

## CHAPTER ONE

**Introduction:**

## Local Forces of Medicalization

A *Typus Melancholicus*, at a big corporation, working harder for three months after being promoted . . . develops a clear case of depression. After taking antidepressants and time off for half a year or so, he returns to work fully recovered. . . . This is a typical depression in Japan.

—Kasahara Yomishi in Kasahara, Yamashita, and Hirose, *Utsubyō (Depression)* (1992:29)

When I first came to the hospital, I felt so liberated from my work and my family that I immediately got better. But now that I've started thinking about going back to work and about what might await me upon my return . . .

—(a forty-three-year-old salaryman; a recovering patient who became depressed again immediately after receiving a call from his boss)

## The Rise of Depression

In Japan, the term *karōshi*, or death from overwork, was coined in the 1980s to describe cases where people have essentially worked themselves to death. In the late 1990s, when Japanese began to see suicide rates skyrocket, other similar terms emerged and gained currency in the national media. These were *karō jitsatsu*, or overwork suicide, referring to the suicide of people who are driven by excessive work to take their own lives, and *karō utsubyō*, or overwork depression, clinical depression that is seen to underlie such an act. The concern about overwork suicide and overwork depression heightened in 2000, when Japan's Supreme Court ordered Dentsū, the biggest advertising agency in the country, to compensate the family of a deceased employee with the largest amount ever to be paid for a worker's death in Japan. While Dentsū argued that the employee's suicide was an act of free will, the Supreme Court determined that it was a product of *depression* that had been caused by chronic and excessive overwork. After the precedent-setting verdict, a number of similar legal victories have followed, increasingly by workers who contend that their depression is work-induced. Alarmed by these legal disputes and the rising number of the depressed in society at large, the government has installed new mental health

measures and launched a series of labor policy changes aimed at taking on stress-induced mental illness as a significant national problem.<sup>1</sup>

While this outcome has often been discussed as a triumph of the workers' movement, I want to call attention to the fact that it has also signaled the beginning of broad-scale medicalization of suicide and depression in Japan, in which psychiatry and psychiatrists have played a key role.<sup>2</sup> Psychiatrists, through the above-mentioned legal disputes and mental health initiatives, are persuading Japanese that those who break down under tremendous social pressure may be victims of depression (*utsubyō*), an illness that until fairly recently had remained largely unknown among lay Japanese. Amidst the prolonged economic recession since the 1990s, psychiatrists have been urging people, with increasing effectiveness, to recognize their sense of fatigue and hopelessness in terms of depression. They have also linked depression to suicide at a time when Japanese have faced disturbingly high numbers driven to self-killing—more than 30,000 annually for twelve consecutive years (which is three to six times the number of traffic-accident deaths per year). Spurred on by aggressive pharmaceutical marketing of antidepressants during the 2000s, this process of medicalization has resulted in a rapid increase in the number of patients diagnosed with depression: between 1999 and 2008, the number grew by a multiple of 2.4 (*Yomiuri Shimbun* [*Yomiuri*], January 6, 2010). Depression is now one of the most frequently cited reasons for taking sick leave. Depression has thus been transformed from a “rare disease” to one of the most talked about illnesses in recent Japanese history. Psychiatry, as part of this transformation, is increasingly called upon to provide a cure for a society in distress.

This book thus examines how, at the turn of the twenty-first century, depression has suddenly become a “national disease” in Japan, and how psychiatry has emerged as a new vehicle for remedying the ailing social order. These changes are remarkable first of all because Japanese, until recently, had long resisted psychiatric intrusion into everyday life. While psychiatry was adopted from Germany and has been institutionally established in Japan since the 1880s, its use had been reserved for the severely ill. Because of its stigmatizing role in confining “deviants,” psychiatry's expansion into the realm of everyday distress had been greatly limited. Its growing influence in Japan in the 1960s was soon disrupted by what came to be known as the antipsychiatry movement, when psychiatry was criticized as being an insidious tool for social management. Psychotherapy as well, though introduced to Japan in 1912 (Okonogi 1971), had been “viewed with deep suspicion” (Lock 1980:258, Ohnuki-Tienery 1984, Ozawa 1996, Doi 1990); some psychiatrists wondered whether the absence of a

<sup>1</sup>These include establishing criteria for diagnosing mental illness in the workplace in 1999 as well as implementing the Basic Laws on Suicide Countermeasures and national incentives for “Building Mental Health” in 2006 (*Kōsei Rōdōshō* 2010: see chapter 9).

<sup>2</sup>Medicalization refers to the process of the expanding jurisdiction of biomedicine over life problems (Fox 1979, Conrad and Schneider 1980).



Figure 1.1. An image of depression; a 2007 pharmaceutical company advertisement seeking research volunteers for an antidepressant clinical trial (courtesy of Shionogi & Co., Ltd.).

psychiatric proliferation in the realm of everyday life problems attested to Japan having attained a modernity without the degree of alienation found in “the West” (e.g., Machizawa 1997). Depression in particular was regarded as “rare” in Japan, prompting some psychiatrists to speculate whether Japanese—who (they claimed) “aestheticize” rather than “pathologize” depressive moods—might have been largely spared the experience of depression (Kimura 1979). Such assumptions about cultural differences were so firm that psychiatric experts dissuaded Eli Lilly & Co. from promoting and selling Prozac in Japan for lack of a market (Applbaum 2006, Landers 2002). All of this has taken a radical turn since the late 1990s, as an unprecedented number of Japanese have begun to suffer “depression” and to seek psychiatric care for it.

While psychiatrists might generally regard their growing influence as a sign of scientific progress, in North America critics have been concerned with how the rise of depression has correlated with the advent of new antidepressants; they warn that it is instilling a form of individualized biological reductionism. This line of criticism draws upon the “medicalization critique” to argue that the rise of depression globally exemplifies a process whereby a problem of living—indicating social origins and social contradictions—comes to be redefined as a problem of individual biology. North American critics who take this view have argued that this biologization of depression constitutes a fundamental assault on the self, which, in the guise of a quick cure via the prescription of antidepressants, silences people’s dissent and diminishes their capacity to reflect upon the social and political roots of their affliction (cf. Illich 1975). Some have argued that such biological reductionism may further lead to biological surveillance, depoliticization, and decreased autonomy (see Rose 2007). Another line of criticism asserts that the medicalization of depression has brought to North America a “loss of sadness” (Horwitz and Wakefield 2007), whereby people are losing their capacity for tolerance, patience, suffering, and grief. Noting how emotional life is being transformed by the act of taking “happy pills,” some scholars suggest that this form of medicalization is creating moral anxiety—seen as impoverishing the cultural resources with which people have traditionally confronted the hardships of life (Elliott and Chambers 2004).

Given the outpouring of such concerns and criticisms in North America, and given that this kind of global medicalization is often equated with “Americanization,” one may wonder why similar concerns have not been voiced as much in a society like Japan, where psychiatry has certainly been accused of this type of individualized biological reductionism in the past.<sup>3</sup> How has Japanese psychiatry overcome strong lay resistance to the intrusion of psychiatry into everyday life? How exactly is it incorporating biological reasoning into its understanding and treatment of depression? Has it succeeded in providing a biological explanation that is somehow acceptable, perhaps even liberating, for

<sup>3</sup> As during the antipsychiatry movement of the 1960 through the 1980s (see chapter 3).

those in distress? Have Japanese somehow found a different path of medicalization from that which has developed in North America—and, together with it, an alternative vision of happiness?

Building from recent anthropological analyses of medicalization and medical practices, this book investigates how psychiatry has come to provide Japanese with a new understanding of “depression” and asks what kind of political subjects this gives rise to. In contrast to the view of medicalization as a tool of top-down biomedical domination and homogenization, anthropologists have of late come to examine this process as grounded in the local, historical contexts of social controversies and political movements. Instead of assuming that medicalization uniformly leads to depoliticization, they have illuminated the way in which it is a generative and politically charged process where local actors come to articulate competing views on the nature of their distress (Lock 1993, 1999, 2002, Young 1995, Cohen 1998, Kleinman 1986, 1995, Scheper-Hughes 1992, Todeschini 1999a, 1999b, Martin 2007). Building upon this approach, I investigate not simply how psychiatry subjugates but rather how it generates new subjects via new or altered norms, knowledge, concepts, and a way of talking about problems of living—or what I refer to here as “psychiatric language.”<sup>4</sup> I show how psychiatric language is essential in constituting the reality that it seeks to represent (Foucault 1973, 1975, Hacking 1995), particularly for those who are seeking psychiatric care for an “illness” that, in significant ways, previously did not exist as such in Japan.

From this perspective, I argue that psychiatry has largely overcome Japanese resistance by creating a new language of depression that closely engages with—in fact reappropriates—cultural discourse about the *social* nature of depression. Particularly through the medico-legal debates regarding overwork depression, psychiatrists have provided powerful descriptions of the depressed, explaining how, for instance, their patients’ self-sacrificing devotion to the company is no longer rewarded in the deepening recession and the crumbling system of lifetime employment. Focusing on what some psychiatrists have termed “Japanese-style fatigue-induced depression” (Kasahara, Yamashita, and Hirose 1992), they have concretely demonstrated how depression is not only a pathology of the individual brain but is also rooted in the Japanese culture of work itself. In so doing, they have elevated depression to a symbol of collective distress faced by many Japanese in times of economic uncertainty. Through this “socializing” language of depression, psychiatrists have emerged as unlikely agents of *liberation*: they are now successfully altering the way Japanese think about the borders of normality and abnormality, health and illness,

<sup>4</sup>The term “language” is not meant to exclude practices (cf. Bourdieu 1977), nor is it an attempt to extract some deep symbolic structure (cf. Levi-Strauss 1963a). Rather, I use it in part to stress a departure from the previous *silence* in Japan surrounding mental illness and a movement toward ways of talking about “depression.”

and reshaping cultural debates about how society should deal with individual subjects of social distress.

The book thus explores how this different form of medicalization in Japan has come about, and what consequences it brings. My analysis of the emergence of a psychiatric language of depression in Japan is based upon anthropological research that stretches from 1998 to early 2010, a decade that covers before and after the onset of the medicalization.<sup>5</sup> I began my preliminary fieldwork in the summer of 1998, when depression was still relatively unknown in Japan. I carried out the main fieldwork from 2000 to 2003, just when a new generation of antidepressants (selective serotonin reuptake inhibitors or SSRIs) was being introduced to the Japanese market and people were learning how to talk about “depression.” While observing the changing depression scenes from Tokyo throughout the 2000s, I also did follow-up fieldwork in 2008 and 2009 by returning to the same hospitals that I had previously conducted participant observation. During the 2000s, the Ministry of Health, Welfare, and Labor made a number of important changes in its health and labor policies, which have provided institutional/material reality to the idea that depression is rooted in social conditions. These policy changes have also led industry to begin dealing with depression as a collective risk, to be prevented and treated through close management. By the last phase of my fieldwork, the notion of depression had become deeply entrenched in the lives of ordinary Japanese; everyone that I talked to seemed to know people afflicted with depression, including those who had taken sick leave because of it. With the growing number of depressed in society at large, however, there has also emerged new public anxiety about the therapeutic efficacy of psychiatry and the nature of the “remedy” it actually offers. Thus, throughout the book I explore whether psychiatry, as it expands further into the realm of everyday life, may end up constituting a new form of domination by subjecting people to further surveillance and biological management; or, if it instead helps to give rise to subjects who reflect on, and act to resolve the social roots of their predicaments, thereby allowing their dissent to become a motor for social transformation.

<sup>5</sup> Research in mental health poses ethical issues that should not be compromised. I presented my research plan and obtained official approvals for my research from the ethic committees of the two psychiatric institutions (a university hospital and a private mental hospital) where I conducted most of my fieldwork. At a psychosomatic clinic, where there was no formal ethics committee, I was given permission from the doctors in charge. With all the patients I interviewed, I first explained the aim of my research, the measures I would take to protect their privacy, and made sure they knew that they had the right to withdraw from participating anytime they wished. It was only then that I obtained their written informed consent. Patients' health and well-being always is a concern that must be given top priority, and I avoided seeking any interviews with people who were under severe distress, and consulted closely with psychiatrists before asking any patients for an interview. Any information that might reveal their identity (including their names and sometimes their occupation) has been changed in order to protect their privacy. As well, most of the psychiatrists who appear in this book are also given pseudonyms.

## The Production of Psychiatric Subjects as Reflexive Agents

The proliferation of psychiatry has been cited as a hallmark of modernity (Rieff 1966, Giddens 1991) and a sign of the changing nature of governance, political surveillance, and possible forms that agency can take in contemporary society (Marcuse 1970, Foucault 1975, Rose 1996). The first generation of critical studies of biomedicine created a forceful polemic against the teleological view of its history as governed by the principles of progress and humanitarianism. Defining works in medical sociology provoked scholars to conceptualize biomedicine in ideological terms that reproduce the dominant social order and power structures (Goffman 1961, Scheff 1966, Zola 1972), while establishing a medical monopoly (Freidson 1970, Illich 1975). Psychiatry in particular has been criticized for having served as a state apparatus for excluding those deemed unfit to fully participate in the social order by labeling them as “mentally ill” (Becker 1960) and justifying its position by claiming the “scientific” neutrality of its knowledge. Central to this scientific ideology is a conceptualization that locates the cause of madness within individual biology/psychology, rather than in a set of social relations (Laing 1969, Szasz 1974, Cooper 1967, Ingleby 1980). By defining depression as a matter of brain anomalies, for example, psychiatry is said to shift people’s attention away from the social conditions that may have given rise to alienation in the first place. According to these analyses, psychiatry serves to silence social contradictions by pathologizing people to the extent that they are denied a voice with which to speak back.

Similarly, scholars of Japanese psychiatry have examined psychiatry mainly as a means of oppression. Because earlier studies commenced under the influence of the antipsychiatry movement of the 1960s, many scholars have drawn upon Marxist critiques in order to expose the ways in which psychiatry has functioned as an arm of the modern state, suppressing alternative forms of healing, classifying and standardizing subjects, and depriving people of the authorship of their own illness experience. They have shown how psychiatry has abused scientific categories to confine people deemed as “unproductive” and concealed its underlying economic rationality. Moriyama (1975, 1988), for instance, has illuminated the long-term history of how psychiatric institutions developed in Japan as part of the expansion of the modern state; Tomita (1992) has demonstrated how the number of psychiatric confinements fluctuated accordingly with the patterns of local economies; and Asano (2000) has analyzed the historical disputes surrounding occupational therapy and the charge against it that it has functioned as an imposed form of labor in the guise of treatment (also see Yamada 2000, Itsumi et al. 1970). While there are other, nuanced ethnomethodological studies, one of which closely analyzed communication breakdowns in a mental hospital (Nomura and Miyamoto 1996), the overall effect of the critique of psychiatry has been to portray it as a monolithic, repres-

sive enterprise. Though the importance of these previous critical studies must not be minimized, it is also evident that their vision of psychiatry fails to explain the current documented rise of depression or why so many people are suddenly, and *voluntarily*, seeking out psychiatric care.

In order to understand psychiatry's changing forms of power, more recent works on the history of psychiatry (particularly in Europe and North America) have analyzed how both an institutional and conceptual transformation of subjects into "mentally ill" have been made possible at all. They have elaborated on the microscopic technologies by which people are conditioned to understand their distress in biological or psychological terms (Foucault 1975, Atkinson 1995). In place of earlier emphasis on experts' domination, these investigations have illuminated the process of *normalization*, whereby certain sets of ideas become produced, naturalized, and stabilized as "facts" or "truth" (Rose 1996, Nye 1984, Turner 1996). This perspective has proved particularly pertinent for analyzing psychiatry as it moves beyond asylums and penetrates deeper into everyday life through social institutions such as schools, the military, and industry (Castel et al. 1982, Rose 1985, Nolan 1998, Herman 1995, Henriques et al. 1984, Still and Velody 1992, Lutz 1997, Turkle 1992). The working of psychiatric power here is no longer conceptualized as top-down oppression and coercion, but as persuasion, incorporation, and habituation (Foucault 1977, Althusser 1971). Through localized and routinized practices, the language of psychiatry becomes, in other words, power *internalized*—intrinsicly woven into the voice of the "lifeworld" of subjects (Foucault 1973, Armstrong 1983, Osborne 1994, Crawford 1984, Eguchi 1987, Miwaki 2000, Corin 1990, Lutz and Abu-Lughod 1990, Battaglia 1995, Sampson 1989, Sawicki 1991). As we see in the emergent discourse about depression and suicide in Japan, this new regime of psychiatry does not so much silence people as it encourages them to share and speak in its own terms—to undertake self-discipline.

In examining how psychiatry is entering the everyday lexicon of Japanese, it is important to understand the institutional and conceptual transformations that psychiatry has gone through in the last few decades. First of all, with policy changes, psychiatrists are no longer secure in their role as society's gatekeepers in mental hospitals. Particularly after the vehement antipsychiatry movement from 1969 on, younger generations of psychiatrists have sought to dismantle the old system by shifting their focus from asylums to community, and in the process they have become much more receptive to the idea of treating a wider range of mental distress than before (often referred to as a shift from mental illness to *mental health*). In addition, the global impact of American psychiatry—in the form of DSM-IV and psychopharmaceutical influences—encouraged Japanese psychiatrists to broaden their definition of depression (Healy 2004). It is in this context that psychiatrists are beginning to include in their practice not only psychotic depression (which was the main interest of psychiatrists before) but also more broadly defined mood disorders in general. In other

words, Japanese psychiatrists, no longer confined by their traditional nosology, are redrawing the borders of what are considered psychiatric problems as opposed to mere problems of living. The fact that the state itself has shown much interest in adopting psychiatry on a much larger scale, for treating mental health in workplaces and preventing suicide, suggests that this medicalization signals an important change for Japanese psychiatry in its attempts to transform itself as a medicine for ordinary Japanese.<sup>6</sup>

## The Biological and Social Causes of Depression

Within this context, psychiatrists are beginning to popularize depression by disseminating in the media two contrasting—yet complementary—languages of depression. One is grounded in the biological, which depicts depression as a disease affecting both the physical and mental condition of individuals, and emphasizes that its cause first and foremost lies in the brain. Biopsychiatrists who use this language write and speak about depression in a manner that differs little from that of American psychiatrists. Often in collaboration with the pharmaceutical industry, they have widely circulated the self-diagnostic list for depressive symptoms, telling Japanese to understand that depression can be a serious illness—possibly leading to suicide—if not properly treated by antidepressants. The other is the social language of depression, promoted mainly (but not only) by socially and phenomenologically oriented psychiatrists (Shiba 1999, Takaoka 2003). Appealing to public anxiety about rising rates of suicide, they have asserted that depression is not only about individual chemical imbalances but foremost about socially caused pathologies. Drawing upon the traditional psychiatric theory of melancholic premorbid personality or “Typus Melancholicus” (Tellenbach 1980[1961], Shimoda 1941), these psychiatrists have popularized the idea that it is the kind of people who have been most valued in corporate Japan—who selflessly devote themselves to the collective good—that are now being driven in great numbers to depression and suicide. They point out how Japanese society no longer rewards or protects those who have internalized the tradition of a work ethic. For them, conceptualizing depression only at the level of individual biology misses the point: the alarming suicide rate requires that psychiatry—and Japanese society as a whole—start thinking about depression in social terms.

<sup>6</sup> Of late, anthropologists of Japan have increasingly turned to analyzing how psychiatry is beginning to enter the realm of everyday distress as a new technology of social management (Lock 1988, 1993, Borovoy 1995, Breslau 1999, Ozawa 1996, Ozawa-de Silva 2006). Though the depression discourse is the latest venture in these developments, what is significant is that it involves the intervention of the state, which has historically employed various means for shaping how ordinary Japanese should think and behave (Rohlen 1974a, 1974b, Kelly 1993, Kondo 1990, Garon 1997, Kinzley 1991, Gordon 1998).

Thus, unlike earlier medicalization in the West where its effect was assumed to be biologizing and individualizing, psychiatry in Japan is gaining influence by questioning the social order in which the depressed must live. Socially aware psychiatrists, in particular, turn depression into not only a symbolic token for the anguish of workers living in a recession but also a practical means of obtaining long-term sick leave and economic compensation. Thus, for those involved in workers' movements, the psychiatric diagnosis of depression has become an indispensable tool. What is notable is that these psychiatrists have opened up the etiology of depression to legal, public debates, turning it into a political battleground for disputing whether the responsibility of an individual's breakdown lies in their biological vulnerability or in the social environment. In retreating from the traditional genetic determinism of Japanese psychiatry, psychiatry seems to be trying to shed itself of the potential criticism that it is a tool of social management, serving as a means of individualizing dissent and reproducing docile workers (c.f. Miwaki 2000). Even so, there is an apparent tension in the way the psychiatric language is being used, on the one hand, by dejected workers and their supports as a channel for vocalizing their dissent, and on the other hand, by the state and industry as a potential means of controlling and quieting such sentiment.

Psychiatry's new political subversiveness in Japan perhaps signals a triumph of social concern, but if we consider the ways in which biomedicine has attempted to incorporate the "social" under its rubric, we would do well to ask if such optimism is warranted. Anthropologists and sociologists who have analyzed reformist biomedical practices elsewhere have often pointed out the alarming developments when the social is translated into individualizing biomedical concepts such as "stress" (Young 1980), "lifestyles" (Comaroff 1982, Armstrong 1983), or "family life" (Silverman 1987). They have repeatedly shown how psychiatry and psychology have found ways to fragment these potentially social factors into individual biological/psychological attributes. In the path-breaking ethnography of medicalization, Arthur Kleinman (1986) demonstrates how the discourse about "neurasthenia" emerged in 1980s China as a state-sanctioned mode of expressing people's social suffering caused by the injustices of the Cultural Revolution. Kleinman shows that, despite its potentially emancipatory implications, the biomedical form of liberation ends up disempowering those who voiced their political dissent in this way, as they are often left pathologized and further isolated (Kleinman 1995). Allan Young (1995) examines the rise of PTSD (Post Traumatic Stress Disorder) and its adoption by Vietnam veterans, who have drawn upon it in order to assert their victimhood, obtain public recognition of their plight as a group, and gain governmental compensation. Despite its political effectiveness, however, Young also shows the emotional, moral price that the veterans have had to pay in adopting the PTSD discourse for expressing their pain because it ultimately deprives them of the historical, political implications of their experience and trivializes the

moral meanings of their *anger*. Furthermore, Young shows how, with the re-biologization of psychiatry (as in the rising dominance of neurobiology), patients' ailments are now increasingly reinterpreted in terms of biological vulnerabilities within individuals.

In order to understand the distinctive politics that characterizes the "socializing" forms of medicalization in Japan, it is important to recognize that the "social" and the "biological" map onto different ideological terrains depending on the historical and political contexts. For instance, biological reductionism is often criticized as the hallmark of American biomedicine; as historian of science Hiroi (1996) points out, this preoccupation in the United States cannot be understood apart from the history in which biological determinism has often been linked to racist discourse (Hiroi 1996:151–56). In Japan, where such biological determinism has not gained the same level of ideological power, what is evoked instead is the image of pathology as a metaphor for "social dilemma" or upheaval . . . , rather than as a label of individual aberration" (Borovoy 1995:7). This socializing discourse in Japan, it has been suggested, derives from an ideology of "socio-somatics," a Confucian-derived political vision of society in which the health of individuals is believed to depend on a harmonious social order (Lock 1987). This cultural ideology has been given further institutional backing by the Japanese state, which has done much to maintain political stability by cultivating a network of family and corporate welfare as the basis of social life (Gordon 2009). Thus, examining the medicalization of socially withdrawn children, Lock (1986, 1988) has shown that socially oriented medical discourse in Japan is not necessarily liberating, but can be moralizing and hegemonizing in the way that it overdetermines the meaning of people's distress (see also Lock 1993).<sup>7</sup> She has explored how this notion has been used to shift the focus from individuals' actual ailments and the possibilities of change to abstracted notions about a collective predicament from which one cannot easily escape. Borovoy (2008) has also shown how this kind of socializing discourse has been used to help legitimize a social (environment-based) interpretation of children's disabilities at the expense of failing to recognize their individual needs.

Thus, while popular discourse and legal disputes are important sites where the meanings of depression are contested, I will in addition examine how depression is talked about in actual clinical practice. Given that the aim of clinical practice is not to voice social critique but to provide a remedy for the disruptions in people's lives, How do psychiatrists direct people's awareness about the nature of their affliction?

<sup>7</sup> Some Japanese psychiatrists I have interviewed have also expressed caution about explicit socializing rhetoric that intrudes into—and seeks to speak for—the experience of patients (cf. Foucault 1973, Armstrong 1983). Such socializing discourse, they suggest, homogenizes patients and thus reduces the complexity of clinical realities (see chapters 6 through 8).

## Therapeutic Encounters as Sites of Persuasion

The current medicalization in Japan, it seems to me, needs to be examined at the level of internal persuasion, if we are to understand how psychiatry has overcome Japanese resistance from understanding everyday distress in psychiatric terms. This proliferation of psychiatric terminology could certainly not have happened while Japanese psychiatry was operating by means of materialistic domination. Until relatively recently, psychiatry in Japan was able to maintain its authority not because its knowledge was accepted as cultural common-sense (far from it), but because it was able to control and monopolize medical knowledge and exercise its jurisdiction for treating those diagnosed as mentally ill even without their consent. In practicing such a brutal form of power, there was no need for psychiatrists to persuade patients about the naturalness of the psychiatric worldview or expect them to understand it—let alone internalize it. By contrast, the emergent form of psychiatric practices of today, most clearly represented by its depression discourse, is seeking to operate at the conceptual level (cf. Althusser 1971); for people to voluntarily see themselves as depressed and in need of medical care, psychiatry, it would seem, has to begin to perform as an “internally persuasive discourse.” Its subtle coercion requires individuals’ own “ideological becoming” (Bakhtin and Holquist 1981:342) of psychiatric subjects (cf. Lunbeck 1994).

Yet, this presupposition seems to present immediate difficulties not only because “consciousness” is a notoriously difficult thing to scrutinize but also because, despite what critical theorists have insinuated, psychiatry’s conceptual hold on people is often shown to be far from complete (see Young 1982a, 1983). Ethnographers have repeatedly illuminated how psychiatric therapeutic encounters are not places of epiphanic conversions but rather sites of contestations (Corin 1998a, Corin and Lauzon 1992, Taussig 1980, Estroff 1981, Saris 1995), where patients’ voices are often dismissed, discredited, or simply “pushed to the margins of ‘reasoned’ discourse” (Young 1982b:275). Without achieving the kind of conceptual transformation that psychiatry’s hegemony would seem to require, psychiatrists are often left to strive for the minimum of shared understanding of the “mental disorder” by staying away from the realm of social meanings associated with the distress. In this regard, Robert Barrett (1996) has given a nuanced analysis of how experts encourage a patient to co-produce a psychiatric narrative about “schizophrenia” by selectively incorporating parts of a patient’s own accounts of the experience. Other scholars have turned to examining how people come to constitute themselves as pragmatic agents of medicalization, without necessarily accepting a psychiatric framing of their distress (Nichter 1998, Lupton 1997, Good et al. 1992). Thus, ethnographic examinations of psychiatry leave much uncertainty as to how it may work at all at the level of conceptual, symbolic transformation (Kirmayer 1993, Comaroff 1982).

In examining how psychiatry may begin to operate at the conceptual level, I show how Japanese psychiatry successfully converges the biological and the social in its particular construction of depression, providing a generic framework that translates individual misery into signs of collective suffering (cf. Kleinman 1986, Kleinman, Das, and Lock 1997). Psychiatrists achieve this first of all by urging patients to objectify their bodies and systematically cultivate an awareness of how fatigued and alienated their body has become. Particularly for those who are preoccupied with the meanings of their dejection and anger, psychiatrists try to defuse such emotions by urging them instead to focus on bodily recovery. At the same time that their intense emotions are tamed and transformed into objects of biological management, psychiatrists emphasize the social pressures that drove their patients to a breakdown, thereby illuminating their *victimhood*. By emphasizing overwork—not just the salaried labor of (often male) workers but also the emotional labor of housewives—psychiatrists achieve what biomedicine has always done best: liberation of the afflicted from the self-blame and moral responsibility to which they might otherwise be subjected (Sontag 1978). In such ways, they are able to help patients reproduce narratives with surprising uniformity and consistency, not because they have thoroughly persuaded and transformed their consciousness, but because they intentionally leave much unexplored. They carefully stay away, for instance, from in-depth explorations of how—through their unreflexive overconformity—patients might have played a part in structuring their own affliction, or what they can do to change it (Suzuki 1997). The resulting language of depression, while it certainly serves as a means of legitimizing individual suffering, is also curiously devoid of individual agency (see chapter 6).

This pronounced lack of interest on the part of psychiatrists to determine individual agency in connection with depression is above all contested in connection with attempted suicide. While most depressed people seem to accept, at least on the surface, the biological language of depression without much protest, some of the patients who have attempted suicide in Japan clearly resist medicalization by evoking the dominant cultural notion of suicide (to be elaborated on in chapter 7). Insisting that suicide be seen as an act of free will rather than as a product of pathology, some patients explicitly question the implications of adopting the biological language. Some psychiatrists try to go beyond this biological reductionism by incorporating the cultural notion of suicide, emphasizing how the patients are victims of societal problems. While this suggests new possibilities for psychiatric dialogues, the resulting depiction of the suicidal as passive victims might serve to take people's attention away from the specificity of individual angst to the abstracted notions about collective predicaments (cf. Lock 1986, 1988). And, by eluding its psychological and existential aspects, psychiatric discourse—particularly for those who wish to explore the individualized meaning of their behavior and ways of changing their lives—falls short of becoming an internally persuasive, *experiential* language.

## What is Depression?

In terms of psychiatry's effects on people's experience, what concerns me in the end is the fundamental criticism of psychiatry, not uncommon in Japan itself, that it assembles an inchoate mass of realities as an illness, cultivates perpetual anxiety in people, and thus creates the problem that it purports to cure. Though this claim comes in different forms, the alleged fact that Japanese rarely suffered depression before modernity, and the alleged fact that they are now suffering en masse, urges us to seriously confront the potential ill-effects of medicalization. Could it be that medicalization is impoverishing the Japanese "cultural self," that, according to some scholars (Kimura 1979, cf. Obeyesekere 1985), has allowed people in Japan to tolerate and even aestheticize depression to the extent that it protected them from regarding it as a pathological experience?

Surprisingly, during my fieldwork, I found criticisms against the ongoing medicalization coming from the most unlikely sources—the Japanese psychiatrists themselves. As noted above, they believed initially that there would not be a sizable market for Prozac in Japan. Even after 2000, when SSRI's were introduced and were becoming widely prescribed, I heard many Japanese psychiatrists proclaim that the sudden rise of depression was largely due to the "conspiracy of pharmaceutical companies." Indeed, as these psychiatrists criticized it, some pharmaceutical companies initially tried to market antidepressants by "altering the language" (Landers 2002)—that is, they adopted the phrase "*kokoro no kaze*" ("cold of the heart" or "the soul catching a cold") for talking about *utsubyō* (depression) in order to give it a more positive connotation. Psychiatrists were also critical of the way these companies were presenting it as an illness that could affect anyone at any time. Apparently, they were uncomfortable treating patients who did not have what these doctors considered "real" psychiatric problems, and were alarmed by the way their own profession was expanding its jurisdiction over problems of living by blurring the accepted distinction between normality and abnormality. Even given the fact that most of the prominent depression experts I interviewed became doctors at the height of the anti-psychiatry movement in the 1970s, and knew how to talk critically of their own profession to an anthropologist, such critiques were remarkably frequent and most psychiatrists seemed genuinely concerned. They worried that people were being "duped" into believing that they have a disease easily cured by medication, when in fact, so many of them might end up becoming chronic patients, seeking a cure for social/existential/psychological problems for which biomedicine can only offer temporary relief.

While the psychiatrists' own skepticism adds complexity to our understanding of the competing forces for medicalization, what I want to emphasize is the fact that the conceptual control of clinical "depression"—traditionally tightly held by psychiatrists—is now beginning to break down. Depression as it is

being talked about is no longer a biomedical monopoly but a bundle of concepts whose meanings are constantly negotiated and redrawn by various actors—including pharmaceutical companies, physicians, and public administrators, as well as lawyers and judges who are playing a part in this medicalization (cf. Lock 1997, 2002, Cohen 1998, Clarke and Montini 1993). And it is in this context—where the meaning of depression itself is in flux—that people are beginning to “recognize” depression and possibly claim different things by it. This leads me to wonder what exactly depression is for most Japanese today. And, second, had the idea of depression (and of psychiatry as a profession) not been so stigmatized previously, might not Japanese have experienced depression differently as early as a century ago, and even sought out medical care for a condition from which they wished to be liberated?

For us to start examining these questions in greater depth, previous historical claims made about depression by cultural psychiatrists may have been too ideologically drawn, it seems, and were based on radically dichotomized notions about the West and the Rest (e.g., Ōhira and Machizawa 1988). Before its currently reported rise worldwide, depression had often been talked about as a quintessentially Western experience. Melancholy, the predecessor to depression, is said to have a long history in the West, dating from when Aristotle claimed it to be an illness of geniuses (Jackson 1986, Radden 2000). Along this line of thought, the symptoms of depression—particularly sadness, a sense of guilt, and self-blame—were regarded as signs of maturity, even of adult selfhood. Later claims were made in the 1960s that Westerners suffered depression because of their Christian notion of guilt, which gave them a sense of interiority and an ability to reflect upon themselves. By contrast, non-Westerners, it was claimed, did not possess reflexive selves and were unable to suffer from depression because their immature and nonautonomous selves did not have a capacity for introspection (see Littlewood and Dein 2000). Japanese psychiatrists have examined, from the 1950s, the claim made by Ruth Benedict (based on Japanese detainees in California during World War II) that Japanese have a cultural self that is based not on guilt but rather on shame (Benedict 1946). They have considered the further implication of this argument and wondered if the absence of depression in Japan might be because the Japanese self was heavily dependent on adherence to external authority and a so-called “relational self.” Indeed, it is against this highly Western-centric discourse that some Japanese psychiatrists such as Kimura Bin began to assert an alternative argument. Kimura adopted the notion of “cultural self” only to invert it to argue that the absence of depression in Japan testified not to an immature self but rather to the strength of their cultural tradition. Unlike “Westerners” who find in depression “something unnatural and abnormal,” Japanese, Kimura argued, maintain a high level of tolerance for, and even find aesthetical dimensions of, depression (Kimura 1979).<sup>8</sup>

<sup>8</sup>The essence of this cultural argument was crystallized in Gannath Obeyesekere’s (1985) work

Miyamoto Tadao (1979) as well urged other scholars to start examining why it is that Japanese had not apparently perceived depression as a medical condition prior to the introduction of Western psychiatry in the nineteenth century. From these perspectives, the current rise of depression documented in Japan might be regarded as yet another example of the encroachment of the West into the intimate realm of the sense of self.<sup>9</sup>

By going back to the time prior to the advent of psychiatry in Japan in the late nineteenth century, however, I have uncovered that there was—and has remained—a rich undercurrent of alternative medical language that recognized “depression” as a form of pathology (see chapters 2 through 5). Contrary to the common claims made by Japanese psychiatrists, traditional medicine, at least since the sixteenth century onward, had a concept of depression as an illness of emotions. In fact, the modern Japanese term for depression—*utsubyō*—came directly out of traditional medicine, when the term was adopted in the nineteenth century as the Japanese translation of melancholia. *Utsubyō*<sup>10</sup> or *utsushō*, as it was formerly called, had strikingly similar characteristics to the Western notion of melancholia: Both referred to the physical and mental condition of stagnation in vital energy—*ki* in the case of Japanese *utsushō* and a humor in the case of Western melancholia. They both accounted for how people might feel “depressed” from the complex interplay between social events, emotional experiences, and physiological changes in the body. Adopted in popular writings and plays, they respectively carried cultural and moral meanings that were far beyond the narrow medical definitions of a “disease.” What partly brought an epistemological break to the premodern notion of *utsushō* in Japan was, I suggest, the adoption of German neurobiological psychiatry in the nineteenth century, which turned this condition into a matter of a diseased brain, while thoroughly erasing for Japanese its social, cultural, and psychological mean-

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on depression in Sri Lanka; he argued that culture interprets the negative affect as a religious experience to the extent that the depressed are saved from being pathologized and socially excluded as mentally ill. These perspectives are important in illuminating the “work of culture” (Obeyesekere 1985) as a mediating force, and examining how certain affects become bestowed with much anxiety in some societies more than others (also see Gaines 1992, Kleinman and Good 1985).

<sup>9</sup>In the postwar period, Japanese psychiatry has paid relatively little attention to milder forms of mental illness in the population at large. A well-known psychiatrist who specializes in depression, Ōhara (1981), suggests that there was a near-absence of depression in the war periods. A leading psychoanalyst, Nishizono (1988:265), notes his amusement at the popularity of depression in the West in 1964. This is not so surprising if we realize that until the 1960s, when antidepressants were introduced, depression was considered—even in the United States—a “rare” disease (Healey 1997). But even after the 1980 introduction of DSM-III, Japanese psychiatrists continued to state that the American concept of major depression is far too inclusive (Honda 1983), and not applicable to Japanese. However, the exclusive focus on academic psychiatry misses, as we will see in chapter 4, the flourishing interest in mental illness in popular culture from the early twentieth century.

<sup>10</sup>The historical origin of this term will be closely examined in chapter 2. Many medical terms were newly invented in the eighteenth and nineteenth century, when scholars were translating a massive number of Western medical texts into Japanese.

ings. Furthermore, modern psychiatry created not just categories of disease but, as Ian Hacking (1986) has argued, “kinds of people”—in this case, the manic-depressive whose brain was assumed to be inherently different from others.’ Psychiatry, in other words, no longer listened to narratives about the depression of ordinary Japanese.

Indeed, one may even argue that the history of modern psychiatry in Japan is characterized by this radical disconnection with subjective pain (Foucault 1975, cf., Duden 1991, Yamaguchi 1990, Porter 1985). Japanese psychiatry, similar to psychiatric practices in other countries, has asserted its scientific authority by determining what is a medically recognized, legitimate “disease” as opposed to an unclassified and undiagnosable (mere) complaint. Moreover, its history started as an importation of Western-born categories, with the result that psychiatrists have paid more attention to making everyday reality fit pre-existing classifications rather than exploring the chaotic realities presented by their patients. By adopting the neurobiological language of German psychiatrist Emil Kraepelin, which replaced the authority derived from patients’ subjective accounts with the experts’ objective observation (Hoff 1996, Radden 2000), Japanese psychiatry may have done much to discredit people’s experience. And it is by means of this selective attention and particular construction of mental illness that Japanese psychiatrists have claimed that Japanese did not suffer from depression. Thus, the new psychiatric language of depression might, in fact, re-cultivate people’s awareness of the interconnectedness of the social with the body and emotions. But this could also serve as a “colonization of the lifeworld” (Habermas 1987), if it begins to function as the authoritative, monolithic language that overdetermines the meanings of subjective experiences (Good 1994).

As one arena where psychiatry exposes its limits as a language of experience, I will examine people’s own narratives about how they have recovered from depression and illuminate the gaps and discrepancies that so often exist between what is reported from psychiatrists and patients. At another level of analysis, I will examine why, statistically, until recently Japanese males were as likely, if not more so, to suffer depression as women—a striking difference from the West, where women are twice as likely as men to suffer depression (these figures have changed rapidly with the current medicalization of depression: see chapters 8 and 10). Through Japanese men’s narratives, I show how psychiatric language might effectively provide a way of understanding—and legitimizing—their distress as a product of overwork. By contrast I show how the same language seems to have often failed to speak in a satisfactory way about women’s “depression,” and how much difficulty women seem to have had, and continue to have at times, in having their profound distress even recognized. By illuminating the gendered structuring of depression (cf. Hubert 2002), I raise the possibility that psychiatrists may listen more attentively to the suffering of certain people to the exclusion of others. And in so doing, I ask for whom this

language may be particularly liberating, and for whom it may be subjugating (Abu-Lughod 1990, Comaroff 1985, Scott 1985, 1990). Whether medicalization results in more diversified articulation of individual suffering, and if these new-found voices serve to counter the effects of medicalization that dominate individual subjectivity, are questions that will be examined throughout this book.

Importantly, I also want to call attention to the pivotal role psychiatrists have played in transforming fragmented individual testimonies of social injustice into a *public language* of pain by focusing on the psychopathology of work (chapter 9). This kind of biomedical validation of suffering—such as a PTSD diagnosis for war veterans (Young 1995) or a medical certificate of disability for the victims of Ukrainian nuclear disaster (Petryna 2002)—has become an indispensable tool for people in contemporary societies demanding economic compensation for their social distress (cf. Kleinman 1986). Also, it is partly because Japanese psychiatrists have portrayed typical depressed patients as hard-working salarymen that they have been persuasive. Both in the media and in psychiatric literature, they have done much to create a strong association between depression and people suffering overwork, loss of employment, bankruptcy, and overwork suicide. Psychiatrists, by providing powerful testimonies for depressed workers, have come to redefine the depressed as victims of both biological and social forces. By emphasizing work as an important cause of depression and by portraying the depressed as subject to the brutal forces of economic restructuring that Japanese society is going through, they have successfully promoted depression as a social problem worthy of political, economic, and legal intervention. It is in this sense that psychiatrists have had their most liberating effects well beyond the narrow clinical domains—and have begun to have a public voice in the political sphere (see chapters 9 through 11). I thus demonstrate the conceptual and institutional links psychiatrists have made between depression, work stress, and recession in order to demonstrate how the difference in medicalization stems in part from particular political and economic concerns that are driving the medicalization of depression in Japan.