen some patients who have even been prescribed three and four classes of antidepressants at the same time, including SSRIs. These patients naturally suffer from interactions and from different side effects, which are exactly what SSRIs are meant to reduce. So, some kind of medicine to deal with the side effect is then added.

But doctors aren't doing this out of any sort of bad intention. This is just the norm here. If you come to the doctor, for example, with a cold or flu, in the United States you would most likely go home with a single medicine. Sometimes with just aspirin. But here, you will most likely go home with a bag full of medicines, including antibiotics which don't even work for flu viruses, along with

vitamins and many other medicines.

KV: Does paternalism have anything to do with this?

Uta: Yes, there are a lot of paternalistic doctors. But understand that a lot of patients want a paternalistic doctor. In other words, paternalism can have positive connotations. Patients want to be seen by an *erai* [high-status, splendid] doctor. Rounds are the exemplar of this. Patients sit up straight and put their best face forward for the *erai* doctor. It makes them feel good to be seen by such a high-ranking doctor. And if patients like this, then this can have a positive effect on the outcome of their treatment. So, paternalism is a complicated issue.

Dr. Uta's discussion of overmedication leads to the issue of paternalism, which is a factor in many critiques of Japanese medicine, not just those targeting psychiatry. It is easy for Americans to reject paternalism out of hand, as if it had no redeeming features. But as Dr. Uta emphasizes, patients' desires and expectations can influence the outcome of treatment. Therefore, if patients do have an image of the *erai* doctor in mind, and if the patient thinks it appropriate for medical decision-making to be in the hands of the doctor, then these expectations must be considered in the discussion of paternalism and its nemesis, informed consent. As I noticed on rounds, many patients do indeed sit up straight and speak to the attending physician in a slightly performative manner, as if they are pleased to have the opportunity for some face time with the highest-ranking doctor on staff. Therefore, there is a possibility that operating within at least some doctor-patient encounters is a placebo effect grounded in the patient's positive attitude toward the doctor not in spite of but precisely because of his "exalted" status in the mind of that patient – a status that ethicists caution leads to paternalism.

But Dr. Uta's assertion that curtailing overmedication is a matter of changing the doctor-patient relationship is a point well taken. Drug-taking practices are indeed embedded in institutionalized social relations.

KV: Tell me about the impact of the recession, restructuring and such, on depression.

Uta: People [in the rest of the world] have no idea that the sort of restructuring that's going on over here means a sort of death sentence to middle aged people. With their heavy loans and having no other way to support themselves, many feel that they have no other option than to commit suicide. There is an assumed link between being laid off and getting depression in that most simple-minded psychiatrists just say "This is depression," rather than focusing of what sort of pressures have caused this state that is being called "depression." There's no looking in depth into the actual matter of what's happening with these people and what's happening in the companies they've been working for.

In closing, Dr. Uta reiterates what much of the public discourse on depression has been suggesting: that workplace stress and depression are going hand in hand and that the ongoing economic troubles are, to a great degree, the culprit. Dr. Uta's criticism, however, targets the psychiatric community's not calling a spade a spade. He disapproves of the practice of inserting the diagnosis of depression in between the suffering worker and the source of his problems. He considers such a practice to be little more than a convenient denial of the real problem.

Dr. Uta, therefore, challenges the habit of applying the standard biomedical model of depression to these many people, most of them men, who are suffering with heavy loans, layoffs, and other financial and work-related problems. Though by virtue of the fact that he prescribes SSRIs for many of his patients, he is certainly not advocating halting the use of the drugs, but merely that the problems not be overly-medicalized and therefore misconstrued. This type of criticism is one that runs through much of the literature criticizing psychiatry in the United States and elsewhere, and Dr. Uta's comments demonstrate that the same criticisms are now appearing in Japan as well.

B. DR. YUTAKA ONO - PSYCHIATRIST

Dr. Yutaka Ono [real name] is one of the most visible and highly-respected experts on depression in Japan. He has published widely in both Japanese and English, is a regular commentator on television news reports and talk shows, works extensively with the World Psychiatric Association and the World Health Organization, and writes a weekly column in the *Nihon Keizai Shinbun*, which is one of Japan's main daily business newspapers. He is President of the Japanese Association of Cognitive and Behavioral Psychiatry, Chair of the Health Ministry's Anti-Stigma Committee, and served on the American Psychiatric Association's DSM-IV Task Force. He received his medical training at Keio University, which is considered by many to be one of Japan's top medical universities, and he conducted post-graduate training in cognitive and behavioral therapy at Cornell University. He is now Professor of Psychiatry at Keio University.

I met Dr. Ono in 2002, and because of his interests in cross-cultural approaches to mental illness and mental health care, we began a series of conversations that lasted for several months. We would meet at his office for approximately 20 to 30 minutes every week or two, and there we talked about a host of issues affecting Japanese society, about his own practice, and about his personal experience viewing mental health care in both Japan and the United States.

Given Dr. Ono's stature in the field and his ability to assess care from a cross-cultural perspective, I was particularly interested in obtaining his comments about how depression was being viewed by his patients, what he and his colleagues at the Health Ministry were doing to reduce stigma and raise public awareness about depression, and about the institutional, cultural, economic forces involved in those processes.

Additionally, I learned during the course of the interviews that Dr. Ono had conducted research on the genetics of anxiety and depression. He was convinced that anxiety had a genetic component to it, i.e. that some individuals have a genetically encoded predisposition for anxiety. His research takes this claim one step further, however, in suggesting that Japanese people as a group share a higher genetic loading for anxiety. In other words, he sees the fact that so many people in Japan are diagnosed with anxiety not as a function of mere psychiatric convention, but as a function of genetics. For him, the Japanese are, literally, by nature anxious. Though he clarifies that this research is only in its infancy, he is dedicated to pursuing it further.

The following is a concatenation of excerpts from those interviews.

KV: How would you characterize the current state of affairs as far as the treatment of depression goes?

Ono: To understand depression in Japan, you need to understand some of the history of Japan. For years, you know, Japan had a feudal system, and though it was changed after World War II, many aspects of that system are still in place. The group system has continued. Even though value systems have changed, people still want to keep this group system.

But these days, group systems are breaking down, and the competitive spirit that used to operate within the group system – the group-level competition – hasn't found another way of operating. It's now more individual-level competition. And so there is lots of misplaced aggression. Older people who have been brought up to function in a group system are having an especially hard time now. You can see this in the increased number of suicides. Most of these are by men in their late 40s and 50s who have either lost their jobs or are having difficulty dealing with changes in their jobs.

A group system has a lot of pressure, but it also has a lot of supports. Those supports are disappearing. Family supports also break down when the husband loses his job. This is his main responsibility to the family. So when he loses his job, it is especially shameful for him. It's also difficult for their wives because most wives depend on their husbands for financial support, and when he is no longer able to provide that, then she too can become depressed.

But other than the breakdown of group systems in companies, the other main circumstance affecting depression is that of promise without achievement. In other words, there is a lot of promise built into the Japanese system: if one succeeds in school, then one will go to a good college, and if one goes to a good college, he will get a job at a good company, and if he gets into a good company,

then he will enjoy a good standard of living and have a good life. Our whole system is designed with this type of progression in mind, and so many people work hard expecting what they have been promised.

Until the bubble burst, this promise was realistic. People could trust that their efforts would be rewarded and that they would move along with the progression. But people are discovering today that that promise is no longer true. They cannot obtain what they have been promised, and so people are discouraged. They can no longer believe in hope. They don't know what to believe in. The old system is breaking down, but nothing is replacing it.

I'm working a lot with companies, and things are getting more competitive among workers, with meritocracy and all. Employees are now competing against each other, and this is different from older norms of group-to-group competition. I work with a lot of these employees, and it's very hard for them. Older workers, under the old system, when they moved up the ladder they didn't have to stay so late and work so hard the way they did when they were younger. But with individual competition, these older workers are having to compete with the younger workers, and many are having difficulty with that.

This is about *wa*, you know.³² *Wa* is about group harmony, but it's really about trust. People trust in their own group. They see insiders and outsiders as different. For example, I work with several companies, and it's easier for me to help out there as an inside employee than it would be if employees there came to me in a hospital outside. So, when I work inside the company, I can learn about the relationships there and how the company operates. You know, a lot of mental health problems are caused by what happens at work, and so if I am inside the company, I can help change things to reduce stress for people. I can make recommendations about how to do things, and I can help correct the situation that was causing the stress. As a psychiatrist, I enjoy this. I can change the mental health situation. I can find out the problem, then talk about it with managers, and we can work out a solution. It's group work really. It's psycho-social psychiatry. **KV:** So this is about management. You're helping companies manage their workforce.

Ono: Yes, I'm getting more interested in this. I'm learning a lot about management techniques. Management techniques are changing a lot in Japan. You know, 20 years or so ago, workers used to go out drinking with each other, and this was a good time to solve problems that they couldn't talk about during the day. But these days, younger workers aren't interested in that. They want to solve the problems on the spot, and then they want to go out with their friends later. It's the same with company events like athletic festivals³³ and employees

³² "harmony, unity, the sum total, peace"

³³ In the post-war era, most large companies would hold an annual athletic festival for employees and their families (See Rohlen 1979).

traveling together. These used to be common, but in the last 10 years, companies have stopped having these things.

KV: About what is the percentage of your clients who are suffering from workplace problems as opposed to problems at home?

Ono: I would say about 2/3 or more are suffering from workplace problems. Especially the patients I see in the company clinic, almost all are suffering from workplace problems. That's why the clinic is there.

KV: Do most big companies these days have psychiatrists on staff?

Ono: Yes, most of the big companies have part-time psychiatrists there. I myself work for several – half days each.

KV: Tell me more about the impact of layoffs on a person's life.

Ono: I think that a layoff is a very catastrophic situation. Until recently, we were used to lifetime employment. So, to be laid off, it means you are useless, and psychologically it is catastrophic.

Also, companies think that a laid off person is less talented, so they don't want to hire him. So, it is a tough situation. I think the American system is different. People often move from company to company. But in Japan, people don't move so much. With that as the general pattern, I think the layoff is catastrophic. The risk of being laid off is relatively new in Japan, and the fear of it causes a lot of anxiety.

KV: Do you think all these *karoushi* and *karoushi-jisatsu* cases over the past few years have triggered a re-evaluation of work?

Ono: Yes.

KV: In what way?

Ono: Because companies are now very sensitive about that. They're trying to develop mental health and stress care systems. I often give talks to people who are going to promote these systems to management, and I help them find ways to change the causes of the stress.

KV: What aspects of the system need to be changed?

Ono: Until now, companies think that employees have to work as hard as possible. They're not sensitive to finding problems. Companies are dedicated to making profit, and will do as much as they can to make it. Mental health care is now a way to maximize productivity.

In keeping with most news reports and media representations of depression in Japan, Dr.

Ono is concerned about the corporate contexts and the workplace environments from which much of the depression problem seems to be stemming. He considers workplace norms – relationships between colleagues, relationships between workers and management, group identity formation, the shift from seniority systems to meritocracies, etc. – as having everything to do with the

distress that is becoming increasingly diagnosed as depression. What is especially interesting, however, is his approach to solving the problem. As opposed to a mere medicalization of the problem and the concomitant dispensing of medications, Dr. Ono works with corporate executives and managers to evaluate and alter their management and production strategies. In so doing, he is promoting Occupational Psychiatry as a means to help companies reduce employee stress, a goal that companies are increasingly taking an interest in, at least in part, because of *karoushi* and *karoushi-jisatsu* cases.

Additionally, Dr. Ono is sensitive to the impact of the restructuring not only on people's financial stability, but on their worldview. In the postwar era, Japanese citizens were indeed brought up on a promise regarding the way the social and economic systems worked. It was a smoothly-running machine. But as he so eloquently stated, the situation today is such that there is "promise without achievement." People, then, have lost more than just financial stability: they have lost hope. And Japan's gloomy long-term economic prospects only reinforce that pessimism. At least this is the case for many of the people coming into the psychiatrist's office and being diagnosed there with depression.

With clarification regarding some of the socio-economic factors that are impacting the diagnosis, conceptualization, and treatment of depression, I wanted to ask more about the cultural issues involved.

KV: Are there any cultural factors regarding the expression of anger that relate to the treatment of depression here? It's easy to express anger in the United States, but it seems more difficult in Japan. Is this true?

Ono: Well, it's not only anger, but other negative emotions too. Socially, Japan is a very closed group. We have strict barriers between inside and outside – *uchi* and *soto*. It's important to keep quiet about negative things within the in-group, for harmony, you know.

There is also a genetic component: Japanese people are less expressive, I think. More anxious, more prone to anxiety. So, we only cautiously express our negative feelings. Also, less expressive, and less impulsive I think. So, there's a combination of genetic and environmental issues.

KV: What are the consequences of this?

Ono: There is a system of *mura-hachibu* [social ostracism]: to keep the harmony of the group, people should be careful about how they express themselves. *Mura-hachibu* means "kicking people out who don't fit in." It's an ancient concept that began in Japanese villages as a way of making sure that people respected the group, the village, the way people there did things. But even in companies today, there is *mura-hachibu*. But it has a different name. It's called *mado-giwa-zoku* [window tribe].³⁴ It's not only the window, though. It's often the basement. So, such places exist. The employee can only sit there; he can't read books or newspapers. He can only sit there. It's a tough situation.

KV: But he gets paid, right?

Ono: Yes.

KV: I have some friends in the States who just might like that – getting paid to sit and do nothing [laugh].

Ono: But to do nothing for eight hours. It is very difficult. They usually leave the company because they're no longer part of the group. It's the being separated from the group that is so unbearable, regardless of the fact that they're still getting paid.

It's related to *taijin-kyoufu-shou*³⁵ actually. We're very sensitive to other people's thoughts about us. We fear being rejected. Also, we fear looking aggressive. This is one reason *taijin-kyofu-shou* sufferers fear looking at other people in the eye. It's not that they fear what comes from other's eyes; it's that they fear that their aggression will be exposed through their own eyes. So, *taijin-kyoufu-shou* is about the fear that one can't successfully hide his own negative

³⁴ When a company wants to pressure an employee into quitting or retiring early, the company will sometimes use *mado-giwa-zoku* as a strategy. The company will require that the employee sit in a chair all day long without doing any work. The employee cannot read, talk on the phone, sleep, or do anything at all except sit. Placement of the chair is important. In the classic version, the chair is placed by a window, which in most Japanese offices means that the chair is placed in a very prominent place where the employee can be seen by everyone in the office. Recently, companies are more likely to place the employee in the basement, where he will sit completely alone. Basically, it is a psychological strategy to make the employee so miserable that he will resign voluntarily, thereby letting the company off the hook as far as the legal and public image problems surrounding firings and layoffs are concerned.

³⁵ "Social phobia," but considered by many to be a Japanese culture-bound syndrome because *taijin-kyofushou* patients are concerned not with embarrassing themselves but with embarrassing those around them.

emotions. He doesn't want to be found out. He's also afraid to be different from other people, and showing anger definitely makes one look different here. To make other people uncomfortable is a very bad thing to do here, and this is what *taijin-kyofu-shou* is all about.

KV: At the WPA [World Psychiatric Association conference held in Japan in 2002], one Japanese psychiatrist was arguing that the demise of groupism had created a need for new individualistic mental health concepts. Do you agree?

Ono: Not really. I think groupism is still good for many people. I think that the problem is that many people want group affiliation, but what they are increasingly faced with is individual competition at work. This destroys a sense of belonging. People can no longer feel safe within the group. Prime Minister Koizumi is now saying that bankruptcies are good things. But the result of bankruptcies are that people can't feel safe anymore. Sure, individuals have the right and ability to be individualistic, but this alone is not enough. The point is to make harmony between group and individualistic orientations.

In a series of seemingly radical leaps, Dr. Ono ties together ancient Japanese village life, ways of making salarymen miserable, a supposedly Japanese "culture bound" illness, and longstanding cultural sensibilities regarding "inside" and "outside." What links them all, however, is the concept of affiliation. For Dr. Ono, group life is still a dominant aspect of personal identity and happiness in Japan; and when group frameworks are threatened or destroyed, the results can be deleterious for the mental health of the individual. Therefore, instead of being content with just sitting in a chair all day while continuing to earn one's full salary, a typical Japanese man will find such a situation intolerable. The point is that the way one experiences and expresses this desire for group affiliation, as well as the way one experiences and expresses what happens when those affiliations break down, are culturally-constructed processes. To understand what people are suffering from, even when they have been diagnosed with depression, one must look beyond issues of mere chemical imbalance and explore these deeper, more cultural issues.

KV: Let me ask you about psychologizing, about emotional digging. One clinician said to me that he thinks Japan is only beginning now to psychologize. By that, he meant the process of getting at a patient's "real" feelings by using any of the various psychodynamic methods. It seems that psychologizing is fundamental

to most psychotherapies and other forms of talk therapy. But it doesn't seem to be a part of any of the clinical sessions that I've seen. Why is this?

Ono: Again, the point is that one shouldn't express his own feelings. If you do, you convey that you don't trust the other person's ability to understand you. To say things directly means that you don't expect much from the person you're talking to.

KV: Most psychiatrists don't seem to want to go into depth about how patients are feeling. They ask "How are you sleeping? How is your appetite?," and so forth, but seem to not delve into how patients are feeling. Is this an accurate observation?

Ono: Yes, and it's too bad that that's the way things are. That's the reason that patients look for a better doctor. They *want* to express themselves! It's changing, but especially the older psychiatrists talk only about sleep, diet, and medication.

KV: Where do patients who want to express themselves go if their doctors don't listen much to them?

Ono: To clinical psychologists. But only if they have money. If they don't have the money, then it is impossible. Basically, psychiatrists have not been trained much in how to communicate with patients, but just how to prescribe.

KV: One critique of SSRIs in America is that there's a risk of doing "cosmetic psychopharmacology," that SSRIs can be used to mold personalities toward a more acceptable social norm rather than treating an "illness" per se. There's this emphasis on newness: on the drugs helping you become something new. In your talking with patients about the effects of SSRIs, have you heard anything along these lines? Just what have patients been saying about how the drug makes them feel?

Ono: Actually, in my experience, patients don't say anything about new self or newness. The patients usually just say whether the drugs are good for symptoms or not. Just a focus on symptoms. They just need a medicine.

But, this might change. Recently, the SSRI market is getting bigger and bigger. I've heard that total sales of Paxil is \$200 million dollars this year, and fluvoxamine (Depromel and Luvox) is \$150 million. SNRIs are at about \$50 million. Before SSRIs, net sales of tricyclics were only about \$150 million. So, the market for depression is about three times what it was just three years ago. It's surprising.

KV: Why has it tripled so quickly?

Ono: First off, because physicians are now prescribing anti-depressants, whereas before they used anxiety drugs. These anxiety drugs are safe. So, when psychiatrists found out that SSRIs were also safe, they started using them more. Also, the pharmaceutical companies and the mass media started talking about depression. And the mass media started talking more about the suicide rate. So, people are getting to know that this is a disorder and that they can go for treatment.

Also related to this, the new commercial for depression makes me worried. In the Prozac Revolution in the United States, like you just mentioned, SSRIs are

prescribed to people who don't really need it. I'm concerned about this happening in Japan. Several leading psychiatrists and pharmacologists are concerned about this. Our generation – chairmen and professors – are worried about this. I'm in charge of submitting guidelines to the Health Ministry regarding the treatment of depression, and I will tell them that monopharmacy is important. But many doctors use polypharmacy for depression, and I am concerned about SSRIs making this worse.

I've had many doctors, non-psychiatrists, ask me if SSRIs are really safe. They're concerned that they have lots of side-effects, just like the tricyclics.

KV: Where did they get the idea that SSRIs are so dangerous.

Ono: I think it's a stigma about mental disorders in general. Anti-psychotics and anti-depressants mean lots of side-effects to doctors.

KV: Are anti-psychotics and anti-depressants lumped together in their own category, with anxiolytics being in another category?

Ono: Yes. Yes. So, psychiatrists think that anxiolytics are safe, but that the other drugs are dangerous.

KV: Is it that the drugs are dangerous, or that the illnesses are dangerous?

Ono: Both.

KV: So it's "OK" to be anxious, but not OK to be depressed.

Ono: Yes. Also, education in medical school effects this. So far, in Japan, medical schools teach that "mental illness" means psychosis, and there are considered to be three types of psychoses: schizophrenia, bipolar disorder, and epilepsy. Unipolar depression is considered part of bipolar disorder. These three categories are very important. These are "psychiatric" disorders.

But anxiety is not considered to be a psychiatric problem, so other doctors don't mind dealing with it. When they have real psychiatric problems, though, they send those patients to psychiatrists. General practitioners do not want to see psychiatric patients. So, this is one stigma. Another stigma is about the medication. Anxiety drugs are prescribed for hypertension, psycho-somatic problems, autonomic imbalances, and other things. These are considered to be just minor dysfunctions, not mental disorders.

But anti-psychotics and anti-depressants have traditionally only been prescribed for more severe psychiatric problems. So, again, other doctors don't want to prescribe these medicines. So, this is why the sale of anxiolytics here is ten times more than other countries.

KV: Going back to the question of SSRIs and their impact on self and personality, have you ever come across a patient who, after taking SSRIs, talks about how "good" he or she feels or how "different" he or she feels?

Ono: I don't think so.

KV: Never?

Ono: If I patient here said that, I would suspect that he is manic.

KV: What would you like to see happen in terms of how depression is diagnosed and treated here?

Ono: I am working now on some guidelines for the treatment of depression to go to the Ministry of Health, Labor, and Welfare. For depression, the main area to target is overmedication. Some doctors are prescribing too many medications. Just recently I saw one new patient whose previous doctor had prescribed five medicines. He was taking one tricyclic, two SSRIs, one SNRI, and a tranquilizer.

KV: Wow.

Ono: Yes, it's an awful prescription. It seems extreme, but unfortunately it is not uncommon. This kind of polypharmacy is common here. It's common to use two, three, or four antidepressants at the same time, sometimes along with anti-psychotics and anti-anxiety drugs. This is a typical kind of cocktail. So, this is why the Health Ministry wants to create treatment guidelines for depression. Polypharmacy grew out of treatment for schizophrenics, and the goal was just to tranquilize them. So, with depressed patients, if one medicine doesn't work well, then many doctors will just add another medicine, then another one, then another one, and so forth. Patients don't go against this because they are too dependent. And many doctors are too paternalistic. So, it's hard to change this.

Another factor is that psychiatrists are not trained in psychotherapy or other psycho-social treatments, so all they do is prescribe medications. The Health Ministry is very much trying to change this reliance on polypharmacy.

On the other hand, some of my patients hesitate to take drugs for depression. They fear becoming addicted, and they think that taking drugs for this means that they're weak. They don't think this is a chemical problem. So, patients are thinking different things about depression.

Dr. Ono has called attention to one issue that may make the sale of SSRIs in Japan more difficult than it should be. If patients are being prescribed the drugs improperly, i.e. if they are being prescribed so many drugs that the SSRIs are not able to work the way they are supposed to work, then the net physiological effect is unlikely to win over patients. Patients would be unlikely to continue with the drugs, and they would be unlikely to spread interest in the drugs via word of mouth. So, in the process of piling on more and more antidepressants in the short term, it is possible that sales prospects and reputation may actually be diminished in the long term. From Dr. Ono's comments, however, it appears as though the Health Ministry and progressive psychiatrists are already aware of the overmedication problem and are actively trying to come up with guidelines regarding how SSRIs are supposed to be prescribed.

These comments demonstrate that the use and effects of SSRIs may be influenced as much by institutionalized prescription patterns than anything else. One wonders if this is at least partly responsible for the fact that the depression boom in Japan is not drug-focused the way the Prozac Revolution in the United States was. In the U.S., thousands of patients were testifying to the effectiveness of the drug. In Japan, it is depression that is center-stage, not the drugs. Maybe if fewer people were being overmedicated, thus negating the very reason for SSRIs existence, then perhaps the drugs would take start taking center stage in public discourse.

But institutional factors are not the only factors involved in how drugs are used. There is the possibility, at least, that philosophical concepts and ideas about the more intangible aspects of life are also involved. One of these that has been written about widely is the notion of the “body-mind.” In much of the more sociologically-oriented literature on Japanese mental health care, there are included discussions of a mind-body unity and its impact on notions of self and, by extension, on treatment modalities. As Wimal Dissanayake states “First, let us consider the question of the Cartesian dualism which informs so much mainstream social theorizing. Traditions of thought in China, India, and Japan emphatically maintain the unity of mind and body” (Dissanayake 1993:33). I wanted to find out if any aspect of the mental health care system comprised one of the traditions of which Dissanayake speaks. Though no one doctor can give a definitive answer, I was nonetheless curious about Dr. Ono’s opinion. After all, Dr. Ono is well-read in Buddhist history and philosophy, and his martial arts training (he has a third degree black belt in karate) has included the study of traditional East Asian theories about body, mind, and soul. Therefore, if principles of mind-body unity existed in Japanese mental health care, I would have expected him to have thought about it.

KV: Many Americans have written on body-mind issues as they relate to Japan, in particular suggesting that Japan offers an alternative approach to Cartesianism. Do you think that a body-mind unity is present in Japan, and, if so, could you tell me if there's anyplace in psychiatry that such a unity can be seen?

Ono: I don't think there's a concept of mind-body unity in Japan, actually. But I do think that the duality may be a bit different. I feel the difference, but it's very difficult to verbalize.

Japanese do separate body and mind, especially in the field of medicine. We focus more on body issues. And in psychiatry, most leading psychiatrists are biologically oriented. But still, I feel that the separation is different. For example, *jinshin-ichiyou* [body-mind unity]. It's a Buddhist concept. Buddhists often talk about body-mind unity, but most people don't know much about Buddhist philosophy, so I think it may be a bit of a myth that Japanese think in Buddhist terms about a body-mind unity. An example is that even today I have a hard time convincing lay people that psychiatry differs from other fields of medicine in that psychiatry is dealing with brain and mind, as opposed to just brain. They think that psychiatry is just about the brain, not about mind and spiritual issues. So, I don't think this would be the norm if people had a strong conception of a body-mind unity. So, they tend to think that psychiatry is just like other medical fields.

Also, psychotherapy is more about the mind than the brain. But in Japan, psychotherapy is not so common. It has a high reputation in the States, but not here.

But it's basic to Buddhism that we cannot explain the important things through words. In English, there are clear cut differences between concepts: mind/body, this/that, and so forth. Sometimes Japanese have trouble with these clear cut differences. We don't take the differences that seriously. The clear-cut "A" and "B," the clear-cut "yes" and "no." There is little ambiguity here. But in Japan, we can't say things so directly. We have to say things vaguely. I know this is confusing for Americans. It's sometimes difficult for us too [laughs]. But, to be not so clear in conversation, this is common. We end up understanding each other, so the result of the conversation, of course, is clear. We achieve clarity. It's just that it doesn't require precise and clear-cut words and phrases. We think that things exist in context, as opposed to existing just purely, as they are, absolutely.

KV: Applying that ambiguity to the question of body-mind, I don't see much ambiguity in Japanese medicine. Doctors are very clear-cut in their interest in a clear-cut body. And when I read the writings by Dr. Kawai [the head of the national clinical psychology association], it seems to me that he is very clear-cut in his beliefs about the mind. Both sides are clear cut. And so when you put each side up against the other, it seems to me that what you have is a classic mind-body distinction. I don't see a unity here. The bio-medical psychiatrists say "Ah, this is a body problem" while the psychologists say "Ah, this is a mind problem." I don't see any evidence of a unity, at least in the mental health field, which is where I would expect to find it, or at least part of it, if it were so prominent an approach.

Ono: Yes, I think it's difficult to find mind-body unity in the mental health field. Some focus on the body; others focus on the mind. There are differences, and it's hard to bring each side together.

You know the phrase, "I think, therefore I am." I heard a Buddhist monk give a presentation recently, and he said that the opposite is true, that "Because we exist, we think." He was saying that thinking is secondary, that only existence was primary. I thought this was interesting, because this is the way we think in cognitive-behavioral therapy. In cognitive-behavioral therapy, we think that reality depends on perspective, that things are how we see them as opposed to how they "are." But cognitive-behavioral therapy is very new here. Cognitive-behavioral therapy crosses the lines between body and mind, but this therapy came from the West! [laughs].

As mentioned earlier, one of the lines of research that Dr. Ono is pursuing is one that attempts to reveal the genetic basis of anxiety, and by extension, attempts to examine the degree to which Japanese have a higher genetic loading for anxiety. His hypotheses are, first, that an individual's basic anxiety level is, at least to some degree, influenced by genes; second, that the Japanese population has, on average, a higher level of anxiety than most other populations; and, third, that this higher level of anxiety is a function of genes (Ono 2003).

There are a host of cultural and biological assumptions therein that will no doubt make critics of sociobiology cringe. But as the above comments and as a mountain of publications reveal, Dr. Ono is anything but a biological reductionist. Therefore, I found his interest in Japanese anxiety fascinating. After all, if one believes in the possibility that basic emotional temperaments can have a genetic basis, and if one believes that one genetic population can vary with other populations in terms of these particular genes the same way they do, say, for sickle cell anemia or rickets, then is it not logical to postulate that there may be population-level variation in the genetic predisposition toward anxiety?

Second, it is interesting that the most "Japanese" of mental health treatments, i.e. Morita and Naikan, both deal with states of anxiety. Third, Japan is indeed the top consumer worldwide

of anxiolytics, topping the competition by ten times! (Yomiuri Shinbun 2002a). Fourth, it is arguable that anxiety has a certain popular resonance in terms of its being a characteristic trait of “Japaneseness.” Many Japanese are quick to admit that Japan has a collective “inferiority complex” [*rettoukan*] in terms of its national identity vis-a-vis other countries.

I do not mean to voice an opinion either way on Dr. Ono’s predictions. But I do wish to suggest that the idea of there being something innately “Japanese” about anxiety does indeed resonate among many Japanese citizens and that Dr. Ono is merely trying to test that assumption scientifically. I would also like to suggest that this is one of the reasons that depression did not resonate for so long in Japan. It is not that Japan was tuned out to issues of emotional problems overall, but that the gaze was merely focused on one emotional state to the exclusion of others. Whereas depression resonates in the United States and Europe in large part because of the long fascination that Westerners, since the days of Socrates and Plato, have had with melancholia (Radden 2000), anxiety has so resonated with Japanese.

The challenge of bringing antidepressant therapies to Japan, therefore, entails either a shifting or a widening: shifting the gaze from anxiety to depression, or widening it to include depression. Given that the sales of anti-anxiety medicines show no signs of decreasing, I would suggest that, as of now, the latter possibility characterizes the situation. So, though SSRI manufacturers would like for Japan to become the next Prozac Nation, it is likely that Anxiolytic Nation will continue to maintain its sovereignty.

I would like to conclude the section on Dr. Ono by reviewing some of the articles that he has written for the *Nihon Keizai Shinbun*. Though this is a daily newspaper with a mass market readership, it emphasizes business and financial news. Some call it Japan’s version of the Wall

Street Journal. Given its focus on business and finance, its readership among businessmen is high. It is appropriate, therefore, that Dr. Ono would reach out to struggling salarymen and others in the corporate world through a weekly column in this newspaper.

A look at the titles of some of his columns reveals his main themes and aims:³⁶

Anxiety:

The vicious cycle of anxiety (11-12-02)

Anxiety's vicious cycle: taking a forward-looking approach (3-18-03)

When anxious, stand on your tip-toes and stretch (4-1-03)

Panic attacks: even though medicines are increasing, environment is also important (11-5-02)

The importance of self-expression:

Expressing yourself through words – you can manage stress (4-22-03)

Talking is also good medicine

A plan for expressing your thoughts (5-6-03)

Exchanging feelings without being imprisoned by words (11-26-02)

Balancing passivity and attack: the role of words (9-19-02)

To bring about a reversal, informing your family is important (3-26-02)

Turning toward your 'plus' side (11-25-03)

Stress:

Deal with stress early (6-10-03)

Because of stress, reality fades from view (8-20-02)

Re-understanding the importance of taking time off (1-7-03)

Colds and stress (10-15-02)

Acceptance:

Acceptance allows everything to change (12-2-03)

Ways to accept yourself the way you are (3-12-02)

Accepting things the way they are takes time

The necessity of recognizing one's limitations (7-22-03)

Suicide:

When everything seems bad - thinking about suicide (12-10-02)

Life unto itself has value - a note from a suicide orphan (3-4-03)

Personal and professional relationships:

Constructing human relationships takes time (9-16-03)

Showing concern for that colleague is important (9-30-03)

³⁶ Original titles (and articles) are in Japanese.

Being understood by another person, you can be yourself
Post-retirement: letting go of work-consciousness and improving your marriage (7-1-03)

Mental health care:

It's not about character, but an illness that has treatment (3-19-02)
Anybody can have "warning signs of the heart" (8-12-03)
The possibilities of psychiatric treatment are widening (11-04-03)
Why *tougoushicchoushou* [new word for schizophrenia]?

Women:

Maternity blues (3-5-02)
80% of domestic violence victims report continuation of the situation
Being frank with your husband about your depression (7-8-03)

The titles of Dr. Ono's articles give us a snapshot of the types of issues that psychiatry is now being looked to for insight. Indeed, though Dr. Ono's column, by virtue of its placement in this particular newspaper, reflects a public stature reserved for only a handful of psychiatrists nationwide, there are nevertheless comparable columns now in many other major daily newspapers. Dr. Ono and these other progressive psychiatrists are expanding psychiatry's purview and its popularity, shifting the field from its long-standing focus on schizophrenia and hospital treatment and directing its gaze more towards the question of how to improve the lives of everyday people. Dr. Ono, then, operates at the forefront of psychiatry in terms of efforts to improve patterns of care within the psychiatric community, reduce stigma against mental illness among the general population, and extend psychiatry's reach not only to those who are severely ill but to those, such as the readers of the above articles, who are more in need of encouragement and wisdom than medicine.

Dr. Ono's public awareness activities, as represented by his weekly column, also calls attention to what the process of medicalization vis-a-vis depression is resulting in. Whereas the Prozac Revolution in the United States medicalized depression to the degree that other, non-

biomedical, approaches were sidelined, the process of medicalization that is represented by Dr. Ono's articles demonstrates not a narrowing of the gaze, a la the Prozac Revolution, but a widening of the gaze. Dr. Ono does not advocate a narrowly biomedical approach to depression in terms of either conceptualization or treatment. Talk therapy, altering one's environment, learning how to communicate better with colleagues and family members, taking time off from work to enjoy hobbies more and spend more time with friends and family, reframing one's view of self... these are not biomedical treatments, but they are "treatments" nevertheless in the mind of Dr. Ono and other progressively-minded therapists.

In looking at these article titles and seeing them as representative of the issues that are factoring into the public conversation over depression, I suggest that the focus on depression is not leading to a narrow focus on chemical imbalances,³⁷ as we saw in the Prozac Revolution, but instead are operating as part of a wider discussion about how individuals can respond to and protect themselves from some the socio-economic disruptions currently underway.

C. PERSPECTIVES FROM CLINICAL PSYCHOLOGY

This section will introduce two clinical psychologists who spoke with me about a wide variety of issues relating to mental health care. Clinical psychology is a relatively new field in Japan. In spite of the West's long history with Freud, Jung and others, that shadow has not spread over Japanese society. Indeed, the Japanese Society of Certified Clinical Psychologists

³⁷ In my fieldwork, I rarely came across the phrase "chemical imbalance" in any of the newspaper articles and television reports dealing with depression. As well, it rarely turned up in conversations I had with doctors. It appears as though the phrase has not caught on in Japan, which is interesting given that it is the single most dominant phrase used by the medical community in the United States to define depression.

(JSCCP) – the main professional association for clinical psychologists in Japan – was founded only in 1988 (*Nihon rinshou shinrishikai* [Japan Society of Certified Clinical Psychologists 2005]). The JSCCP's affiliate, the Japan Certification Board for Clinical Psychologists (JCBCP), serves as the certifying body for clinical psychologists in Japan (*Nihon rinshou shinrishi shikaku nintei kyokai* [Japan Certification Board for Clinical Psychologists] 2005). Given that the government does not (yet) have an official license for clinical psychologists, the certificate granted by the JCBCP operates as the primary stamp of approval for professional clinical psychologists.

In 1988, there were 1,595 certified clinical psychologists in Japan. By 1997, however, that number had increased to 5,654 (*Rinshou-shinrishi-hou* [Clinical Psychology Bulletin] 1999), and such growth has continued since. Today, the JSCCP has about 15,000 members (*Nihon rinshou shinrishi shikaku nintei kyokai* [Japan Certification Board for Clinical Psychologists] 2005). Clinical psychology is a growth field in Japan.

The overwhelming number of clinical psychologists work in schools (Yomiuri Shinbun 2005b). The JSCCP forged a relationship with the Ministry of Education back in the 1980s, and together they have tried to place clinical psychologists in as many schools as possible. The Ministry has backed up that effort by allocating ever-higher funding amounts for such services starting in the mid-1990s. In 1996, 154 schools in Japan had a clinical psychologist on staff, and the national expenditure by the Education Ministry totaled 370 million yen (about \$3,000,000 by today's exchange rate of \$1:120 yen.). By the year 2000, the number of schools with clinical psychologists had grown to 1,554, and the Education Ministry allocation had increased to 3 billion yen (about \$25,000,000)(*Rinshou-shinrishi-hou* [Clinical Psychology Bulletin] 1999:63).

Basically, clinical psychologists had increased their presence in Japan's schools by about ten times over a mere four-year period.

The 1990s represent the period when the profession of clinical psychology came into its own in Japan, and this process is continuing. In spite of a longstanding animosity between the Ministry of Health and the Ministry of Health, Labor, and Welfare, the latter has decided that schools are not the only arena in which clinical psychologists should be welcomed. For the past few years, the Ministry of Health, Labor and Welfare has been working with psychiatrists and other physicians to develop a national licensing system for clinical psychologists. By law, only those with a license from the Health Ministry can offer "medical" care officially defined, and only those services offered by nationally licensed individuals can be paid for by national health insurance. Psychiatrists consider there to be a growing need in hospitals and outpatient clinics for services by clinical psychologists, and so psychiatrists have been among the strongest advocates for the license. Such a license would put clinical psychologists on par with psychiatric social workers and psychiatric nurses, both of whom, because of their licenses, can now provide reimbursable services to patients.

The prospect of becoming licensed by the national government, however, has not been welcomed by the leadership of the JSCCP. They insist that clinical psychology is categorically different from psychiatry – that psychiatry is a medical field that helps cure patients while clinical psychology is a non-medical field that helps otherwise normal, i.e. non-sick, individuals deal with a broad range of life problems. There is a foundational conceptual divide, therefore, between those who see clinical psychology as a medical profession and those who do not.

Additionally, there are other issues that have stood in the way of the JSCCP's advocating a national licensing system. If such a system were instituted, then clinical psychologists, like social workers and nurses, would have to work under the supervision of doctors. In the Japanese medical system, doctors operate as the final authority on all medical decisions; therefore, all other care-providers must operate under the official supervision of a doctor. Many in the JSCCP do not like this. They do not see doctors as sufficiently expert in matters of clinical psychology to justify their supervision of clinical psychologists.

Also, there are financial and status-related considerations involved given that a national license from the Health Ministry could de-legitimize the certificate currently offered by the JSCCP.

In short, then, clinical psychology is in the midst of growth and controversy in Japan. It is an exciting time to be a clinical psychologist given that job opportunities in schools are growing, and given that, should a license through the Health Ministry become a reality (Minami 2005), job opportunities in the medical industry would increase dramatically.

As mentioned earlier, many clinical psychologists call themselves "counselors," and the public visibility of counselors is increasing. I, therefore, considered it important to interview clinical psychologists/counselors to get their perspectives on the state of Japanese society, the state of Japanese mental health care, and the state of depression. Because clinical psychologists working in private clinics and schools do not carry the same responsibilities for teaching that university medical centers do, I was unable to sit in on any clinical sessions. However, the interviews I had with psychologists yield insights into the cultural context in which the depression boom is operating.

D. DR. AKA - CLINICAL PSYCHOLOGIST

Dr. Aka (pseudonym) is a female counselor who was raised in Japan but who went to the United States to obtain a Ph.D. in clinical psychology. She then returned to Japan, obtained certification from the JSBCP, then started providing counseling services full-time. She has been providing such services for over 15 years now. She is interested in cross-cultural issues relating to the experience, diagnosis and treatment of depression and other conditions, and she exhibits a keen understanding of the changes underway in Japanese society today that are affecting mental health and mental health care. She was particularly interested in modes of expression and the impact of those modes of expression on the experience of suffering and the treatment of that suffering. Also, she, like the other clinicians here presented, is concerned about the cultural aspects of care, which in her mind includes moral and aesthetic sensibilities such as *gaman* and *aware*.

Picking up on the theme of self-expression, our conversation proceeded as follows:

Aka: I think we have troubles expressing ourselves in Japan, and I think you even see this on the international stage. We're not good at explaining ourselves, and this is why the image of Japan as an enigma continues. Also, we rarely stand up to the United States, but instead follow what we are told.

I think this is deeper than just politics, though. It's cultural. When I was growing up, we learned how to write, but we did not learn expository writing. We didn't learn how to present an argument or express our own opinions through writing. The only writing was sort of free-floating essays about the book we read. Persuasion was not the goal. It was mainly demonstrating understanding, but not persuasion. And logical argument was not so important. Demonstrating some sort of intuitive understanding of the book – that's what we were after. As opposed to convincing someone else of some point.

I think this relates to therapy as well. Talk therapy isn't as popular here as art therapy and the other non-verbal therapies. We are not comfortable explaining deep feelings and thoughts verbally, so expressing them non-verbally fits us better.

When my father died, I knew that I had some issues that I had to deal with. I knew I had to deal with them. But I did not want to do psychotherapy. I did not feel comfortable talking. So, I saw a specialist of collage therapy give a

presentation, and so I decided to pursue that. The therapist was a clinical psychologist, and I liked her because of her sensitivity and because I felt I could trust her. What she did in her therapy was allow me to experience the feelings and emotions first, rather than hastily verbalizing them. I like that. If you think intellectually and try to label your feelings, that is premature. She gave me room to just experience the feelings, to float in the feelings. Then, later, if I want to put those feelings into words, then I can. But in psychoanalysis, I would have had to verbalize. If I float in the feelings for a while, then I can get in touch more deeply with those feelings. But if I put them into words hastily, then I don't really experience them so well. So, she helped me do this.

KV: So, she gave you room to experience without requiring anything in return, without requiring any analysis.

Aka: Yes, but she stays there, giving stability, caring for me. But she doesn't intervene. I also did sand play, and this was very interesting.

KV: What did you do?

Aka: Oh, it was wonderful. It is like playing. Like becoming a kid again. To enjoy the freedom and playfulness. She doesn't give any interpretation.

KV: She doesn't?

Aka: Most of the clinical psychologists who do this in Japan don't give any interpretations. They just feel the experience together with you. They come to an understanding with the client.

So, though I myself have a tendency to intellectualize – this is probably why I went to the United States to be trained – but I realized that I am also very intuitive. And this side is very important, and gives me a lot of strength. Maybe it has something to do with aging, but I have come to feel more comfortable relying on my intuition.

KV: Do you think that there is a higher demand for the more non-verbal therapies [in Japan] than there is for the verbal ones?

Aka: I think there is an increasing demand for both. The world is changing. Japanese society is changing. Information technology, and so forth. How our “selves” work is changing too.

KV: In what way?

Aka: From a relational self to more independence, more assertive, more aggressive, more self-expression, more argument, more debate, more persuasion. We Japanese have not been taught these skills, but increasingly we are having to learn them. So, the “self” is changing. It's having to change.

KV: You know Takeo Doi's book, *The Anatomy of Self*, about the Japanese self. As of today, how accurate do you think that book is?

Aka: I read it a long time ago. Then, I agreed with most of what he said, but I think these days we have to pay attention to individual differences. There is no one Japanese psychology. We have more diversity. The generation gap is very great. Family life is changing. Parent-child relationships are changing. Communication styles are changing.

Dr. Aka raises interesting points about self-expression and diversity. Though some Western writers on Japan, and though some Japanese themselves, have tended to homogenize Japanese psychology and culture,³⁸ more current research has emphasized the diversity that exists in almost all walks of life. This is not to say, however, that patterns do not exist. Dr. Aka indeed discusses such patterns when she talks about Japanese education and its impact on patterns of self-expression.

Dr. Aka's comments about the importance of non-verbal therapies in Japan resonates with the fact that talk therapy, in general, has been very late in coming to Japan. As the discussion in chapter three about Freud suggested, the idea of talking one's way to mental health did not resonate for most of the 20th century. Dr. Aka's comments suggest that patterns of education may have played a part in that.

KV: Continuing with this idea that the education system doesn't encourage students to express themselves, where else can we see a pattern of not talking about things?

Aka: In terms of the job situation, I think for many people, having depression or other mental problem means that you're suffering because you're weak, because you're not strong enough. So, people are hesitant to reveal much about their work-related stress.

KV: Why is this?

Aka: Because we don't want to face the problem. It's a "*shikatta ga nai*" kind of thing.³⁹ Maybe something to do with just resigning oneself to the situation, or just accepting reality. Americans intuitively believe in their ability to make changes, but Japanese somehow don't have that kind of belief. Americans also emphasize

³⁸ *Nihonjinron* [theories of Japaneseness] literature. The most extreme example of this that I have come across is a book entitled *The Japanese Brain* (Tsunoda 1985). The book opens with images of two sets of brain scans: one from a "Japanese," the other from an "American." On the next page is written, "As a result, this EEG topographical color display method has verified Tsunoda's finding that brain dominance patterns do differ between Japanese and Western people" (Tsunoda 1985:iv).

³⁹ *Shikatta ga nai* translates as "It can't be helped," and it is often used to express the belief that the situation is hopeless, that there is no solution possible.

action, doing something. But Japanese tend to think of waiting, seeing how the natural course of events will develop. And many times, the natural course of events will take care of the issue, right? But aggressively trying to do something about it – that’s not a common way of thinking here. So, resignation and acceptance can be positive - a way of expecting that the natural course of events will work out OK.

Dr. Aka here makes reference to the notion of *gaman* explained in chapter three. Just as *gaman* is about patience, so too is patience considered not only a virtue unto itself, but a way of solving problems. Through *gaman*, one has faith that things will turn out OK. It is a justification for not aggressively trying to correct the situation on the spot, but instead waiting, with patience and perseverance, with the expectation that the situation will correct itself in its own time. In short, Dr. Aka has reiterated the connection between silence and perseverance (Lebra 1987); and she has suggested, through her comments about the popularity of non-verbal therapies, that the connection influences the actual modes by which patients can deal with their personal struggles.

Aka: We have been trained to exercise self-control even when we are suffering with something or when we deal with difficulties. We have not been trained to express it openly. So, as a result, I think, even though we have been feeling stresses throughout history just like all other human beings, we just have not been paying much attention to the fact that we feel so stressed. So, suddenly these days, we’re realizing, we’re discovering what we’re feeling. And maybe because we’re just discovering it, maybe we suffer all the more.

Given that Dr. Aka was trained in the United States but had practiced for over 15 years in Japan, I was curious about her observations regarding the domestication of Western therapies. If notions of “self” were significantly different between Japanese and non-Japanese persons, I wondered how such differences would manifest themselves in psychological therapies.

KV: In Okonogi-sensei's seminar,⁴⁰ one of the things that is most interesting to me is that there is no Japanizing of theories or methods whatsoever. They will read a [Western] text, then analyze it at face value, with the assumption that it, as it is, is applicable to Japanese clients. There's never any discussion of the need to Japanize something or that "Well, this is the way it is in the West, but here in Japan, it's so-and-so." Texts by Erikson, Winnicott, Klein⁴¹ – they're all examined just like they would be in a seminar in the US. Cultural differences are never discussed. Granted, what goes on in the actual sessions, in their offices with clients, may be different. But in terms of the training of psychologists, I find it interesting that cultural differences don't factor into the process, at least in what I've seen of Okonogi-sensei's seminars.

Aka: Hmm, yes, I think there are differences in what goes on in the sessions. When I came from back from the States, after being trained there, I had to modify what I had learned.

KV: In what way?

Aka: Verbalizing. I got used to verbalizing thoughts and of expecting clients to verbalize their thoughts. But this didn't work so well, because some patients thought I talked too much and that I was going too fast. I had to learn to be more patient. Verbalizing feelings takes time, and I think it's a more subtle process with Japanese. I have to indirectly encourage them to verbalize, through cues, as opposed to just jumping directly into a conversation. This is why the non-verbal therapies work so well here.

KV: Do you think this is the norm with most other clinicians as well?

Aka: Yes, I think that many clinicians and professors in Japan feel that they do have to Japanize Western methods and that patients are a little different here. Even Okonogi-sensei has written on the Ajase Complex (Okonogi 1979) and on other aspects of Japanese culture that relate to psychology. It may be that because all of his students are Japanese, maybe it's unnecessary to talk about Japanese culture because they all know it. But after they have studied Erikson or Klein and so forth, I think that they, perhaps even unconsciously, modify things when they actually interact with a Japanese client.

Again, in Dr. Aka's mind, one of the main components of mental health care is that of verbal self-expression. To her, talk therapies originated and operate in a particular cultural

⁴⁰ Dr. Keigo Okonogi (1930-2003) headed the training program for clinical psychologists at Keio University, and his program was considered one of the top training opportunities for clinicians in the country. Dr. Okonogi permitted me to sit in on his weekly training seminars for several months.

⁴¹ These are major theorists in Western clinical psychology, and Dr. Okonogi's seminars had covered the writings of each of these, and others.

context, and for them to be transferred over to another cultural context, there must be some alteration. The level at which such alteration takes place, however, is ripe for study. Judging from my observations of Dr. Okonogi's seminars, it would appear that Western theories are not viewed there as "Western" theories, but as just "psychological" theories, i.e. ones that have cross-cultural applicability. But Dr. Aka suggests that there are more unconscious processes involved and that in these more subtle processes of communication and expectation we can see domestication at work. Clarification of this will require additional study.

We next moved into a discussion of the way in which ideologies and worldviews can affect mental health and mental health care. In particular, I wanted to inquire about attitudes toward death and the way those attitudes influence understandings of sadness and suffering. The discussion led in several directions. But, again, many of the paths led back to *gaman* and *aware*.

KV: In all my sessions, I only saw one case of bereavement problems, and it was with a woman whose teenage son had died suddenly. She was Christian. I'm curious as to why there is so little bereavement counseling in Japan. Is it due to all the funeral rituals, or is it a matter of belief, worldview, or what?

Aka: There is not so much of a clear-cut boundary between life and death.

KV: I have a hard time grasping that.

Aka: Just personally, I know my father is dead. And I miss him even now. But at the same time, I feel that he's looking at me from somewhere, looking over me and protecting me. Whenever I go to the grave, I always ask him to help us, to help us be happy.

I know that my father had a very strong will. In the war, he had to have his appendix removed, but there was no anesthesia. So, it was removed without anesthesia, and he survived. So, he had a very strong will. When he was dying, he did not complain at all. He had a very dignified death. At the end, his eyes were open wide. They were even pretty in a way. How do you say, when people accept some sort of fate, a feeling of acceptance, and they emit a sort of glow of life in the eyes. His eyes were like that. It was very peaceful when he died.

So, now, I know he is gone. But I feel there is some essence of him that is not gone. Maybe I carry some of him, something I inherited from him. I still feel connected to him.

Anyway, I don't know if this is general. In terms of ideas about death, the main difference I think has to do with monotheism. Japan is not monotheistic;

there are many gods, and there is no concept of an absolute deity or an absolute morality. And in the deities we do have, they are rarely 100% good or 100% bad. Even our demons [*oni*] can do good things. So, maybe this affects the way we view death.

KV: Yes, black and white, life vs. death, heaven vs. hell. One is not the other. There's a lot written about the search for categories and the desire for oppositions and distinctions in the history of Western philosophy and in the Western book religions. Cartesian dualities and so forth. Culture is supposed to help people deal with problems, but I wonder if this way of thinking is harmful when it comes to dealing with death.

Aka: I do think there is something cultural about accepting death, and accepting loss. I think there is this kind of sympathy with dying things, things which are being lost. Like the sympathy with falling cherry blossoms. It's a melancholy.

*Tasogare*⁴² reminds us of something sad, but at the same time, it has an aesthetic appeal to it. Kind of empathizing with those who are disappearing, and those remaining in the twilight, which is on the verge of disappearing. I think this emotion is strong; it's a part of being Japanese. Even though we find beauty in the bright sunshine and so forth, there is also a type of beauty that is more appealing to us. It's about feeling sympathy with those who die an untimely death. You see this in our literature a lot. *The Tale of Genji*, for example. We find a beauty in dying. It brings tears, like *enka*.⁴³

KV: *Aware*.

Aka: Exactly.

KV: Yes, I see this in Japanese movies. Americans demand the happy ending, most of the time. The Japanese don't. In these sad endings, it's as if the audience wants to be saddened. I wonder if it's a matter of seeing sadness as an acceptance of reality and a sign of maturity. Do you think there's any truth to this?

Aka: Yes, absolutely.

KV: Tell me about sadness Japanese-style [laugh].

Aka: I think it has something to do with acknowledging the frailty of human existence. Acknowledging vulnerability of your own self. Acknowledging your eventual emptiness.

KV: Emptiness?

Aka: We are destined to emptiness, at the end, when we die. Or at least transience. Life doesn't last. There are limitations. I think that in America, when

⁴² She refers here to a movie entitled *Tasogare Seibei* [Twilight Samurai], which had been released just a few months before our conversation and which we had discussed previously. The movie depicts a samurai at the end of the Tokugawa Era who was struggling to balance duty to his lord and the administrative needs of the estate with duty to his two young girls, whom he was raising single-handedly given that his wife had died. We had both found the film very moving.

⁴³ *Enka* is a form of Japanese folk music famous for its themes of sadness and loss.

we talk about light and shadow, the emphasis is almost always on the light. People don't want to pay much attention to the shadow. Always looking on the bright side of things. This is becoming increasingly the case in Japan. But in Jungian psychology, there is emphasis on accepting the shadow parts of ourselves, even utilizing the shadow parts of ourselves that beforehand weren't so utilized. And looking back on Japanese history, especially before and during World War II, we tried to ignore our shadow part. But after the defeat, we were reborn. We thought we could begin everything afresh, and we just focused on economic development and prosperity. But now, I think, some of the shadow parts are starting to express themselves. Suicide, *hikikomori*, disintegration of families. Not just Japan, but many countries are being challenged by the same issues.

KV: Do you think Japan is better at being in touch with the shadows?

Aka: Politically, we are not. But deeper, more culturally, I think we are.

KV: This interest in sadness is interesting, so it's strange why depression has been so taboo for so long. In the US, sadness is bad, and depression is bad. It goes together. But in Japan, in a way, sadness can be good, yet depression is definitely bad.

Aka: Yes, but here, it's not about sadness. It's about *gaman*. To be depressed has meant that you don't *ganbaru*⁴⁴ enough.

KV: The more I study and experience Japan, the more I think that all roads lead to *gaman*, that this is perhaps the most important word in this entire culture [laugh]. In the US, you can't understand much of anything that goes on there without understanding what Americans think of when they say "rights." But here, I think "*gaman*" is the key word. It's not a political thing, but a personal thing.

Aka: Yes, we put so much emphasis on our own responsibility. It doesn't lead to making changes in society. If you emphasize rights, you go outside of yourself and criticize something that infringes on you. But with *gaman*, the emphasis is on something internal, within yourself.

KV: Yes, I think it goes against the idea of rights. Rights is about recognizing something that you want and insisting on getting it. It's getting what you want. *Gaman* is about not getting what you want, at least immediately. It's about tolerating the situation. Working really hard, and maybe in time you'll be rewarded. But it doesn't seem that the reward is the issue. It's about the doing of the task on a daily basis, and doing it as fully as you can. There are so many TV shows that show some regular person, not a celebrity, trying to overcome some hurdle. Like some overweight salaryman losing five pounds in two weeks. You see the studio audience watching him struggle, and they're in tears. It's just a small, personal task, yet it's tremendously moving, and it's on TV every day. They're crying over his *gaman*. It's seeing his trying that matters. It's not the goal that matters. Any goal is good enough.

⁴⁴ *Ganbaru* is a verb whose meaning is very close to that of *gaman*. It can be translated as "to do *gaman*, to act in a *gaman*-like way." (See Singleton 1989).

Aka: Yes, but this goes back to the war. A common phrase during the war was “Until we win, I will not ask for anything [*hoshii ga arimasen, katsu made wa*]. This is the model. We will *gaman*; we will not ask for anything.

KV: The problem is that *gaman* is a great tool for an oppressor. And this is the flip side of *gaman*. It can contribute to obedience, and this can easily be taken advantage of by a government or a company. Do you think that *gaman* can have very undemocratic consequences, that it can prevent you from criticizing the people above you?

Aka: This is the tragedy with these *karoushi* and *karoushi-jisatsu* cases. We are beginning to realize that we have too much *gaman*. We are seeing that the changes coming about with the economy are not going to be good for most people. Many more will lose their jobs. And most of these are men, of course. It’s about roles of men. There are some groups in Japan who are now trying to challenge the traditional roles of Japanese men. Men’s groups. Men are to work and bring home money for the family. It is the women’s job to raise the children and run the household. So, if he loses his job, there is nothing left for him. He has failed his role totally. But, also, I think it goes beyond just roles. Hope also factors in. I think, and it’s just an interpretation on my part, that a lot of these men no longer have any hope. So the real problem is one of hopelessness.

In sum, Dr. Aka suggests that there are several factors influencing the way that individuals experience and respond to certain forms of suffering: communication patterns, especially the tendency toward non-verbal expression; ideas about perseverance and problem solving; conceptions of sadness; and reasons, or lack thereof, to be hopeful about the future.

In my conversations with her, I was struck by her ability to weave together these different factors and articulate how one interacted with the others. She showed linkages between otherwise disparate elements – beliefs about the afterlife, notions of personal responsibility, pre-war propaganda, aesthetic sensibilities, etc. – and suggested ways that these linkages played themselves out in the way people responded to the novel pressures they are having to face these days. Though, as she concluded, some of these pressures are leading to a sense of hopelessness, it appeared to me that if Dr. Aka were in any way representative of the few yet growing number of Japanese clinical psychologists, then mental health care was in a good position to counter that

sense of hopelessness with sensitivity, compassion, and a patient, listening ear. I always left our conversations thinking that she had her finger on the pulse of those individuals who were otherwise not quite able to voice their thoughts and feelings, especially their feelings of loss and fear. Her ideas about non-verbal communication and therapies, based as they were on fifteen years of clinical practice as well as on her own experience as a client, convinced me that good therapy need not be word-based. Words certainly have their place; but for the person not so comfortable in them, having someone who can listen and understand the silence can also open doors.

E. MR. ANDREW GRIMES - COUNSELOR

Andrew Grimes is one of the very few Westerners to be certified as a counselor in Japan. He was born and raised in Great Britain, but came to Japan in the 1980s and has lived there ever since. He entered a clinical training program in a well-known Japanese mental clinic two years after his arrival, and upon completion of the program and subsequent earning of his certification has been providing clinical psychological services to Japanese and non-Japanese clients for the past fifteen years (Grimes 2001). Now in his late 40s, he speaks fluent Japanese and is frequently sought out by Western journalists for his commentary on Japanese mental health care.

Mr. Grimes has a unique position in Japanese mental health care in that he is a Westerner yet his clinical training was conducted in Japan and within the Japanese clinical psychology system. Therefore, unlike other American clinicians who have trained in the United States then moved to Japan to practice, Mr. Grimes is to a large degree a product of the Japanese clinical enterprise.

I sought out Mr. Grimes because of his position “on the bridge” so to say. Granted, most of the up-to-date physicians of any sort in Japan are fluent enough in English to read the international literature, and many of those have trained to some degree or another in the United States or Europe. Therefore, it is common to find Japanese clinicians who are “on the bridge” in that sense. But with Mr. Grimes being a Westerner who trained within the Japanese system, he offered a different perspective.

Mr. Grimes works in the Ikebukuro Counseling Center, which provides a full range of mental health care services. The center has a staff of three psychiatrists and 27 clinical psychologists/counselors. It offers individual, couples, and family counseling and psychotherapy services, and it runs a day-care program for those with schizophrenia and other more serious illnesses (Hozumi Clinic 2005).

I met with Mr. Grimes eleven times over a course of five months. Most conversations lasted about two hours, and each conversation was tape recorded. The following narratives represent a concatenation of excerpts from those conversations. Together, we covered a range of issues including the sources of stigma, the recent surge in demand for counseling services, cultural differences affecting therapy, and the impact of economic restructuring on mental health.

KV: How about telling me a little bit about the stigma against mental illness in Japan. Almost all of the articles in newspapers and journals talk about it, and some even mention it in the very first sentence. So, though everyone seems to agree that there’s a strong stigma over here, how can we know that it exists and that it’s so bad? Where can we see it exactly?

AG: To identify stigma, one has to look at the concept of what “mental illness” is and how it has been perceived. Up until now, it has had to do with the belief that certain behaviors, attitudes, and ways of being that were out of the norm could be transmitted genetically, and that anyone whose family had a history or a member who had been mentally ill, then that family would not be a suitable family [for marriage] for fear of the consequences for the future.

I don't know enough about pre-war Japan to say, but in terms of post-war Japan, in the late '40s and '50s, there was a lot of concern about just providing for the family, about who was a suitable, strong person in terms of being able to put food on the table and maintain an emotionally and physically demanding, self-sacrificing lifestyle in order to provide for the present generation and the next one. Therefore, any stigma that existed previously would become more exaggerated and intensified due to the struggles that families were going through after the war. People had to be extraordinarily careful about who they let their sons or daughters marry because they were trying to do one thing and that was to make sure that the family survived. Family members were all that people had. It was a country that was devastated to a degree that people find hard to imagine nowadays, and I think that fear was a very high motivating factor in seeking a sense of security through family, in a country that had lost its sense of security. So, with the enormous financial, social and psychological insecurity, and with the need to depend upon one's family members to achieve anything approximating security, any family would be critically concerned with who would be coming into their group.

So, I think that fear led to a reinforcement, perhaps "distortion" is a better word, of a traditional idea about genetics. I think that stigma is mainly about family.

Mr. Grimes voices here his theory about a connection between stigma and family in post-war Japan. Leaving behind the more "cultural" theories about the sources of stigma and adopting a historical approach, he emphasizes that the desperate conditions in which many Japanese families found themselves after the war rendered the internal stability of the family all the more important. Many families in the immediate post-war years had very little to rely on other than themselves, and so it is logical that they would consider the question of who enters the family or whose family they allow their sons and daughters to enter to be of primary importance. In such an environment, beliefs about the genetic basis of mental illness would take on an invigorated urgency.⁴⁵ Grimes continues:

⁴⁵ I myself saw first hand an example of this belief in the genetics of mental illness: A friend of mine in Japan is an amateur match-maker [*nakoudo*] and she takes pride in the fact that she has matched 27 couples and that, of those, none has divorced. In talking with her about her criteria and methods for matching, I discovered that one of her responsibilities is to investigate the medical backgrounds of each family, going back as far as she can. If there is any evidence whatsoever of mental illness, she will match that candidate only with another candidate whose

Basically, you had an entire society suffering from post-traumatic stress disorder. There was so much shock, fear, and grim reality. So, I think this is part of the complex reason for why there arose so much stigma.

But all that I've known in these 17 years [since arriving in Japan] is that this stigma definitely exists. There is enormous reluctance to admit that one has a child who is suffering from mental illness. Not just schizophrenia or one of the more severe mental illnesses, but even the milder, the stress-related mental illnesses. The result has been, until recently, a pattern of hiding people away.

But that is changing now. People are picking up the telephone. They're talking. They're reading things in magazines. And they're doing so in increasingly large numbers. Just to give you an idea: We moved our center from the building we were in before to this one almost five years ago. In the last building, we had three rooms, and rarely were all three of those rooms utilized at any one time. On some days, we didn't even have one room that was being used continually all day.

This was the way things had been since the counseling center started about in the late 1980s. But in the past four years, we've had to build an additional office and add additional rooms, so now we have a total of eight rooms, and we now see about 200 people a week. My sense is that in another two or three years, we'll have to move out and find a larger facility. People are really reaching out for counseling services now.

KV: Why now?

AG: I think there are large numbers of people in this country who are putting up with enormous amounts of stress and depression and not even aware of it. I'm sure you've seen them on the train. You can just get on the train and look around. You see people who are exhausted, worn out. They certainly look depressed.

Don't get me wrong. I don't want to call Japan a "sick society" at all. I've seen too much of the care, the humanity involved not only, for example, during the Kobe earthquake, but there's just a good-hearted spirit of people in Japan that is very much alive. And I think that's what we're seeing here today in terms of the interest in mental health care.

As is abundantly clear in the newspapers, on television and so forth, the shift of which Mr. Grimes speaks in terms of the increasing "reaching out" for counseling and other mental health services is indeed taking place. And it is not merely a matter of drug companies revamping and marketing psychiatry and medications. Instead, as Mr. Grimes suggests, the demand for such

family has a similar background. The irony is that her own son has a history of emotional instability and has obtained mental health care services. She admits that her son and family probably would not do very well if they had to use a match-maker. She also asserts that her policy toward mental illness is standard for match-makers across the board.

services is based in just that: demand. There is a need for these services, and now that people are discovering the existence of the services and are not as afraid of using them as they might have been previously, there has been a recent upsurge in these services being utilized.

The time period that Mr. Grimes is talking about here overlaps the period in which SSRIs were approved and then marketed. Therefore, what he has established is that at the same time that the demand for SSRIs is increasing, i.e. as the demand for the biomedical treatment for mental illness is increasing, so too is the demand for talk therapies, i.e. non-biomedical treatment, also increasing.

KV: Tell me a little about the modes of therapy. Do you think that talk therapies are practiced any differently here than elsewhere, or that modes of expression within therapy are any different?

AG: No, I don't. In fact, I want to get away from the idea that there is a particularly "Japanese" mode of therapy that differs from an "American" or any other mode of therapy. Some Western journalists have been quick to suggest this. It's very easy to fall into stereotypes here. Japanese people need to express themselves just like anyone else, and I as a therapist can tell you that they do it very well! After all, this is talk therapy that we do here, and so there must be lots of talking, and lots of laughing! [laughs].

I think that there's a rich variety within any culture that you look at. I would rather the question be directed more at the internal variety in a culture than in the supposed difference between cultures. I think you'll find that in terms of socio-economic status, region, age and so forth, that's where you might find some interesting differences.

What's important is the sense of encouragement that people are given in terms of expressing themselves in certain ways. In Japan, there's *honne* and *tatema*⁴⁶, but you know in England we have *honne* and *tatema* too. We're all social beings, and so we each have to decide how much of ourselves to express to other people in that particular circumstance. So, in my experience, Japanese people have no problem expressing themselves in therapy.

The Japanese people that I see feel a lot, an enormous amount. And when listening to them talk about their feelings, it completely demystifies the stereotypes: the unfeeling, the roboticized, the worker-bee, the consensus-oriented and so forth.

⁴⁶ *honne*: one's real intentions, real feelings, true colors. *tatema*: official stance, professed intention. Often related to the principles of *uchi* (inside) and *soto* (outside).

In contrast to most of my other informants (which were all Japanese), Mr. Grimes opposed the more “cultural” explanations. He opposed the use of culture to explain much of anything, and he asserted that in the therapeutic process, cultural patterns of expression, communication, notions of self, etc. factored very little.

But he did support a historicizing of the phenomena in question. He asserted that larger historical shifts were indeed influencing what was going on in counseling sessions. In particular, he spoke about the impact of the economic situation on attitudes toward work, notions of personal security, and mental health.

KV: You’ve been talking about work, family, post-war history and sense of security as far as mental health goes. Obviously, work is important, as it is just about anywhere. But do you think that the recession has generated a re-evaluation of work in the past few years? And if so, what impact, if any, does this have on what you do here and on mental health care more broadly speaking?

AG: The definition of work has been fundamentally shaken, I think. For many people, this is because their companies went bankrupt, layoffs, lifetime employment evaporated and so forth. “Restructuring” is a death sentence, you know. Oftentimes, there’s nothing left for these people. So, people are trying to re-evaluate “Where is a safe place to be?”

I think for the middle and older generation, work definitely was seen as something that provided stability and security. And this is why workers were willing to make so many sacrifices for their companies. There was an element of trust that characterized the relationships between companies and employees.

Some people today feel that there is no longer a place in which they can place their trust. No sense of security. I think this is one of the factors for *hikikomori*, which affects about a million young people. Most of these seem not to have any sort of depression or anxiety or anything. But they do seem not to know how to communicate, and most importantly, they just don’t know what to do with their lives. So they don’t join the workforce. You also have “freeters” [*fureetaas* - “free timers”], who are making a conscious decision not to join companies.

I see a lot of people in the clinic here, in their 20s and 30s, who are under tremendous stress within themselves, and from their families, because they want to have a measure of hope, happiness, and satisfaction and want to follow something creative, do things on their own terms; but they can’t bring themselves to go against the wishes of their families who want them to find a job in a good company. Especially in the current economic climate, parents are not seeing

“follow your dreams” as a good strategy, so they intensify the pressure. I see a lot of cases in which this kind of tension and confusion leads to severe depression. They’re torn between two desires: to do what one wants to do in life, and to please and respect the parents and find something stable. The problem is that they don’t want to follow their parents’ path, especially young men who often don’t want to follow their father’s path, but they still feel a sense of obligation and gratitude.

These people don’t know where to go to for help. They’re in an environment in which basic values are being questioned, and that environment itself does not look so promising, with the continuing economic downturn and unemployment and all. In most other countries, when you don’t want to follow in the footsteps of your parents, it’s not an issue because they are other alternatives. But in Japan, there just haven’t been so many alternatives. Or at least there hasn’t been much encouragement about finding alternatives. There certainly isn’t enough of it. Flexibility and finding outside opportunities just aren’t built into the model over here.

So this is a lot of what we do here: provide encouragement. We deal with family problems, personal problems, confusion, and types of social issues as much as we do the more severe mental illnesses, and a lot of these cases are a matter of providing encouragement more than anything else.

And this isn’t just about younger people, but about people in their 40s, 50s and 60s who have lost their jobs. For these people too, there has to be encouragement and compassion. They need help in finding ways to keep going.

With the current work situation, unemployment and all, they look at the TV every day and see that the US and the rest of the world is zooming ahead, but that Japan isn’t. The system that they worked so hard to create turns out not to have worked, and this contributes to depression.

When people are dealing with such pressures, they may never get to a place where they can think that they’re safe. It’s hard to get a sense of security when you look back and see that things just didn’t work, that lifetime employment and all didn’t work. And I don’t think that the post-war system was just a matter of economics. I think that people were driven, that society was driven, by a desire to get to somewhere safe.

Combine all the stresses and desires for change, the lack of security, need for alternatives, and I think that what a lot of people are seeking, at least the people that I see here, is just hope, and freedom from a sense of inevitable loneliness.

KV: Wow, what a last sentence.

AG: I think it’s true. Loneliness is a big problem.

KV: So what types of alternatives are helping?

AG: Well, that is the question. And it’s difficult to answer precisely it’s a situation in process. It’s true for individual people seeking help, and I – I don’t want to go too far here – but I think it’s true for much of the country: it’s more a matter of actively looking for alternatives than a matter of having yet found one. We’re in a midst of a transformation here. But I personally am optimistic about it because I

think that even with the loss of some of the basic norms like security in the corporate system, that other basics are very strong and will continue: endurance, effort, dedication, and so forth. But, again, it's hard to identify what's happening nationally regarding the transformation because it's rather headless right now. So, many people are doing their own searching for alternatives.

Mr. Grimes here establishes the psycho-social context in which mental health has come into prominence in the past few years. There is a need for such services precisely because people are feeling so insecure, torn, confused, and alone. Going back to Gay Becker's term, they are in the midst of a disruption.

Mr. Grimes eloquently summarized the situation at one point in our discussion when he said that, in terms of the importation of SSRIs, the expanding utilization of counseling services, and the increasing public interest in depression and mental health care overall, Japan was simply "fertile ground" for all of that. His summation resonates with Stuart Hall's theories about the importance of local demand on the flow of ideas, goods, and other cultural products. For Grimes and for Hall, it is precisely the fertility of the ground that determines what ends up taking root.

Applying this to SSRIs and the expansion of counseling, it is indeed one thing for the purveyors of a particular solution – be it a form of therapy, a type of drug, etc. – to come into a new place and offer that solution for consumption. It is quite another thing for people to accept the offer to consume. In Mr. Grimes view, it is the consumption, the demand for the solution, that is the pivotal factor in explaining why mental health care is undergoing such a dramatic shift in Japan today. Mental health care is expanding not just because of successful marketing, but because people are seeking alternative solutions for their problems. And, in his experience at least, there is an idealism that motivates those who decide to dedicate their careers to helping clients find those solutions. The mental health community is stepping up to the plate, and by virtue

of the fact that schools across the country have been seeking their services and that now the Health Ministry is poised to license those services for use in the medical system, it is clear that the mental health community has been successful in its efforts.

Mr. Grimes' comments bring into relief one critical component of the normalization of antidepressant medications in Japan: that though the growth in sales of SSRIs seems dramatic when looked at just by itself, to get the full picture of what is happening one has to line those sales figures up with the corresponding surge in the utilization of counseling. In short, they are parallel consequences of the same phenomenon. They are both gaining popularity for the same reason: fertile ground. And that fertile ground is comprised of all the elements regarding the breakdown of trust in companies, the loss of security, the trauma of layoffs, the re-evaluation of work, and the need for individuals to find their own alternatives and solutions. SSRIs, therefore, do not so much represent a marketing phenomenon unto itself as much as they represent a single component of a much wider social phenomenon.

F. CONCLUSION

Clinicians offer their own perspectives on mental health care – perspectives that may differ from those of patients and perspectives that may even differ from those of other clinicians. This is to be expected, for mental health care is a robustly diverse as well as a robustly controversial enterprise. Questions such as what constitutes a mental health care problem; who gets to decide what constitutes said problem; who should treat it; how it should be treated; what are the aims of treatment; how should progress toward those aims be evaluated; what role should medications play; what role should talking, listening, advising, encouraging, or other communication strategies

play; what does “clinical psychology” mean; what influence do notions of “self” have over treatment; what is the proper doctor-patient relationship; to what degree does, or should, issues of “culture” factor into treatment... there are a host of questions that factor into the debates around the world about how to improve mental health care. And given that there seems to be no country that has found all the answers yet, perhaps hearing from those not frequently heard from might offer something new.

Japanese clinicians are among those who are not frequently heard from in the international arena. Though there is certainly some excellent research coming out of Japan’s psychiatric community, especially regarding schizophrenia (eg. Kashima et al. 2002), in terms of the Western popular press, Japanese psychiatry often gets a bad rap. Because of the longstanding problems with institutionalization and the corresponding difficulties in promoting community-based care and other treatment alternatives, it has been easy to bash Japan’s mental health care system as being “30 years behind,” which has indeed become a commonly trotted-out summation.

But as I hope this chapter has demonstrated, not all Japanese clinicians are dedicated to locking people away and tranquilizing them for the rest of their lives. Quite the contrary, a number of Japanese clinicians are leading the way in terms of helping the mental health care system respond professionally and compassionately to the myriad new problems that are appearing in the wake of “Stress Society.” I have merely sought to give voice to a few of those clinicians in the hope that their successes and aspirations will encourage others who are aiming for similar goals. Though Dr. Ono’s efforts in particular garner national and international attention, I do not think he should be viewed as a lone beacon. There are many like him, not as visible, but equally dedicated to helping patients and improving the system on behalf of those patients. So as

there is “fertile ground” in Japan these days, there is also a growing number of highly capable gardeners who are sensitive to the needs and working diligently to fulfill those needs.

IX. IMAGES AND DISCOURSES

*I do **not** want to go to work!!*

character in ad for antidepressants

Depression has become a common topic of public discourse in Japan. Articles on depression appear regularly in major newspapers. Pharmaceutical companies have created attractive websites to inform and advertise to consumers (Utu-Net Committee 2004). Television reports on depression are explaining symptoms, causes, and treatments. Recovered depression sufferers are taking their stories public (Ogawa 2001). And clinicians are writing self-help books on how mental health care can help sufferers return to normality (Izumi 2002).

But, to be sure, depression is not the only mental health concern gaining attention. Anxiety, schizophrenia, eating disorders, *hikikomori*, social phobia, adjustment disorder, and, especially, suicide and *karoushi* are also becoming increasingly visible.

This attention, especially that directed at depression, is relatively new. Clinicians, patients, and lay people report seeing very few of these articles, books, and shows until about ten years ago, with the most significant increase starting only five years ago.

In previous chapters, I explained that several key events took place in these past five or so years which paved the way for this type of media concern. The suicide rate exceeded 30,000, *karoushi* cases against major companies started being won, and SSRIs obtained approval. There was, therefore, a rather sudden convergence of problem and possible solution that primed the way for a new public discourse.

This chapter will review some of the dominant images of depression that appear in these public discourses, with particular emphases placed on language and visuals. I suggest that shifts in the words and images used in discussing mental health represent changes in public perceptions more broadly speaking. Indeed, as I have argued before, and as will be more applicable to this chapter than previous ones, the depression boom is taking place in a wider context of which attitudes toward suffering, stress, modes of expressing negative emotions, and mental health care are all a part. Language is playing a role in this wider context, with new words emerging to describe several phenomena relating to mental health. What are the new words? Who is producing and reproducing them? To what degree are they resonating? These are some of the questions that this chapter will explore.

In terms of visuals, I will examine the images used in print media, television reports, websites, and advertising that are accompanying verbal discussions of depression and other psychiatric conditions. It will become clear that in terms of the images used in advertising in particular, pharmaceutical companies have tailored their images specifically to the Japanese market. By examining these companies' strategies, we can see both the intended targets of resonance (what advertisers hope will resonate easily in the minds of consumers) as well as the conceptual hurdles (those ideas within the minds of consumers that pharmaceutical companies feel must be overcome). I, therefore, will present a "critical" reading of the marketing strategies currently being used.

The images being used in marketing, however, cannot be examined alone because the marketing images are not differing significantly from those being used in news reports. Perhaps this is because journalists themselves are viewing and being influenced by the advertisements. Or,

perhaps it is because journalists face the same challenges that drug manufacturers face in terms of seeking ways to identify with consumers/readers. Or, perhaps it is simply because the social problems – suicide, *karoushi*, stress, etc. – are what they are, with the result being that both advertisers and reporters are starting with the same raw material. Whatever the cause, it is nevertheless true that there is overlap between marketing and news-based images, as I will demonstrate in the pages that follow.

In short, there is an air of discovery about depression in Japan. People are curious as to what the condition is all about. Within such an environment of curiosity, drugs are not at the forefront, i.e., they are not the dominant concern. Most of the news reports are not so much interested in extolling the virtues of a particular type of drug or in debating the pros and cons of using that drug. Instead, the “depression boom” is focusing more on the problem itself than the pharmaceutical solution. Interestingly enough, a superficial glance over the advertisements yields the same conclusion: that even the ads themselves are downplaying the medicines.

Regarding this observation that the current boom is not focusing so much on pharmaceutical solutions (at least in comparison to America’s Prozac Revolution), I will suggest that part of the reason for this is that there is a surge in interest not just in one type of solution, but in many types of solutions, or, perhaps, an interest in the possibility that there is any type of solution available at all. What is being emphasized in the various discourses, then, is that there are alternatives to the pattern of silent suffering – alternatives in the form of drugs, treatment by psychiatrists, treatment by counselors and psychologists, talk therapies, nature therapies, and other forms of help. The message, therefore, is not a one-sided one proclaiming that there are new drugs to cure the problem, but a more open-ended one revealing that there exists this

problem called “depression,” that many people suffer with it, and that it can be helped. Precisely how it can be helped is secondary to main point, which is merely that the problem exists, is widespread, and that there are multiple forms of help available.

In short, the current media discourse is, on the one hand, contributing to the medicalization of depression. It is doing this by presenting psychiatrists as the experts on the matter, thereby framing the problem as one for which medical care is appropriate. At the same time, however, there is a parallel focus on other forms of care, mainly counseling, such that the process of medicalization here is not narrowing the gaze, i.e. pointing to it firmly and exclusively in a single direction toward drugs, but is widening the gaze, by encouraging people to seek any number of forms of help. This widening of the gaze comprises one of the differences between America’s Prozac Revolution and Japan’s depression boom.

A. NEW WORDS

For most of the post-war era, the word “psychiatry” has generated bad images, mainly that of a locked institution into which crazy people enter and never come out. Treatment has been viewed as that needed only by the most severely ill of individuals. Additionally, psychiatrists have sometimes been seen as being a little “odd” themselves. Regarding patients, criminality has been a part of the dominant image, reminiscent of the Reischauer Incident. And in terms of psychiatric illnesses themselves, assumptions of severity and incurability have comprised the dominant perception.

Such images have been fed in no small part by the reality of the Japanese mental health care system, a system that is still burdened by a heavy reliance on long-term institutional care. The

fact is that a number of patients *do* enter locked institutions and are rarely heard from again. But images have also been fed by the fact that Japanese streets are so safe and behavior on them is otherwise so predictable. In other words, with unpredictability and disordered behavior being a hallmark of the psychotic state, it follows logically that the psychotic state would garner more attention in those environments characterized by order and predictability than in those environments in which order and predictability are not so expected. As evidenced by the low rate of street crime, by the trains' "running on time," and by norms of etiquette governing behavior towards strangers in particular, there is a level of predictability regarding public behavior in Japan that has been commented on by foreign visitors for decades. Psychotic behavior does not fit in with such expectations.

1. "Schizophrenia"

One of the primary goals of efforts to reduce the stigma of mental illness in Japan, then, has been to alter this image of the mental patient as an unpredictable, dangerous, severely disordered person who should be locked up because he poses such a threat to public order and safety. One of the prime players here has been Zenkaren, Japan's largest mental illness advocacy group (Zenkaren 2005). Staffed primarily by volunteering parents who have mental patients in their family, Zenkaren has worked over the past two decades to alter the face of mental illness in Japan. One of their chief campaigns during the past ten years has been to convince the government and the medical community to officially change the word for "schizophrenia." Though it took over ten years of talking with patients and patients' rights advocates, of consulting with leaders of the psychiatric community and of negotiating with legislators and bureaucrats, the

effort finally succeeded.⁴⁷ In 2002, at the World Psychiatric Association conference in Yokohama, leaders from the Ministry of Health, Welfare, and Labor announced that Japan was officially changing the name of schizophrenia (Asahi Shinbun 2002e). The old word, so the announcers said, contained too much baggage and too many inaccurate associations to be used further. The new word, coined by committee, was henceforth to come into official use in the effort to let people know that schizophrenia was no longer an illness that signified a debilitating condition for which hope was lost. The new word was designed to present a lighter image of mental illness, one that could reduce stigma and counter the long-standing associations between psychiatric illnesses and locked hospitals.

These efforts by mental health advocates are important for understanding the context in which depression is being normalized in Japan, for it would be unfair to suggest that shifts regarding public attitudes toward depression are operating in a vacuum. The shifts currently underway regarding the softening of depression's image are being boosted in no small part by the efforts of Zenkaren and other advocacy organizations that are working to reduce the stigma of mental illness more broadly speaking. Efforts toward normalization, therefore, are operating on different fronts; and even though they may be operating separately, they are nonetheless paralleling each other and aiming for similar, if not identical, goals.

In essence, Zenkaren's efforts to soften the image of schizophrenia by altering language as well as by their other efforts to alter actual treatment modalities contribute to the efforts by

⁴⁷ The old word was *seishin-bunretsubyou*, which translates as "split mind disease," but which connoted a severe and debilitating split in the personality and integrity of the individual as a whole person. The new word is *tougou-shicchoushou*, which translates literally as "integration imbalance syndrome." The new word connotes more of a treatable "condition" than an incurable "affliction."

GlaxoSmithKline and other makers of antidepressants because breaking down the association between psychiatry and “severe” mental illness, especially schizophrenia, is a necessary step in the campaign to create an image of depression as being, on the one hand, a psychiatric illness, but on the other hand, an illness that is not severe and debilitating. The shift in language that is underway regarding the words for “schizophrenia,” therefore, presents one pointed example of the connection between public attitudes and language. Words help structure perceptions, and many in the mental health care community are hopeful that shifts in language, such as that regarding schizophrenia, will succeed in shifting public perceptions on mental illness, thereby increasing the possibility of reducing stigma and improving care.

2. “A Cold of the Heart”

With mental health care advocates working diligently to alter the image of mental illness and reduce Japan’s reliance on institutional care, makers of antidepressants started promoting an image of depression as being a less-severe illness, one that anyone could come down with, and one that was treatable. Given that the term for depression was *utsubyou*, which, like the old word for schizophrenia, connoted a more severe condition, there was a need for linguistic modifications. Though it is unclear who coined the term, or even if one person or company coined it consciously, the fact is that one catch phrase in particular has caught on in the past few years. That phrase is *kokoro no kaze* [ko-ko-ro no **kah**-zay], which translates directly as “a cold of the heart.” In most of the newspaper articles and television reports on depression, *kokoro no kaze* will be mentioned at some point (eg. Asahi Shinbun 2002c). It is not used as a formal diagnosis, but merely as a casual euphemism. Nevertheless, the phrase has quickly become part

and parcel of the widening discourse on depression.

The phrase is notable for several reasons. First, a cold is something that anyone can get. The notion of depression's being something that anyone, as opposed to only those with "bad genes" or "bad families" can come down with, is key for normalization. Relatedly, colds are treatable; in contrast to the prevailing image of mental illness as something permanent. Second, there is no "*byou*" attached to the end of the word. In *utsubyou*, as well as with the old word for schizophrenia, *seishin-bunretsubyou*, the "*byou*" kanji helped connote severity, for only the more severe illnesses end with *byou*. But *kokoro no kaze* has no *byou*, and therefore has a softer feel to it. Third, *kokoro* contrasts with more standard psychiatric terms because *kokoro* is not a technical term, and it is rather ambiguous. It translates as "heart," but it connotes the more ambiguous, intangible side of the English "heart," rather than its physical side. In other words, it refers to essence, not organ. *Kokoro* is not the heart in "heart attack," but the heart in "my heart was broken." Relegating depression from the realm of the former to the realm of the latter has helped soften its image.

There is a tension, however, in patients' and clinicians' attitudes toward this notion of depression's being akin to a mere cold. Though some patients find comfort in the idea that depression is neither debilitating nor incriminating, others find in it a denial of depression's actual severity. In other words, some patients want depression to be taken more lightly, while others insist that it should not be taken lightly at all. As Dr. Ono explains,

Some of my patients don't like that phrase [*kokoro no kaze*]. They know that their condition is not like a little cold. In fact, after I was on TV two months ago, a lady wrote me a letter, and she said that her daughter had had depression and had killed herself. So, she didn't think it was right to talk about depression as if it were a cold. It's heavier, more severe than that (personal communication).

The conflict over the legitimacy of the phrase, then, reflects a wider tension regarding the way that people should be conceptualizing the condition. In a context in which stigma is strong and sufferers are unlikely to seek help, softening the condition's image is one way to promote help-seeking behavior. On the other hand, care must be taken not to trivialize the condition in the process of reconfiguring it. If the idea of depression's being some sort of trivial matter, like a mere cold, were to take hold, then stigma against it could actually *increase*. Peers may grant sympathy to someone suffering from a serious problem, and bosses may even grant days or weeks off work for it. But few peers and bosses would be so generous for something akin to a little cold.

Ultimately, however, I do not think that the situation in Japan is anywhere near the latter possibility. Stigma against mental illnesses of all types, depression included, are such that the likelihood of anything within the sphere of mental health care becoming trivialized, at least in the near future, is low.

In the meantime, *kokoro no kaze* is continuing to be used to introduce and explain a problem about which much of the population still knows little. Though no studies exist to determine the precise meanings that the phrase carries in the minds of individuals, its repeated use in public discourse suggests that it is indeed resonating.

3. "Counselor"

In terms of image, part of the baggage that psychiatry as well as the rest of medicine in Japan carries is that of the hierarchical doctor-patient relationship. Efforts within the medical

community to promote the concept of informed consent within its ranks have been strong, but medical rights advocates are still quick to accuse doctors of being paternalistic.

Psychiatrists, however, carry a double burden in that not only does the image of paternalism target them as well, but that image is tinged by the notion that psychiatrists suffer from psychiatric problems themselves. According to one clinician/informant, this image stems from Japan's reliance on institutionalization, in that it is often assumed that doctors, spending so much time in a locked facility with disordered people, themselves become slightly disordered. This image has not been helped by such scandals as the Utsunomiya Incident, in which doctors seemed to have "gone off" and beaten a patient to death. Another informant, also a clinician, suggested that the field of psychiatry simply attracts odd and eccentric people.

Such notions are not unique to Japan. One often hears similar rumors about psychiatrists in the United States. However, the criticisms regarding paternalism in Japan cannot be dismissed as mere rumor, for lawsuits have been won in the past few years on the argument that the doctor failed to abide by the principles of informed consent. Let it suffice, then, that progressive doctors these days are attempting to alter this negative stereotype of the paternalistic, insensitive clinician.

As mentioned in the last chapter, clinical psychology is a growth field in Japan. There are more counseling clinics than there ever have been; graduate programs are producing more and more clinicians; and the Japanese government is considering creating a special license for clinical psychologists so their services can become reimbursable under the national health insurance system. But interestingly enough, when I asked several "persons on the street," so to say, if they knew what a "clinical psychologist [*rinshou-shinri-shi*]" was, the answer was almost always

“no.”⁴⁸ When I asked if they knew what a “counselor [*kaunseraa*]” was, however, there was almost immediate recognition.

The clinical psychological community in Japan often uses the word “counselor” in lieu of the more formal title “clinical psychologist.” As one psychologist explained to me, this is due to their wanting to separate themselves from the image of a paternalistic, academic clinician and instead present themselves as they themselves indeed saw themselves, i.e., as accessible, non-hierarchical and supportive professionals outside of the medical apparatus.

“Clinical psychology” sounds technical, academic, and slightly off-putting in Japanese, according to my informants. But a “counselor” sounds like someone who is easy to approach and talk with. As one counselor explained,

When I introduce myself to people, especially at the school and the firm [she works part time at a school where she counsels students and at a large architectural firm where she counsels employees], the response is “Wow!”. “Counselor” means something new and good. I don’t think that the field of psychology even had an image five years ago, but today, it’s a good image. It seems that people appreciate what we are doing.

One problem with the term, however, is that individuals in other fields have also found useful its associations with accessibility and support such that there are now golf counselors, make-up counselors, aerobics counselors, and many others. But in spite of such terminological popularity, *kaunseraa* still has its mental health care meaning as its primary one.

Counselors are increasingly important resources for patients being diagnosed with depression because psychiatrists realize that these individuals oftentimes need someone to talk with. But, time is one thing that most psychiatrists have precious little of. Many psychiatrists,

⁴⁸ I went out to dinner on numerous occasions with clinical psychologists; and in many of those outings I would introduce them to the servers and then ask if they, the servers, knew what “clinical psychologist” meant.

therefore, are encouraging patients to seek out counselors, and this move by psychiatrists goes hand in hand with the fact that it is psychiatrists who are among those groups encouraging the Ministry of Health, Labor and Welfare, to license clinical psychologists so they can work officially as “medical care providers” proper.

Additionally, for those patients who do not view their problems as “medical” but who are suffering with those problems that a doctor would in all likelihood diagnose as depression, going to a counselor is a very workable solution. This is why counseling services are enjoying increased demand these days.

The point is that softening the image of the field of clinical psychology by the use of the term *kaunseraa* has contributed to the ability of clinical psychology to present itself as something distinct from the paternalistic stereotype that has haunted its predecessor and close associate, psychiatry.

In keeping with the resonance of the word *kaunseraa*, it is interesting to note that many counselors are working in *mentaru kurinikku* [mental clinics]. Though there are certainly words in Japanese that have been used since early Meiji to represent those places at which psychiatric services are offered, the designation gaining currency these days is a foreign word. Words like *mentaru kurinikku*, as *kaunseraa*, and indeed as many other foreign loan words, are usually adopted because they connote something that native Japanese words do not (Japan Times 2003a). In the case of these two words, the novel connotation is clear – it goes against the overall grain of psychiatric illnesses and their accompanying treatment as being something about which sufferers and their families should be scared. English loan words are acting as useful tools for helping soften the image of mental illness.

B. PSYCHO-DOCTOR



Figure 5 PsychoDoctor [DVD cover].
(copyright Nippon Television Network, 2002)

With a few examples of how language is being used to alter popular conceptions of depression and other components of mental health care thus presented, it is useful to delve more specifically into a single representation – in this case a television series – that brings many of these examples and concerns together.

In 2002, Nippon Television Network aired Japan's first-ever television series featuring as its main character a psychiatrist and featuring as its main theme the practice of psychiatry. In this

series, we have a snapshot of contemporary discourse on Japanese mental health care – complete with examples of the shifts in language and visual images currently underway.

The series was entitled *PsychoDoctor* [*Saiko-dokutaa*](Figure 5), and it centered on the practice of Dr. Kyouzuke Kai, a 30-something year old psychiatrist who lives and works in Shinbashi, a neighborhood of Tokyo. Aired in eleven prime time episodes, each episode dealt with a different problem: bulimia, multiple personality disorder, *hikikomori*, alcoholism, panic attacks, sexual abuse, and others (Nippon Television Network Corporation 2002). One episode was devoted exclusively to depression, and it centered on the struggles of a middle-aged salaryman who, along with one of his colleagues, was working under the threat of restructuring. The website for the series summarizes the episode as follows:

Banker gets help from Dr. Kai

A banker's health is deteriorating under the stress of having to pressure a subordinate into retiring due to restructuring. Dr. Kai's diagnosis is that the banker, Mr. Kitatake, has depression. Kai tells him to take some time off from work, tell his family about his condition so they can help him out, and just take it easy. But Mr. Kitatake won't listen. His body gets more lethargic and his energy continues to dwindle. He's suffering under the weight of having to follow through with laying someone off. However, to make matters worse, he is shocked to discover that Mr. Hayase, the one he must pressure into retiring, is himself suffering from depression (Nippon Television Network Corporation 2002).

I would like to examine parts of this episode in detail, for it reveals something about the questions many Japanese are having these days regarding depression. But first, here is a synopsis of the episode:

We are introduced to the patient, Mr. Kitatake, as he sits at his breakfast table, unable to concentrate on either the newspaper he's holding or the food his wife is trying to hand him. He looks sad, tired, and a little disheveled. His son tries to talk with him, but he does not respond.

At work, we learn that he is a *bucho* [section manager] at a bank and that his exhausted demeanor has followed him to work. He sits at his desk, seemingly unable to take interest in his responsibilities.

Distraught, he makes an appointment with Dr. Kai. We are then introduced to Dr. Kai's office – a dark and mysterious room. Kai sits upright and matter-of-factly behind his desk; Mr. Kitatake sits just to the other side. It looks more like a face off than a medical examination. Only a small desk lamp lights the otherwise dark room. The mood is ominous, as if this were a room for dark secrets.

After encouraging Mr. Kitatake to talk at length about his present state of affairs, Dr. Kai makes a diagnosis of depression, then explains that depression is often called a “cold of the heart.”

After hearing Dr. Kai's explanation as to what depression is and how it should be treated, however, Mr. Kitatake remains unconvinced. He views his problem as one of will, and so he leaves, determined to handle things his own way.

In the next scene, Mr. Kitatake's boss (one of the episode's “bad guys”) calls him in and orders him to pressure a subordinate, Mr. Hayase, into retiring. Mr. Hayase has been at home on medical leave for several months now, and, as the boss announces, his diagnosis is depression. The boss makes clear that there is no room for anyone with depression in his bank.

Mr. Kitatake is distraught. He didn't realize that Mr. Hayase was suffering from depression. Mr. Hayase is someone with whom he has worked side-by-side for years, and they have shared many happy moments. He cannot bring himself to fire him.

We next see Mr. Kitatake visiting Mr. Hayase at home, only to find a severely ill individual, in his pajamas, exhausted, and unable to function. He spends all day lying in bed, has no contact with friends or colleagues, and looks to be on the verge of death. His mother has been taking care of him, and she is terrified for his life.

We learn that Mr. Hayase has actually been seen by a doctor, however. The only problem is that the doctor, in keeping with the worst of stereotypes, diagnosed him after only a perfunctory, one-minute or so interview, and immediately put him on drugs that were inappropriate for his condition. In other words, the doctor knew very little about depression and even less about how to treat it. Yet, in keeping, again, with the worst of the stereotype, his arrogance renders him uninterested in either learning about or correcting his mistakes. He is the classic paternalistic doctor: behind the times, dismissive of informed consent, and dispassionate.

Mr. Kitatake returns to Dr. Kai, agrees to begin taking medicines, and goes home to announce to his family the news of his diagnosis. Sitting in the living room, with tears pouring, he confesses to his wife and son that he has been diagnosed with depression. It is the most intense scene of the episode. He apologizes, begs their forgiveness, and asks for their help.

In spite of his willingness to begin treatment, however, Dr. Kai has warned Mr. Kitatake not to get his hopes up too high, for some patients do not respond well to the medicines. Some start to feel worse; some experience side effects; and some feel euphoric at first only to feel suddenly worse shortly thereafter. As one

might expect – after all, this is a prime time drama – Mr. Kitatake proves the latter type. After an initial few days of renewed vigor, his condition reverses. He disappears from his house in the middle of the night searching for a way to kill himself, and the suspense builds as both his wife and Dr. Kai search desperately to find him. Finally, Kai finds him about to jump off a bridge; but just as Kai arrives, Mr. Kitatake climbs down off the guard rail, obviously having decided on his own not to follow through with his plan.

The next scene shows him crouching on the grass, on the side of a large soccer field, watching in secret as his son practices soccer. He realizes that his son gives him a reason to live, and it is this realization that initiates his recovery. From that point on, he starts exercising and taking long walks in preparation for starting to play soccer with his son. He's going to be fine.

Discussion

We can see several images and themes at work in this episode. The first and most important one is that the episode is dedicated to explaining what depression is all about. Presumably, this is necessary only to the extent that the viewing audience itself is unfamiliar with it. As proxies for the audience, Mr. Kitatake himself hears an explanation, followed by his wife's hearing additional details, then by the son's hearing yet more details. Together, the three explanations work together to present the standard biomedical model of depression to viewers. We are told that 1) that anyone can suffer from it, i.e. that it is not some rare condition that only severely disordered individuals get, 2) that it is often associated with workplace stress, 3) that it can be treated, but that some treatments, especially medicines, work better than others, and 4) that if not treated, it can become serious enough to cause people to commit suicide. In terms of his diagnostic skills and explanations, Dr. Kai personifies the best of contemporary psychiatry.

Two characters, however, represent those images that progressive psychiatrists are trying to overcome. The first is the character of the doctor taking care of Mr. Hayase – an older, paternalistic doctor who presumes to know much but in actuality knows very little. He is unaware of psychiatry's advances of the past few years, and he exhibits little compassion for

patients. He, along with Mr. Kitatake's boss, are the episode's "bad guys."

The second negative image still holding sway is represented by the character of Mr. Hayase himself, who symbolizes the more traditional view of depression, i.e. the view that depression is a very severe condition for which hope is all but lost. Mr. Hayase collapsed under the pressure of work and cannot seem to recover, yet no one is asking what his condition is all about. It is as if his condition, once diagnosed as depression, no longer surprises anyone. His boss knows about it and isn't surprised. His mother, though terrified, is not asking about what he is really suffering from. Mr. Kitatake himself, upon visiting Mr. Hayase, is disturbed but not surprised by what he sees. No one, then, seems curious about Mr. Hayase's condition. He has been diagnosed with depression, and as a result everyone seems to accept the severity of his condition as being natural. Obviously then, Mr. Hayase represents the older, yet still extant image of depression – one of a severely troubled person, unable to emerge from his room, incapable of doing almost anything, utterly dependent on someone else, with little hope for recovery, and on the verge of death.

Dr. Kai's treatment of Mr. Kitatake, however, shows that there is, now, a better way. And presenting this better way is the message of the episode.

The episode rests, therefore, on a sense of discovery. The thematic goal is to explain what depression "is," with the understanding that neither the patient – an educated and successful banker – nor his wife, son, nor even Dr. Kai's secretary (she too asks him what depression is when they are eating lunch together) knows much of anything about it.

On the surface, then, the episode flows like an extended pharmaceutical advertisement. But actually, this is not the case, for Mr. Kitatake's condition actually worsened after he started

taking medications, as Dr. Kai explained was indeed a possibility. What actually generated his recovery, then, was not medication, but an epiphany regarding his reason for living. He decided that his son and wife made his life worthwhile.⁴⁹ And the mechanism by which he put that epiphany into action was to get outside and start exercising more. This theme of getting out of the house and office and spending more time outdoors, enjoying nature, is one that is repeated in many of the discourses on depression, especially in the public testimonials of recovered patients (eg. Baba-san 2001).

A second element that goes against the episode's being a cheerleader for pharmaceuticals is the epiphany regarding the relationship with his company that Mr. Kitatake experiences after his realization that his son and family are his new priority. As mentioned earlier, the boss at the bank is the show's other bad guy. The boss represents the domineering company, one that just expects workers to passively accept being jerked around. But, in one of the final scenes, Mr. Kitatake pretends to hand over his own resignation note to the boss, only to withdraw it as the boss reaches out his hand to accept it. The boss had, before then, suggested that he would demand resignations from anyone dealing with a psychiatric problem. Mr. Kitatake's epiphany regarding why his life was now worth living had, then, a work-related component to it: no longer would he remain passive in the face of abuse. He decided to stand up for himself. This is not part of the biomedical model; but it is part of the total situation under an idiom of distress model. Workplace stress was the problem; not Mr. Kitatake's brain chemicals. He was responding normally to a painful stimulus. To help "cure" himself, he challenged the stimulus. This is not medicine. This is decision-making. This is guts.

⁴⁹ This is reminiscent of what Mrs. Ichi's doctor (chapter seven) advised her regarding her daughter.

A final element of the episode that goes against its operating as a proxy pharmaceutical ad is that Dr. Kai himself suffers from a psychiatric problem. In keeping with the stereotype of psychiatrists being a little odd themselves, Dr. Kai is a compulsive hand-washer, and each episode shows him in his bathroom scrubbing his hands, as he does dozens of times a day.

He has other quirks as well. Even though he is an expert on human relationships, he himself is a loner, slightly uncomfortable and humorously awkward even in those social situations that most people consider part of daily life. In short, Dr. Kai is a bit of an outsider as far as mainstream society goes. But his outsider personality gives him a sensitivity that helps him peer into the troubles of others who are feeling like outsiders themselves because of the various struggles, psychiatric and otherwise, that they are enduring. Therefore, in spite of his outsider status, or perhaps precisely because of it, Dr. Kai is a brilliant judge of character, a wise clinician, and an honorable man. Between his humanity and his clinical expertise, ultimately he gives an excellent face to contemporary psychiatry.

PsychoDoctor, then, gives us one example of a media representation that brings together much of the changes that are taking place in Japanese psychiatry today regarding the treatment of depression and related issues. Overcoming the image of depression as a severe and untreatable illness; normalizing depression by clarifying that anyone, especially salarymen, can suffer from it; challenging the hierarchical doctor-patient relationship; promoting standards of informed consent; emphasizing the need for clinicians to listen and give support; replacing a character model of depression with a socio-medical model; encouraging family members to get involved; developing the ability to say “no” to inappropriate workplace demands... all these issues are involved in today’s depression boom, and they were all represented in this one television drama.

C. UTU-NET

Another sight for an analysis of media representations is that of pharmaceutical advertising. Though most of the ads used in Japanese professional journals, i.e. those ads with physicians as the target audience, are identical with those used elsewhere around the globe, direct-to-consumer ads are tailored specifically for the Japanese audience. One example in which we can see this strategy in action is a website called *Utu-net* (*Utu-Net Committee 2004*). This was the first large-scale corporate-sponsored website for marketing depression in Japan, and it is still up and running. Though there is no mention of the sponsor on the site, it is actually affiliated with GlaxoSmithKline, which is the maker of Paxil, the first SSRI sold on the Japanese market. The site, therefore, has standing as both the first as well as well as the most sophisticated (in terms of visuals, content, status of celebrity endorsers, etc.) Japanese website dedicated to depression.

As will become evident with the examples featured below, the particular link between the needs to explain depression and to relate to Japanese consumers has resulted in a merger of suffering and cuteness. The message of depression provides the suffering; the medium of cartoons provides the cuteness. If Marshall McLuhan was right in suggesting that “the medium is the message,” then *Utu-net* demonstrates that Japanese marketers have been shrewd in nurturing depression’s entry into Japan by having it enter through a medium that resonates widely throughout the country. As Sharon Kinsella, Susan Napier and others have demonstrated, cartoons (or, *manga*, in Japanese) are one of Japan’s main public media, even among adults (Kinsella 2000; Napier 2001). Drug manufacturers have merely appropriated it.

Here are four examples of *Utu-net*’s use of *manga* to explain depression. The first two *manga* tell the stories of working men; the latter two of working women:

Case 1: Having made an appointment in advance, I went to the doctor (40-year old male).



Figure 6 Case 1: 40 year old male. (copyright Utu-Net Committee, 2005)

Top row, reading from right to left:

Box 1: I work at a so-called IT company. However,...

[Sign on building reads: “Company.”]

Box 2: One of his subordinates calls: Excuse me, Chief [section chief], my computer screen just froze up. It won't work. What's wrong with it?

Section Chief laments: My company has a lot of employees...

Box 3: He thinks: There are only a few people here who understand computer systems and can operate them.

He mutters: What is this?! This is supposed to be an IT company!

[Employees in the back are all calling “Chief!” to get his attention.]

Box 4: At home, in front of his own terminal, the chief thinks: Because I have to handle so many other people's problems, I never have time to get my own work done. Here it is 1:00 in the morning, and I've got a meeting tomorrow at ten. Ahhh!

Bottom row, from right to left:

Box 5: Lately, I've been dizzy, and my ear is ringing. It's really bad. I can't concentrate on work, and I can't sleep.

Box 6: It's too much! I want to go to a psychiatrist! But, I might have to wait to see him, and in

the meantime I'll probably get worse.

His wife asks: Are you OK?

Box 7: *Top: Wife says:* Why don't you look into calling the hospital. Maybe they can tell you if there's an opening.

He says: Yes, that's a good idea.

Bottom: Psychiatrist's office on the other end of the line says: I understand, how about 3:00 sharp?

Box 8: Without any delay, I had an appointment, and now six months have passed. Occasionally, I still get dizzy, but overall, I'm much better.

Employees at bottom chant: Chief, Chief, Chief!

(continued on next page)

Case 2: With just guts and willpower alone, recovery is unlikely (32-year old male).



Figure 7 Case 2: 32 year old male. (copyright Utu-Net Committee 2005)

Top row, from right to left:

Box 1: What? I'm being transferred?

Colleague says: You're being transferred and promoted.

Box 2: Suddenly, my worksite will change.

Box 3: [At the new office, following the transfer] I don't know anybody.

Boss says: Hey. Yeah, you. You're the one that's just come from Tokyo, right?

Box 4: He thinks: So, my boss is a woman. That's not a problem, but...

Boss says: I'm moving up in the world, got it? Don't think you can mock me just because I'm female. Heh, heh, heh [sarcastic laugh].

Bottom row, from right to left:

Box 5: [At dinner with his new colleagues] He sighs, then thinks: I just don't have drive like she does.

Boss says: See?! So young, but not the least bit ambitious, are you.

Box 6: No matter what, I just can't seem to mesh with this person.

Boss says: Ahh, I envy you, having worked in Tokyo as an up-and-coming elite. But I get the feeling that you're not going to make it out here in the boonies.

She thinks: I just expected something more (from him).

He says: Jeez...

Box 7: [Several months later] My stomach hurts. I can't sleep. I have no appetite. I don't want to go to work.

[Caption to the left reads: He's come down with depression.]

Box 8: [Caption to the right reads: With just will power and guts alone, recovery is unlikely.]

[Later, after starting treatment] He thinks, as he takes his morning medicine: Going to the hospital and continuing with treatment, I'll cure this.

Case 3: The first time I went to the psychiatrist. (28-year old female)



Figure 8 Case 3: 28 year old female. (copyright Utu-Net Committee, 2005)

Top row, from right to left:

Box 1: I don't feel like going to work.

Husband says: You better hurry or else you'll be late.

Box 2: One colleagues says: Lately that girl has been looking down, huh.

Other colleague says: Yeah, lately, she hardly talks at all.

She says: Talking to people is a real bother.

Box 3: [Caption reads: At home, she doesn't do anything.]

Husband says: Eh? You haven't turned on your computer? It's blank.

Box 4: Husband: You usually like using the internet. What's wrong?

She: I don't have any interest in anything.

Bottom row, from right to left:

Box 5: I don't want to read, don't want to watch TV.

Husband says: This is bad, you know. But these days, these problems are common.

Box 6: Husband says: Go to a psychiatrist!

She says: But I don't want to go to that kind of place.

Box 7: [At the psychiatrist's office] She gasps in surprise, seeing that the people there look so

normal.

[*Bolded caption reads: Very normal.*]

Box 8: [Talking with her husband after the appointment] My diagnosis was “mild depression.”

The place was not at all like I expected.

Husband says: Keep making your appointments. Don't miss any.

Case 4: Things are fine, now that I've seen the doctor (24-year old female).



Figure 9 Case 4: 24 year old female. (copyright Utu-Net Committee, 2005)

Top row, from right to left:

Box 1: [At home] One day, I realized just how tired I've been feeling.

Box 2: I do not want to go to work.

Box 3: Mother calls: Breakfast is ready. Hurry so you won't be late.

She answers: OK.

Box 4: [Caption reads: No appetite.]

I don't want to eat anything.

Mother: Eh?

Bottom row, from right to left:

Box 5: I do not want to go to work!!!

Mother says: Well, this is just "lazy disease." Now hurry up and go to work.

Father mutters: Your mother's right. I don't want to go to work either.

Box 6: [At work] She bursts out crying: Wahhhhh!

Colleague asks: What's wrong?

Box 7: [Ribbon reads: Doctor's office (one who specializes in psychosomatic conditions)]

Doctor says: It's a good thing you came early. You'll start getting better soon.

She says: So, what's wrong with me?

Box 8: [*Caption reads:* Somehow, I knew it was a mental kind of problem. It's good that the doctor helped me. His diagnosis was "depressive condition."]
[*In bed*] I'll be strong. I'll take some time off from work, and I'll feel better.

Discussion

The first thing to notice about these *manga* is that they are indeed cute. In keeping with the cover of *Let's Go to the Mental Clinic!* discussed in chapter one, cuteness is often used these days as a marketing tool to cut through the fear of mental illness. By virtue of its cuteness, *manga* offers a disarming and accessible genre, and so the makers of this website have chosen a medium that succeeds in presenting its message in a non-threatening, non-technical, anyone-can-understand-this manner.

Additionally, these particular *manga* are brightly colored and vivid, and the characters are quite charming. Combined with the brevity and concision of the messages, the visual impact of these *manga* is one that leads to a brief, pleasant, entertaining yet educational reading experience.

So, with accessibility achieved, what are the messages conveyed in these *manga*, and how do these messages relate to the broader issues of normalization, medicalization, and the viewing of depression as an idiom of distress? What do they say about social problems, about views toward the self, and about attitudes towards work? What are the main problems that these soon-to-be-diagnosed-as-depressed individuals are complaining of, and why does GlaxoSmithKline think that these problems, in particular, will resonate among readers? Do these problems suggest that the drug maker has “Japanized” depression to any degree as part of its marketing strategy?

Let me start by suggesting that the *manga* should be read as much for what they do *not* say as for what they do say. In the first place, there are no elderly patients represented in them. Given that elderly women have one of the highest rates of suicide, the fact that *Utsu-net* does not target them is notable. Perhaps it is due to the fact that so few of these women are using

computers, or perhaps it is due to the possibility that geriatric depression is still not widely diagnosed and therefore not considered by drug manufacturers to be a good potential market, at least not yet.

Second, there are no child patients. Computer use by children in Japan is high; therefore, it is more likely that their absence here reflects the fact that children are rarely diagnosed with depression or with any psychiatric condition for that matter in Japan.⁵⁰

Third, the focus on medicines is implicit – only one of the four *manga* mentions medicines at all. Though Japanese readers already consider there to be a direct association between going to a doctor and coming back with medicines, thereby making unnecessary an explicit reference to the fact that doctors in the *manga* are prescribing medicines, it is nevertheless true that there is little in these strips extolling the virtues of the medications themselves. SSRIs are not singled out by name, and nothing about them is explained. They are the hidden, back-stage character in these scenarios.

Fourth, there is no mention of chemical imbalances.

With these absences duly noted, we can then start examining what *is* presented in the scenarios. The first and most obvious observation is that each and every one of the characters presented is having workplace-related problems. And, they all work in similar workplaces, i.e.,

⁵⁰ Though truancy is now being dealt with by psychologists and psychiatrists, the trend of using psychiatric medications with children for behavioral or alleged psychiatric problems has yet to catch on in Japan to any degree approximating the norm in the United States (Sax 2003).

white-collar offices.⁵¹ Basically, the one message that comes across very clearly in all four *manga* is, “I do *not* want to go to work!” Though some of the other symptoms that characters complain of are included in the DSM-IV’s symptom checklist for depression, “not wanting to go to work” is not on the list. What we have operating underneath the surface, therefore, is the assumption that people *should* be wanting to go to work, and that if they don’t then it must be for one reason and one reason only: they are sick. This assumption gets stretched especially far in *manga #2*, in which the recently-transferred employee encounters a difficult boss, one who has an axe to grind with male transferees from Tokyo. It is doubtful that the man has had a history of depression or troubles at work or else he would probably not have received the promotion. What seems clear is that his new workplace situation is simply a difficult one. Yet, rather than do anything to challenge or correct that situation, he merely internalizes the problem, considering it to be his own fault, and this message is instantiated in the act of his complaints being interpreted by the psychiatrist as depression. To put it bluntly, the *manga* suggests that dealing with a difficult boss translates as having depression. In keeping with my comments in chapter two about how the word “disorder” directs our gaze at the individual, this *manga* directs our gaze away from considering the possibility of changing the situation at work and directs that gaze toward the individual as the sight of the problem. Ultimately, therefore, it is a pacifying gaze, one that promotes the passive acceptance of corporate power. Built into it is the assumption that workplace norms are not to be challenged.

⁵¹ There are no characterizations of artists, teachers, small-business owners, blue-collar workers, or other types of workers other those of mainstream, middle-class corporate employees working in an office.

What does the fact of these characters not wanting to go to work say about workplace norms in Japan right now? Why would that complaint in particular be resonating so well? I suggest that the answer is simple: that depression is working well as a gloss for workplace stress – a problem that, in this era of worsening long-term economic prospects, is affecting a greater number of Japanese citizens. These *manga* demonstrate the medicalization of those feelings about the workplace. That being said, however, I do not wish to criticize the website for any sort of manipulation, for the desire to medicalize workplace disenchantment and stress is being welcomed by many individuals struggling with those problems. For individuals who are working for bad bosses, who find themselves in unchallenging or inappropriate jobs, or who for whatever reason are dreading going to work each day but who have not found any other option especially given the difficulty of shifting to another company after a certain number of years on the job, finding any sort of assistance is a good thing. If they do not find any assistance, then, as the suicide rate and the *karoushi* cases show, many Japanese workers will simply work themselves to death. Ultimately, then, it is not that drug manufacturers are pressuring citizens toward one particular solution. Instead, it is that there is a need for solutions, and drug companies have been shrewd in putting their solution in the public eye, only to see it being welcomed with open arms.

There are any number of other situations that could be generating depression and stress and that, therefore, could provide the set-up for these *manga*: bereavement, financial problems, raising children, taking care of elderly parents, having a bad marriage, studying for university admissions exams, domestic violence, workplace discrimination against women, loneliness, growing old... the list is endless. But these ads emphasize one particular source of stress, and I

suggest that this emphasis tells more about where Japanese society is right now than about chemical imbalances in the brain.

D. TELEVISION COMMERCIAL

GlaxoSmithKline has pioneered not only the use of the internet for marketing antidepressants and raising public awareness about depression in Japan, but television as well. In September of 2002, the company began running Japan's first-ever television commercial targeting depression. It was a 30-second clip that featured testimonials from three patients.⁵²

The commercial opens with a businessman who looks in his late 30s or 40s, is nicely dressed in suit and tie, and is sitting casually on a sidewalk bench along a canal downtown (Figure



Figure 10 (copyright GlaxoSmithKline)

⁵² The patients were not celebrities or other well-known individuals, and their names were not given. Therefore, whether they were actual patients or actors is not specified.

10). Skyscrapers line the background, and a beautiful blue sky provides the backdrop. In reality, this location would usually be filled with throngs of people, especially on a nice day like this; but in the commercial there are no people around. He sits, unbothered, seemingly enjoying the nice day. In a casual, confident, pleasant manner, he says, “Basically, my body felt heavy, so heavy that I thought I wanted to sleep; but, I couldn’t. I also had completely lost the desire to do anything.”

The screen cuts to an image of a blue sky with wisps of clouds, with a caption reading “Depression stories [*utsu no hanashi*]” (Figure 11). However, the word used is *utsu*, which is a derivative of the standard word for depression, *utsubyou*. Removing the *byou* removes some of the term’s heaviness. The meaning of *utsu*, then, lies somewhere between “depression” and “feeling down.” Additionally, *utsu* is in quotation marks, thereby suggesting either that its



Figure 11 (copyright GlaxoSmithKline)

meaning is ambiguous, is not known by the viewing audience, and/or that the commercial is precisely going to establish its (new) meaning.

In the next scene, we see a young man, perhaps in his 20s, dressed casually in an orange t-shirt and sitting in what looks to be his home (Figure 12). He sits in front of a large window, through which we again see a beautiful blue sky. He says, “I didn’t know that what I had was *utsu*. I was struggling all alone, and I rapidly started going downhill [*ochi-konjau*]. But, after meeting with a doctor, I realized that’s what I’d needed.”



Figure 12 (copyright GlaxoSmithKline)

We next see a pretty woman, perhaps in her 30s, standing outside, with a background of apartment buildings and, again, a blue sky (Figure 13). She says, “Having gone to the hospital, I was really relieved. I got some medicine, and before you knew it, I was OK.”



Figure 13 (copyright GlaxoSmithKline)

The commercial then shows the sky screen again, on which is written telephone contact information and a website address. Lastly, we see the woman again, this time in a close-up, as she smiles (Figure 14). The caption reads, “If sickness, there’s medicine.”



Figure 14 (copyright GlaxoSmithKline)

Discussion

Using Kress and von Leeuwen’s tools for a semiotic analysis (Kress and von Leeuwen 1996), we can dissect the commercial in terms of the way it uses visual imagery to convey its message – a message from which we can learn about how GlaxoSmithKline is using the social construction of depression as part of its marketing strategy.

Kress and von Leeuwen suggest that “visual communication is always coded,” meaning that decisions regarding which objects to include, where in the screen objects are positioned, how they are framed, what colors are involved, where the characters are directing their eyes, how much distance there is between object and camera and so forth all work as items in a code. As

part of a code, their meanings can be decoded. Kress and von Leeuwen have suggested ways to go about that decoding process.

In terms of a brief summary of their method, Kress and von Leeuwen divide visual representations into two components: narrative elements and conceptual elements. Narrative elements include what the actors say and do. Conceptual elements include the visual elements providing the physical context of the characters' actions and words. Narrative elements may include who the actors are (male, female, young, old, etc.), whether the actors are sitting or standing, moving or being still, how they are positioning their hands, whom they are talking to, their facial expressions, etc. Conceptual elements may include the setting, the time of day, the weather, background music, clothing, camera angles, the number of times the camera angles change, the colors included in the scene, the fades from one image to another, and so forth. Together, narrative and conceptual elements work together to convey meanings.

Using Kress and von Leeuwen's language of visual representation, then, we can make the following observations about the depression commercial. First, the choice of characters reveals to us GlaxoSmithKline's target audiences. In contrast to the dominant image of depression in the United States as being the middle-aged, married, middle-class white woman (Metzl 2003:11-13), this commercial does not present a single representative individual, but three different individuals. This would suggest that there is no single dominant image of "the depression sufferer" in Japan. We can, however, assume that the first character introduced in the commercial, the one that must grab viewers' attention by immediately establishing legitimacy, would be one of, if not *the* most dominant of images. In this case, we have the image of the middle-aged businessman.

He is placed in the lower left of the screen. According to Kress and von Leeuwen's analysis, the place on the screen where an object is positioned conveys meaning. Objects positioned on the left represent what is "given," i.e. things that are already established, predictable, non-surprising, and part of the everyday world. Objects on the right, on the other hand, represent the "new," i.e. those things that viewers are supposed to be introduced to and the direction toward which conceptual shifts should be going. Objects positioned on the bottom represent the "real," those things that are well-grounded and concrete. Objects on the top, however, represent the "ideal," i.e., the aspired to, the aimed for (Hanganu-Bresch 2004).

Not only is the businessman positioned in the lower left, but all of the three characters in this commercial are positioned in the lower left, with the message being that these are existing characters that viewers should be very well-acquainted with. In other words, these characters are typical – viewers are already familiar with them.

But even though the businessman is positioned in the lower left, the object that takes up the bulk of the screen is the sky – a big, blue, cloudless sky on a beautiful day. If the top-positioned object represents the "ideal," then the prominence of the sky suggests that the ideal, the aspiring to the clarity and beauty of the big blue sky, is what the commercial is after. So, though the narrations by the characters concern the past, i.e. though in words the message is one of looking back, the visuals present a counter-narrative of looking forward, away from the real and toward the ideal. This, then, is an optimistic message – "the sky's the limit."

Also, behind the businessman lies an urban skyline: a row of tall, downtown buildings. This is a corporate world, and he, presumably, is part of that world. Therefore, we have the

message, expressed through his suit and the buildings, that there is a link between the corporate world and depression.

The next scene, however, differs significantly. Here, we have a young man, dressed not in a suit and tie but in a casual t-shirt, sitting, presumably, in his home, positioned next to a stereo speaker, in front of a large window, with one of the panes open. Linking to the previous scene, a big blue sky which we see through the window fills the background. But why is he sitting inside his home, as opposed to any number of other settings in which he could have been placed? He is obviously not being associated with the world of work, for his casual dress and his placement at home do not hint of anything business-related. At that age, one might expect him to have a job already. But actually, in Japan these days it is common for young men that age to be resisting the prospect of climbing onto the salaryman conveyor belt as their fathers did. In the most extreme version of this resistance, we see *hikikomori*. Though I do not know if GlaxoSmithKline actually had *hikikomori* in mind while conceptualizing the scene, it seems nevertheless clear that this scene, in contrast to the others, is emphasizing being on the inside, at home, not in the corporate world, and being casual and enjoying one's personal freedom, as represented in the young man's listening to his stereo system. What we have here, then, is the image of a young man who has not yet ventured out, but who is perhaps now ready to do so given that he has discovered how to deal with his depression. With his depression under control, the window is literally now open, leading to the outside world.

The third image is that of a woman. In contrast to the fact that most ads for antidepressants in the United States have featured images of women, this commercial only allots

one-third of its attention to women. This reiterates my earlier observations about depression's not being primarily a "woman's disease" in Japan.

This woman is identified with domestic life. There are apartment buildings behind here, representing home, and she is standing in front of a yellow piece of playground equipment. In combination with the tree that frames the right side of the screen, it appears as though she is standing in the middle of one of the thousands of small neighborhood playgrounds located throughout Japanese cities and in which one can on any nice day see women talking together as they watch their children playing.

With the bright blue sky again in the background signifying aspiration, the message seems to be that this woman is happy to be where she indeed should be, i.e., in the playground, thus either returning to being a good mother or perhaps now being ready for motherhood.

Putting these three characterizations together, we see that the commercial is building upon recognizable "types," as if depression had been typecast. If conveying a straightforward biomedical message about SSRIs were the point of the ad, there would be no need for characters at all, but the point is to resonate with people's existing understandings of who is in need of help, with the goal being to stimulate the target audience into action by having them identify with the personas presented in the commercial. In other words, the commercial shows us 1) who the Japanese are associating depression with and 2) who of those so identified are the most sought-after target audience for buying antidepressants.

We must also analyze the commercial in terms of those elements that are absent, for there indeed are several. First, there are no doctors. Though the characters mention the fact that going

to the doctor prompted their recoveries, there are no images of doctors or of clinical settings. Secondly, there is no mention of the word “psychiatrist.” Instead, the general term “doctor” is used. Third, there is no mention of the drug, Paxil, that this commercial is promoting. It is as if the designers wanted to minimize the reality of the medical treatment process – its people, institutions and methods – and merely skip forward to the desired outcome of that process: the happy individual. Perhaps GlaxoSmithKline wants to bypass the actual use of psychiatrists altogether. Or, perhaps they want to merely bypass whatever images in the minds of viewers the mention of psychiatry might generate. Whatever the motivation, the net result is that there is a conception of healing here that minimizes the interaction between clinician and patient as well as the time required for healing to take place. It is as if healing were almost automatic, immediate and effortless: “I just went to the doctor and, voila!, I got better.”

Lastly, there are no people around the characters presented here. The characters are not presented as social selves, but as independent, autonomous selves. Each is presented alone, even though the businessman and the woman are each set in places that would ordinarily be bustling with people. Perhaps the message of this is that the experience of depression is at its core an individual experience, as opposed to a social one, or, perhaps, that the aimed-for state is an individual one, as opposed to a social one. Whatever the case, the individuated characters call into question the ideas of the “ideal” Japanese self as being a social one. If this were indeed the case across the board, then would we have not expected the post-treatment image of the recovered sufferer, the restored individual, the one made whole and well again, to be one who was now fully engaged in the social context? But even the woman, presented as she is in the

playground, is not interacting with any children. She, like the men, is presented as a representation of the individuated self.

In sum, the commercial conveys several messages, through several strategies, about the social construction of depression in Japan circa 2002 either as the main producer of SSRIs there sees the situation and/or as it wants viewers to see the situation. First, in terms of the depressed patient, the emphasis leans slightly more toward men than women, in contrast to the norm in the United States. Additionally, among the men presented, there are two main types being suggested as those most susceptible: the middle-aged businessman and the younger man who is closer to the world of home and play than the world of work. Second, depression is something that need not remain in the dark; it is OK to bring the discussion literally into the light of day. This transition is helped along by depression's being downgraded, from *utsubyou* to *utsu*, such that we are no longer talking about a severe illness, but a milder condition. Third, recovery from depression need have only minimal contact with the medical industry, and indeed none at all with psychiatry. GlaxoSmithKline, then, has created a sophisticated commercial that combines, on the one hand, personas that will be considered believable by Japanese viewers and, on the other hand, expectations for recovery that the company wants viewers to buy into. It offers, then, a promise, grounded in common sense, and it makes that promise to particular types of individuals who are commonly viewed as needing help.

I will close with a reminder, however, that this is a television commercial, designed to market a product. Therefore, though it may reveal much about the current state of discourse on depression, it is also a sales pitch, designed more to influence behavior than present facts.

When it comes to a discussion of the factual basis of the impression the commercial was trying to convey, I found several doctors who were not pleased. One doctor spoke especially candidly about it:

KV: What did you think of the GlaxoSmithKline's new commercial for depression?

Dr.: One of my patients saw it and said he wanted to break the TV.

KV: Why?

Dr.: Because, one, the patients don't look like patients at all. They're too positive and bright. Two, because one patient on the commercial said she was "relieved" to go to the hospital and get medicine. It made it look as if she went to hospital once and got immediate relief. It's unrealistic.

KV: What was *your* view of the commercial?

Dr.: The tone of the commercial is not depressive. It's too light. The people on there look too normal. They look supernormal!

KV: Why do you think they [GSK] made it that way?

Dr.: Maybe they wanted people to think that depression wasn't a big deal, that if people just took some medicine, then all the symptoms would just disappear, like it's not a big deal.

KV: But isn't that a good thing?

Dr.: I don't think so. I think there's some denial in that commercial. Like "a cold of the heart." This phrase tries to play a trick on people. Real depression is more serious than some cold. So, I would've liked if they had presented people who actually looked more depressed.

This psychiatrist sees a minus side to the idea of normalizing depression if that normalization comes at the cost of accuracy. However, to what degree should we demand accuracy in the impressions that pharmaceutical advertisers are striving to create? And, should governments even allow direct-to-consumer advertising for pharmaceuticals in the first place? Though these are both important questions, they go beyond the limits of this study.

To give credit for GlaxoSmithKline's advertising strategy where it is due, though, I will close by noting that, in spite of any criticisms the commercial may have garnered from clinicians or patients, Paxil remains today the best-selling antidepressant medication in Japan. Sales in 2003

alone, the year after the commercial started airing, topped \$298 million, and forecasters are optimistic about its future (Schultz 2004).

E. CONCLUSION



Figure 15 Aera magazine cover: Shokuba no utsu (Workplace Depression).

The above image is the cover of the December 8, 2002 issue of *Aera*, one of Japan's most widely-read news and pop culture weeklies. The title reads, "Workplace Depression" [*Shokuba no*

utsu], and the entire issue is devoted to examining the increasing prevalence of depression among Japan's corporate workers. With the lead article entitled "Returning to work" [*Shokuba ni modoru*], and with other articles such as "An account of my depression," "Secrets for overcoming depression: words from the wise," and "Don't feel stress," the issue reads as much as a self-help guide as it does a source of news and commentary. The cover art, however, sums up much of what is contained therein. It depicts a white shirt with a band-aid affixed to the pocket. It is a magnificently concise summation of the state of discourse on depression.

The shirt belongs to a male worker in Japan's corporate labor force. White shirts have been one of the main symbols of Japan's so-called "salarymen" since the post-war era. Therefore, the image of depression presented here is that it is associated with men, and especially white-collar working men. Additionally, the shirt is clean and perfectly ironed. So, the owner of the shirt does not appear unkept, troubled, unstable, or in any way abnormal. He, on the surface at least, is performing well. He keeps up appearances, sticks to his routine, fulfills his obligations, does not let on that anything is wrong.

The band-aid, of course, is at the heart of the matter, for it is located over the heart of the matter, literally. This is a heart that needs some help. But, by virtue of the help's coming in the form of a band-aid, one can conclude that the problem was ultimately not all that severe after all. Band-aids are not for major problems, just minor ones. And there is no blood seeping through, for this has been a painless recovery. Nothing to be afraid of.

Why is the band-aid not placed on the man's head? After all, is depression not a "mental" problem? Biomedical psychiatry asserts that it stems from a chemical imbalance in the brain, not

the heart.

The image here presented, without a head or face to personalize it, is of a problem that can affect anyone, especially anyone who wears a white shirt to work. Depression, therefore, has become generalized. It is not just a small and narrowly defined group that is vulnerable, but much of the nation's corporate workforce.

Lastly, the image contains no sign of medicine, nor of doctors. The image speaks reservedly, then, as opposed to jumping ahead and recommending a particular medicine or other form of treatment. It is condition-oriented, not drug-oriented. It is merely taking a first step to call attention to the "Everyman" aspects of the condition, then taking a second step to suggest that the condition is something a band-aid can handle. I suggest, therefore, that the image is one of description and assurance: describing a problem in terms of its widespread prevalence and then assuring everyone that the condition is not so severe. In putting these two points together, *Aera* offers a beautifully orchestrated image of normalization. This image and the articles that accompany it all strive to normalize workplace depression.

I have indulged in this bit of visual analysis because I myself think that this image sums up much of what is going on in the public sphere regarding depression. As the other accounts in this chapter show, journalists, doctors, drug companies, and patients themselves are striving to discuss depression as if it were something that does not speak of "abnormality" either in the statistical or judgmental sense. The message is that "normal" people are increasingly coming down with depression and that the condition itself is as normal as, say, a cold.

To make such a claim, however, some older images have to be either corrected or discarded. After all, psychiatry in Japan has been, and to a great extent still is, associated with long-term hospital stays and severely disordered patients. To suggest that a “psychiatric illness” is one that need not require long hospital stays and one that need not imply insanity requires some re-conceptualizing. This is precisely what is taking place in Japan, and a great number of clinicians and observers assert that it is a process long overdue.

Though it is easy to conclude that the process of normalizing depression in Japan is merely one of pharmaceutical manufacturers convincing the public that drugs are the answer, one must also keep in mind what this effort represents vis-a-vis the current mental health situation. Currently, that situation is one of a high suicide rate, an increasing number of individuals dying from overwork, a hesitancy to seek out professional assistance, and an extended economic stagnation from which few anticipate a recovery anytime soon. If drug companies, doctors, and journalists are guilty of over-simplifying depression in the public sphere, it is because the road ahead of them is so long.

SSRIs entered a U.S. market that had a long history of hoopla over psychiatric miracle drugs. As a result, popularizing Prozac, though certainly laudable from a marketing perspective, was made easier by that particular history. Americans were already familiar with depression, with other not-necessarily-severe psychiatric conditions, and with the idea of taking medications for those illnesses. A great many personal problems, therefore, had already been psychiatrised and psychologized.

In Japan, on the other hand, pharmaceutical advertising has many more hurdles to clear: fear of psychiatry and institutionalization, low public awareness of Freudianism and other clinical psychological theories, distrust of Western medicines, an assumed correspondence between “mental illness” and schizophrenia, a tendency to associate workplace stress with lack of drive and perseverance, and a respect for silent suffering. Should pharmaceutical companies overcome these hurdles such that there arises a risk of “cosmetic psychopharmacology” regarding SSRIs in Japan, then we can conclude that Japan’s depression boom has become merely a second Prozac Revolution. But most clinicians that I talked with think that that is unlikely to happen any time soon, precisely because the above-mentioned hurdles will not be cleared so easily.

Until then, we certainly have the attempt to clear those hurdles, and this chapter shows several examples of how that process is taking place. With language, we have the adoption and popularization of several new words. These are words that break loose from the image of mental illness as being something scary and untreatable. With television, we have new ground being broken with the airing of Japan’s first series revolving around a psychiatrist’s clinical practice and with the series’ makers striving to give accurate information about current treatments for clinical conditions. We also have the first television commercial for SSRIs. Additionally, the internet has become a primary site for public dialogue about depression. Though this chapter only featured one website, there are several other Japanese websites and chatrooms devoted exclusively to depression, with most of them being run by sufferers themselves. Newspapers and other news outlets are also paying attention to depression, thereby conveying a message that depression has become a public health issue. This has no doubt been spurred on by the suicide rate, but

increasingly there is a sense that at least some of these suicides can be prevented, if people only discover the truth about what depression is and how it can be treated. In sum, public images about depression suggest that a shift is taking place in terms of how the public is viewing and talking about depression and other mental illness and that this shift is guided, in large part, by good intentions, i.e. to let sufferers know that they are not alone, that they are not crazy, and that there is help available. Though these messages may seem cliché to Americans long used to Prozac Nation and the ever-prolific self-help industry, they are indeed very new to a great number of Japanese.

X. CONCLUSION

Yes, as far as the planting of new ideas about depression and SSRIs and counseling and many other aspects of mental health care, Japan is very fertile ground.

Andrew Grimes, counselor

So, is Japan “becoming depressed”? And is depression becoming normalized as a result? The data suggest that an increasing number of individuals in Japan are indeed being diagnosed with depression, that a large number of those are being prescribed antidepressant medication, and that depression is becoming an increasingly important topic of public concern. I suggest, therefore, that depression is indeed becoming normalized in Japan.

But there are other questions that undergird that of whether or not depression is catching on in Japan, and those questions operate along the lines of “why,” “how,” and “to what end.” I hope that the previous chapters have put forth plausible answers to these questions. Admittedly, however, no answers are definitive precisely because the process is so new and still underway such that a truly historical perspective is thus far impossible to achieve. Instead, I have attempted to paint as thick a picture as I could of the current moment, with the goal being to demonstrate the socio-economic, ideological, biomedical, and psychological factors that all converge on the question of why an increasing number of individuals are becoming diagnosed with depression and being prescribed SSRIs.

I suggested in chapter one that the historical process underway involves several transitions: 1) the shift from institutionalization as the dominant model of mental health care toward a search for alternatives, 2) the shift from stoicism and silence toward a more open acceptance of the expression of negative emotions, especially those that we might characterize as “calls for help,” 3) a shift from the sense of security as generated by the extended postwar period of economic productivity to a sense of insecurity and malaise as generated both by an extended period of economic stagnation and restructuring and by the prospects for an ever-graying society, 4) the medicalization of depression, but a medicalization that steers clear of implicating genes, and 5) the normalization of depression, i.e. the reframing of depression as something that can anyone and everyone can suffer from, that is treatable, and that is therefore not a sign of “mental illness.”

The process of Japan’s “becoming depressed” and welcoming SSRIs, therefore, is not merely the story of pharmaceutical marketers entering a new territory and spreading the word about a novel treatment. To be sure, pharmaceutical marketing has been a major, if not *the* major catalyst for change. But Japan’s “becoming depressed” is a bio-social process that encompasses more than just a marketing success story. It involves the history of mental health treatment modalities; normative values regarding the expression and experience of emotions; the disruptions caused by the combined losses of financial stability, cultural pride and hope; and the onus of having to search for alternative ways of dealing with the stresses that are increasingly wreaking havoc with people’s lives.

But lest this sound overly-gloomy, the story is also one of progressive individuals in the mental health care field, in government, and in the advocacy community striving to develop the

treatments, alter the social norms, and construct the legislation necessary for helping struggling people manage their problems. In my opinion, these individuals receive too little attention in the English-language press. Indeed, it has become a pattern since 1999 to report on the suicide rate and conclude that Japan is “Suicide Nation” and that people are not getting the help they need because mental health care is still in the “Dark Ages.” Granted, the suicide rate is high, and the mental health care system has significant problems. But reform *is* underway, and the increase in the rates at which people are utilizing mental health care demonstrates that the system is providing at least something useful for those consumers. The growth in clinical psychology is perhaps the most dramatic representation of this. In a nation struggling with low economic growth and increasing medical expenditures, the government is poised to actually increase its funding of mental health services by implementing a licensing system for clinical psychologists, thereby allowing their services to be covered by national health insurance. Therefore, unlike some other countries, one is hard-pressed to conclude that policy-makers in Japan are turning a blind eye to mental health needs.

SSRIs entered Japan when the stresses of restructuring were starting to take their most dramatic toll. In the same year that SSRIs were authorized for use, the suicide rate topped 30,000 for the first time. Therefore, it is hard to establish whether the increase in use of SSRIs represents a wave of its own making, or whether the timing was such that SSRIs happened to catch an existing wave (a wave of need) at exactly the right time. Either way, the result is that SSRIs have become big business in Japan and pharmaceutical makers are optimistic about that business’s future.

But does it appear that SSRIs are being used and perceived in the same way in Japan as they have been in the United States? This dissertation suggests not. SSRIs in the United States are not merely a medical phenomenon; they ended up achieving celebrity status, with Prozac's becoming a household word. Not many drug names achieve household word status, but Prozac did it in just a couple of years, with the result being the so-called "Prozac Revolution."

The Prozac Revolution simply means the overwhelming popularization of SSRIs in the United States, complete with hundreds of thousands of people taking the drugs, with many of those people reporting positive results, and with media taking notice of the popularity. Supposedly, Prozac "revolutionized" the way depression and perhaps by extension other mental health problems were perceived and treated. But there was actually a history of placing great hope and faith in psychiatric and other pharmaceuticals in the United States, with Valium being the last one prior to Prozac. So, Prozac had a historical wave that it caught in the United States as well, but one of a different type.

But what began the doubts and criticisms about the Prozac Revolution was the possibility that SSRIs had, in essence, become too successful, that they were being prescribed to people who really were not suffering from depression, and that they were helping these people achieve a state of confidence more in lines with a high-powered corporate culture. Articulated first by psychiatrist Peter Kramer in *Listening to Prozac*, the possibility of SSRIs becoming more a matter of "cosmetic psychopharmacology" rather than a depression treatment narrowly defined became the ethical question that has nipped at American psychiatry ever since.

Since then, however, new doubts have been raised: about the medication's effectiveness, about its causing suicidal ideation in teenagers, and about the legitimacy of the idea that has come to permeate much of American psychiatry, i.e. the belief in the "chemical imbalance." Though most ads for SSRIs and other medications for depression and anxiety say that the cause for the conditions are "chemical imbalances," some critics call attention to the fact that there is no laboratory test or other method that has established the existence of the alleged chemical imbalance. In other words, the critics say that the chemical imbalance is a theory, not a fact, but that it is a theory presenting itself as fact and that in the process other theories as to what depression is and how it should be treated are sidelined. In short, critics suggest that representing the problem as a chemical imbalance narrows the clinical gaze by funneling research and discussion all toward chemical treatments.

Lastly, as mentioned earlier in the dissertation, one new book by psychiatrist Jonathan Michel Metzl has demonstrated that another problem with the Prozac Revolution and the entire modern history of depression has been that it has been so gendered (Metzl 2003). Starting with early work by Freud, Metzl traces the history of the American mental health care community's instilling the discourse on depression with traditional and somewhat stereotypical images of American womanhood, especially as played out in the life of the middle-class, middle-aged white woman. Basically, then, Metzl shows that depression has for years been the site of discourses about womanhood as much as a site for discourses about mental illness.

Does the American experience matter in terms of understanding what depression is meaning these days in Japan? Clinically, I do not think so, for clinicians are responding to patients

and their needs as they present themselves in the clinical environment. What happens in American offices and what has happened in the American press is, for the most part, not a major concern of either Japanese doctors or patients. Their plates are already full enough.

But from a social scientific perspective, any differences between the historical trajectory of depression in one country vis-a-vis another country can suggest to us that, as those in the social science of medicine are quick to point out, medicine is to a large degree a social science. If “depression” means one thing here and another thing there, then perhaps this difference suggests that “depression” is not as valid an entity as the biomedical and pharmaceutical communities would prefer. It is for this reason – for calling into question the degree to which “depression” is a thing, out there, that can be diagnosed the way polio can – that cross-cultural differences are important.

So, this dissertation concludes that there are differences between America’s Prozac Revolution and Japan’s “Depression Boom” and that these differences question the validity and usefulness of the term “depression.” In terms of the key differences between the two cultural contexts, I will arrange my observations in the following table:

Table 1 America’s Prozac Revolution vs. Japan’s Depression Boom

America’s Prozac Revolution	Japan’s Depression Boom
Drug-focused	Condition-focused
Feminized	Masculinized
Fear of overuse via cosmetic psychopharmacology	Fear of underuse due to stigma against mental illness
Chemical imbalance	Stress
Narrowing the clinical gaze	Widening the clinical gaze

First, the Prozac Revolution in the United States was drug-focused in the sense that the drug itself was at the center of attention. Comments about “happy pills,” about how the drug was capable of altering personalities to the point that cosmetic psychopharmacology could be envisioned, and about the overall effectiveness and safety of the drug comprised the heart of the matter. Given America’s long history of thinking about and striving to create so-called “miracle drugs,” this drug-orientation should come as no surprise. But in Japan, it is not the drug but the condition itself that is garnering attention. Most of the discussion focuses on the suicide rate, on *karoushi*, and on the fact that individuals simply seem to be dealing with stresses that they are ill-equipped to deal with. The discourse, therefore, is more about sympathy with sufferers and with suffering than it is about hope for a wonder drug. Quite the contrary, with the memory of pharmaceutical scandals still on the minds of many in the Health Ministry, the medical community and the general population, there is an overall caution used when considering the importation of new drugs, especially strong ones, and especially strong ones from the West.

Second, whereas America’s Prozac Revolution and most of the 20th century discourse on depression in the United States has focused on women, and as antidepressant medications have been prescribed two-to-one to women over men, the situation in Japan is slightly different. There, the salaryman has become the primary (though not the only) image of depression. As shown in chapter nine, the marketing for antidepressants as well as the images of depression in news and entertainment have mainly been of men. Additionally, though the data is only anecdotal, it appears that SSRIs are being prescribed in Japan either at about equal rates for men and women. This slight masculinization of depression mirrors the reality of Japan’s suicide rate, in which the

majority of those killing themselves are middle-aged men, and the largest growth in suicides since the early 1990s has been that among middle-aged men.

Third, critics of the Prozac Revolution are concerned about the possible overuse of medications. This factors into the questions about cosmetic psychopharmacology. But in Japan, with its history of reticence regarding the use of psychiatric care except only regarding schizophrenia and other more severe illnesses, and with there being a continuing problem today of individuals needing mental health care resisting the idea of getting such care, Japan's problem is not one of using SSRIs on people who don't really need them, but of getting SSRIs and other forms of assistance to those who do need such assistance. Again, the primary bit of data in this regard is the high suicide rate. Perhaps, in a few years, the possibilities of cosmetic psychopharmacology will become reality in Japan; but at this point at least, the opposite problem is at hand.

Fourth, there is little discussion of chemical imbalances in Japan, and I posit that the reason for this harkens back to Andrew Grimes' comments about the sources of stigma. There is a longstanding notion in Japan that mental illness is a genetic matter, that it runs in families. This is precisely the reason that my friend, the match-maker, was required by her clients to investigate the medical backgrounds of potential matches. If one person was affected, it was assumed that others in the family were affected and that any future children would also be affected. Therefore, most Japanese who are struggling with psychological problems do not want to hear that the problem is genetic, for it implicates the entire family and hints of a problem that has no solution, i.e. that it is built into the physical constitutions of the individual and the family. In the West,

however, framing psychological problems as genetic has served to steer attention away from the “bad family,” which in the early years of psychoanalysis was often considered the source of adult psychological problems. In the Western trajectory, framing mental illness as a genetic problem actually relieves the family of responsibility, whereas in Japan it accentuates that responsibility, albeit in a different way. The net result is that one rarely hears about depression being a matter of chemical imbalance. Instead, it couched in terms of stress. It is viewed more as an environmental one than a physiological/genetic one and, as such, can resonate as being one that 1) almost everyone dealing with stress (which is indeed just about anyone) can relate to and 2) is treatable and therefore temporary.

Fifth and finally, I suggest that one consequence of Japan’s “becoming depressed” is that there is a widening of the gaze as far as mental health care is concerned. It is arguable that the success of Prozac in the US and the determination by the pharmaceutical industry to frame depression and other conditions as chemical imbalances has resulted in a narrowing of the clinical gaze such that chemical solutions have become the most logical and immediate response to the chemical imbalance. In that process, talk therapies have been sidelined.⁵³ In Japan’s depression boom, on the other hand, the increasing use of SSRIs parallels the increasing demand for clinical psychologists. Patients are becoming increasingly comfortable with medical solutions for psychological problems, but they are at the same time becoming increasingly comfortable with

⁵³ A neuroscience professor at the University of Pittsburgh once said in class that clinical psychology was a “useless discipline.” He speaks for those psychiatrists who have come to see medications as outdistancing, in terms of speed and quality of results, the benefits of talk therapy.

new yet non-medical solutions for those same problems. I suggest, therefore, that there is an atmosphere of discovery right now in Japan not only about what depression “is” but about how to treat it, with the idea being that there may be multiple treatment possibilities out there. The focus, then, is not on only a single mode of treatment – the biomedical mode – but on the recognition that alternatives to suffering exist. Therefore, the focus is on expanding peoples’ thinking about the problem as opposed to narrowing their thinking about the solution. I characterize this as a “widening” of the clinical gaze.

In summary, these subtle differences between Japan’s Depression Boom and America’s Prozac Revolution are not presented here in any effort to proclaim that “depression” is a house of cards. Virtually everyone who has explored mental health care seriously agrees that severe depression appears around the world and bears the marker of a universal condition. But in terms of what is glossed as more moderate forms of depression, the issues are more complicated, mainly because of the fact that people’s understandings about depression depend on a number of social, economic, and ideological factors. Therefore, what is important may be not so much what depression “is,” in the absolute sense, but what it means for people in particular places at particular times. My goal has merely been to put forth my take on what people in one particular place and time are themselves saying not only about depression but about the wider context within which the word “depression” is being increasingly used. Ultimately, I think that it is this wider context that is the heart of the matter. Depression in Japan does not operate in a vacuum; it is part of several larger processes comprising issues of national economic stagnation, disruption of long-standing sources of stability, shifting attitudes about work and one’s relationship toward

one's company, the virtues of perseverance and endurance, institutional reforms in the mental health care system, and the recognition that stress is taking an unbearable toll on the lives of many people. SSRIs seem to be helping, as do the new generation of clinical psychologists; the progressive psychiatrists educating their colleagues and reaching out to sufferers; the journalists putting the ills of stress in the public eye; the bureaucrats at the Health Ministry and the officials at many levels of government who are gathering data, raising public awareness, and funding research; the public interest advocates who are pressuring companies to institute more human workplace norms; and the patients themselves who are creating websites and support groups and going public with their experiences so that other sufferers will not feel so alone. These are the processes that comprise the wider social context into which the acceptance of SSRIs and the normalization of depression are taking place.

Yes, Japan has “become depressed,” and a number of difficult-to-resolve factors are involved in that process. But this is not to say that Japan will remain depressed. People are now tuned into the problem. Stigmas are breaking down. People are seeking and finding alternatives. New notions of normality are emerging.

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