Society in Distress:
The Psychiatric Production of Depression
in Contemporary Japan

Junko Kitanaka
Department of Anthropology
McGill University
Montreal, Quebec
Canada

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To Chris

Abstract

This dissertation examines the rising medicalization of depression in Japan and asks how it has become possible that Japanese, who reportedly barely suffered from depression until recently, are now increasingly becoming "depressed." Drawing upon two years of fieldwork in psychiatric institutions in the Tokyo environs, I examine this change from three different angles—historical, clinical, and socio-legal. First, my historical analysis questions the assumption held by Japanese psychiatrists that depression did not exist in premodern Japan; I show that traditional Japanese medicine did indeed have a notion of depression (called *utsushô*), conceived as an illness of emotions in which psychological suffering was seen as intimately connected to both physiological and social distress. Though the premodern notion of depression was effectively obscured by the 19th-century adoption of German neuropsychiatry that located depression in individual brains, the current medicalization of depression is nevertheless deeply informed by an indigenous psychiatric theory emphasizing that depression is in part socially produced. Second, I examine how Japanese psychiatrists use this local language of depression in clinical practice in attempting to persuade patients that they are victims of both biological and social forces lying beyond their control. The lack of any psychiatric model of agency concerning depression, however, leads some patients—especially suicidal patients—to question psychiatry's jurisdiction over the meaning of their distress. Third, I analyze how the psychiatric language of depression has been adopted in legal discourse surrounding "overwork suicide," where corporations and the government have been found liable for workers' deaths on the grounds that excessive work stress can drive workers to depression and suicide. Furthermore, the psychiatric language is curiously limited in the sense that, in contrast to the West, in Japan it is men rather than women who have been represented as typical victims of depression. By examining patients' narratives, I demonstrate how psychiatry constructs a gendered discourse of depression, closely tied to local politics about whose distress is recognized as legitimate social suffering. The medicalization of depression in Japan thus suggests not a hegemonic, global standardization, but the emergence of psychiatry as a politically potent—though limited—force for social transformation.

Résumé

Cette thèse porte sur la médicalisation croissante de la dépression au Japon et pose la question suivante: Comment se peut-il que les japonais, qui ne souffriraient de dépression que depuis récemment, soient de plus en plus « déprimés »? Suite à une recherche de terrain d'une durée de deux ans au sein des institutions psychiatriques des environs de Tokyo, j'examine ce changement dans son contexte historique, clinique et socio-légale. Dans un premier temps, l'analyse historique permet de questionner l'idée exprimée par les psychiatres japonais de l'absence de la dépression dans le Japon pré-moderne. La médecine traditionnelle japonaise identifie pourtant un concept de la dépression : l'*utsushô*, une maladie des émotions qui lie intimement la souffrance psychologique à la détresse physiologique et sociale. Bien que cette conception pré-moderne de la dépression ait été remplacée par l'adoption de la neuropsychiatrie allemande du 19ième siècle qui localisait cet état dans les cerveaux des individus, la médicalisation contemporaine de la dépression puise de façon significative dans la théorie psychiatrique traditionnelle qui prône le rôle de la société dans la production de la dépression.

J'examine ensuite la façon dont les psychiatres japonais se servent de ce langage local de la dépression dans leurs pratiques cliniques pour persuader leurs patients qu'ils sont victimes de forces biologiques et sociales hors de leur contrôle. Pourtant, l'absence d'un model psychiatrique d'action individuelle conduit certains patients, particulièrement ceux qui sont suicidaires, à remettre en question le monopole de la psychiatrie sur le sens qu'elle donne à leur détresse. Finalement, j'examine l'adoption du langage psychiatrique de la dépression par le discours légal portant sur la question du « suicide du surtravail », dans des cas où des entreprises et le gouvernement ont été trouvés responsables du suicide de travailleurs en raison d'un stress excessif au travail. De plus, le langage psychiatrique est assez limité puisqu'au Japon, contrairement à ce qui ce passe en Occident, ce sont les hommes plutôt que les femmes qui sont représentés comme étant les victimes typiques de la dépression. En examinant les récits des patients, je montre que la psychiatrie construit un discours genré de la dépression, discours qui est étroitement lié à une politique locale qui établit la légitimité de la souffrance sociale selon les individus. La médicalisation de la dépression au Japon semble conduire non à une régularisation hégémonique et universaliste, mais plutôt à l'émergence d'une psychiatrie qui, malgré certaines limites, agit comme une force pour la transformation sociale.

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[1] Japanese names are written in the order of family name followed by given name.

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Chapter 1: Introduction: Local Forces of Medicalization

1. The rise of depression

In the 1990s, amidst a prolonged economic recession and the reported rise of "depression" (utsubyô) in Japan, psychiatry emerged as a new vehicle for remedying the ailing social order. Theses changes were significant first of all because Japanese psychiatrists had assumed that Japanese rarely suffered depression, and also because Japanese had long resisted psychiatric intrusion into everyday life. While psychiatry has been institutionally established in Japan since 1879 when it was adopted from Germany, its use there had been reserved for the severely ill. Because of its stigmatized role in confining "deviants," its expansion into the realm of everyday distress had been limited. Its growing influence in the 1960s was soon disrupted by the rise of what is known as the antipsychiatry movement, when psychiatry was criticized for being an insidious tool for social management. Psychotherapy as well, though introduced to Japan in 1912 (Okonogi 1971), had long been "viewed with deep suspicion" (Lock 1980:258; Ohnuki-Tienery 1984, Ozawa-de Silva 1996; Doi 1990); some cultural commentators have even claimed that the absence of a psychiatric proliferation attests to the strength of Japanese culture, which, to them, had avoided the alienating effects of modernity. All of this, however, took a radical turn in the 1990s. With a record-high number of suicides (more than 30,000 annually for nearly 7 years, which is three to four times the number of the traffic-accident deaths), psychiatry increased its influence by arguing that suicide was caused by depression (Strom 1999). Featured in the media above all as a workers' ailment, the rise of depression thus prompted quick involvement both from the government and industry (Kôsei Rôdôshô 2001, Yamazaki 2001, Nikkei September 7, 2001). If not thoroughly embraced by the general population,

psychiatry is nonetheless increasingly called upon to treat problems associated with mainstream Japanese society.

Drawing upon the anthropological analyses of medicalization[1] and medical practices, this dissertation examines how psychiatry is beginning to overcome Japanese resistance to it by providing a new language for understanding "depression," and asks what kind of political subjects this gives rise to. While internationally psychiatrists might see their growing influence as a sign of scientific progress, social scientists have expressed concern that their treatment of depression is another case of medicalization, a process whereby a problem of living— indicating social origins and social contradictions—comes to be redefined as a pathology of individual biology or psychology. Critics argue that this could lead to psychiatric intrusion into the realm of the private, thereby subjugating people to surveillance, depoliticization, and decreased autonomy (cf., Illich 1975, Zola 1972). Following Michel Foucault, I propose instead to examine not how psychiatry subjugates, but rather how it generates subjects via new norms, knowledge, concepts, and a way of talking about problems of living—or what I refer to here as "psychiatric language." 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." 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, for many Japanese, previously did not exist as such.

Anthropologists have analyzed medicalization as grounded in the local,

[1] Medicalization refers to the process of the expanding jurisdiction of biomedicine over life problems (Conrad & Schneider 1980).

historical contexts of social controversies and political movements (Lock 1993, 1999, 2002, Young 1995, Cohen 1998, Kleinman 1986, Scheper-Hughes 1992, Todeschini 1999a, 1999b). In this vein, I draw particularly upon the medicalization analyses of Margaret Lock (1991, 1993, 2002), which have shown—by illuminating the distinctive discourses on aging and death in Japan—how medicalization is not necessarily a homogenizing force but a politically-charged process of articulating competing local, moral views on the nature of people's distress. Building on her approach, I argue that what has especially enabled psychiatry to overcome Japanese resistance to its expansion is its linkage with a local discourse about suicide, whereby psychiatry has emerged as a voice for the weak. Since the late 1990s, socially-oriented psychiatrists and lawyers have argued that an alarming number of workers have been driven to what Japanese have called *overwork suicide* (karô jisatsu) or suicide due to the stress brought on by excessive overwork. In a highly publicized lawsuit, the Supreme Court ordered Dentsu, the biggest advertising agency in Japan, to pay the sum of 168,600,000 yen (approximately US$1,500,000) to the family of an employee who committed suicide. The court determined that the employee's suicide was induced by depression that had originally been caused by chronic overwork, for which the corporation had to take responsibility. By defining suicide—and depression—not as a problem of the individual but of the Japanese work culture itself, such verdicts have prompted the government to change its labor policies and have thus been hailed as a triumph for workers' movements (Kawahito 1998). Yet I want to highlight the fact that this also promotes medicalization, whereby psychiatry is apparently rapidly expanding its influence by emphasizing—in theory—the social etiology of depression, while concurrently promoting—in practice—individualized, biological management. Also by challenging the traditional notion of suicide as an act of free will—and redefining it as a product of pathology—psychiatry is altering the way Japanese think about the borders of

normalcy and abnormalcy, health and illness, and the cultural debates about how society should deal with social misery and individual subjects (Lock 1988, Kleinman 1986). My ultimate goal is thus to examine 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 does indeed help to give rise to subjects who reflect on, and act to resolve their social predicaments.

II. The production of psychiatric subjects as reflexive agents

The proliferation of psychiatry has been cited as a hallmark of modernity (Reiff 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 (Friedson 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 Kimio (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 Mikio (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 & Miyamoto1996), the overall effect of the critique of psychiatry has been to portray it as a monolithic, repressive enterprise. Though the importance of these previous critical studies must not be undermined, 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 & 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*—intrinsically woven into the voice of the "lifeworld" of subjects (Foucault 1973; Armstrong 1983, Osborn 1994, Crawford 1984, Eguchi 1987, Miwaki 2000; Corin 1990, Lutz & 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 1968 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)*. As well, the global impact of American psychiatry in the form of DSM-IV and psychopharmaceutical influences encourage Japanese psychiatrists to broaden their definition of depression (cf. Healy 1997). 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, who are no longer confined by their traditional nosology, are now significantly redrawing the border of what are 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.[2]

III. The biological and the social causes of depression

Within this context, psychiatrists are beginning to popularize depression by disseminating in the media two competing—if potentially

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[2] 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 1998). 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).

complementary—languages of depression. One is grounded in biological language, that 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 causing suicide—if not properly treated by antidepressants. In their attempt to portray depression as a physical illness, they apparently try to de-signify its moral, cultural, existential meanings (Sontag 1978, Luhrmann 2000). The other is the social language of depression, promoted mostly (but not only) by socially and phenomenologically-oriented psychiatrists (Kasahara 1989, 2003; Shiba 1999, Takaoka 2003). Appealing to public anxiety about rising rates of suicide, they have asserted that depression is not only about an individual chemical imbalance but foremost about socially caused pathology. Drawing upon the traditional psychiatric theory of "melancholic premorbid personality" (Tellenbach 1980[1961], Shimoda 1941), they 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 people as a whole —start thinking about depression in social terms.

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 leaves 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 (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.

While psychiatry's new political subversiveness in Japan perhaps signals a triumph of social concern, if we consider the ways in which biomedicine has attempted to incorporate the "social," under their 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), "life styles" (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 one of the earliest ethnographies 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 being disempowering for 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. 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 (also see Lock 1993).[3]

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[3] It is important to recognize that the "social" and the "biological" map onto different ideological terrains depending on historical and political contexts. For instance, biological reductionism is often criticized as the hallmark of American biomedicine; as Hiroi (1996), historian of science, points out, this preoccupation with biological reductionism in the U.S. cannot be understood apart from the history in which biological determinism has often been linked to racist discourse, creating powerful political ideologies that intellectuals have had to struggle with (Hiroi 1996:151-156). In Japan, however, such biological determinism has rarely gained ideological power. Instead, what is evoked 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 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). It seems to me that too often 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. Some Japanese psychiatrists I have interviewed have also expressed caution about explicit socializing rhetoric that intrudes

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?

IV. 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 against 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, as was formerly the case. Until relatively recently, psychiatry in Japan was able to maintain its authority not because its knowledge was accepted as cultural commonsense (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

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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.

"ideological becoming" (Bakhtin 1981:342) of psychiatric subjects.

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 the place of epiphanic conversions but rather a site of contestations (Corin 1998a, Corin & Lauzon 1992, Taussig 1980, Estroff 1980, 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 his 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 & 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 de-fuse 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 that they might otherwise be subjected to (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.

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 people with depression 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 come to 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 the victims of society. 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.

IV. 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. Apparently their assumption that depression was a

rarity in Japan was firm enough that some of them had even told Eli Lilly & Co. that "Japanese barely suffer from depression" and advised it against promoting and selling Prozac in Japan for lack of a market (Applbaum 2006, Landers 2002). 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" or "the soul catching a cold" for talking about "utsubyô" (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 anytime. 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 normalcy and abnormalcy. Even given the fact that most of the prominent depression experts I interviewed became doctors at the height of the antipsychiatry 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, public administrators, as well as lawyers and judges who are playing a part in this medicalization (cf., Lock 1997, 2002, Cohen 1998, Clarke & 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 based on radically dichotomized notions about the West and the Rest (e.g., Ôhira & Machizawa 1988). Before its currently reported rise worldwide, depression has 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 the time 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 sense 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 non-autonomous selves did not have a capacity for introspection (see Littlewood & Dein 2000). Japanese psychiatrists have examined,

from the 1950s, the claim made by Ruth Benedict (based on Japanese detainees in California during WWII) 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 (1979) 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, even find aesthetical dimensions of, depression (Kimura 1979).[4] 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 19th 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.[5]

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[4] The essence of this cultural argument was crystallized in Gannath Obeyesekere's (1985) work on depression in Sri Lanka; he argued 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 & Good 1985).

[5] 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, Ôhara (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

By going back to the time prior to the advent of psychiatry in Japan in the late 19th 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. Contrary to the common claims made by Japanese psychiatrists, traditional medicine, at least since the 16th century onward, had a concept of "depression" as an illness of the emotions. In fact, the modern Japanese term for depression –utsubyô—came directly out of traditional medicine, when the term was adopted in the 18th century as the Japanese translation of melancholia. Utsubyô[6] or *utsushô*, 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—qi in the case of Japanese *utsushô* and hormones 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 *utsushô* in Japan was, I suggest, the adoption of German neurobiological psychiatry in the 19th century, that turned this condition into a matter of a diseased brain, while

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antidepressants were introduced, depression was considered to be--even in the U.S.--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, the flourishing interest in mental illness in popular culture from early this century.

[6] The historical origin of this term will be closely examined in Chapter 2. Many medical terms were newly invented in the 18th - 19th century when scholars were translating a massive number of Western medical texts into Japanese (e.g., for the invention of "kônenki" and its changing meanings, see Lock's work on the history of menopause in Japan (Lock 1993:26-29)

thoroughly erasing for Japanese its social, cultural, and psychological meanings. 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 to other people. 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 unclassified and undiagnosable (mere) complaints. Moreover, its history started as an importation of Western-borne categories, with the result that psychiatrists have paid more attention to making everyday reality fit preexisting classifications rather than exploring the chaotic realities presented by their patients. By adopting the neurobiological language of Kraepelin, that 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.

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 they and their psychiatrists report. At another level of analysis, I will examine why, until recently, it had been the situation that, statistically, 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 to suffer depression then men (these figures have changed rapidly with the current medicalization of depression: see Chapter 8 & 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 rather than 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 dissertation.

The outline of the dissertation

This dissertation examines how the medicalization of depression and suicide in Japan has been made possible from three different angles: historical, clinical, and social.

Part I provides a brief history of psychiatry and concepts of depression in Japan. Chapter 2 questions the long-held psychiatric assumption that Japanese did not historically suffer from depression. Contrary to this view, I demonstrate how traditional medicine provided Japanese with a language of *qi* that allowed them to express the emotional distress they felt in terms of "depression" (*utsushô*) and to seek medical care for it. I examine the changes this premodern notion of depression went through as it became popularized and reinterpreted throughout the Edo Era. I also point out certain parallels between this notion and melancholia in the West, as they were both used to express the intimate connection between mind and body. I examine in the end what has made this notion so obsolete that contemporary Japanese can no longer recognize it.

Chapter 3 provides a brief overview of the history of Japanese psychiatry. I divide its history into three phases: 1) its institutionalization as the state-sanctioned medicine; 2) its post-WWII expansion and the subsequent antipsychiatry movement; and 3) its recent, increasing interest in *mental health*. I show the processes through which psychiatry has attempted to transform itself from a hegemonic, biological apparatus of excluding deviants to a popular means of treating milder forms of mental illness. I also illuminate the contradictory effects of the antipsychiatry movement, which have helped turn psychiatry into a language of social critique, thereby paving the path for its greater expansion into the realm of everyday distress.

Chapter 4 describes the alleged "epidemic" of neurasthenia that occurred in Japan at the beginning of the 20th century. While such an epidemic was of a global concern at the time, it took a distinctive form in Japan as it helped familiarize Japanese with the Western concepts of nerves and the brain. As an early case of the broad-scale medicalization, the discourse about neurasthenia had many parallels with the current depression discourse, most notably the public debates over its causality—i.e., whether neurasthenia was a result of overwork or of personal weakness. I show how psychiatry relentlessly expanded the neurasthenia concept, only to later stigmatize those who had resorted to it and internalized this illness category —an ominous sign for what may be in store for the medicalization of depression today.

Psychiatrists and lawyers have used a distinctive, localized theory of melancholic premorbid personality in order to support claims for the social origins of depression. Chapter 5 examines the history of this theory and its transformations through the American influence in the 1950s, the introduction of antidepressants in the 1960s, and the antipsychiatry movement of the 1970s. I also discuss the conceptual ambiguity of this personality theory, as it has been used to support arguments for both biological and social causes of depression.

Part II is based upon two years of anthropological fieldwork I conducted at three psychiatric institutions, and illustrates how psychiatrists and patients actually deal with depression and suicide in everyday clinical encounters.[7] Chapter 6

[7] 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

starts out with the question of why it is that many Japanese psychiatrists—even those who are critical of biological reductionism—regard psychotherapy to be taboo for treating depression. Describing diagnostic interviews, hospitalization, and case conferences, I illuminate how psychiatrists try to contain patients' reflexivity and avoid intruding into the realm of the psychological, in order to protect patients' already fragile sense of self. Defining depression as an alienation from one's own body, these psychiatrists instead urge patients to focus on their bodily changes and social distress. What emerges there is a surprisingly uniform set of narratives about depression, designed to create a sense of social legitimacy for patients' suffering. I also problematize how these psychiatrists, notwithstanding their clinical sensibilities, leave unexamined the important issue of how the depressed can act—beyond merely being passive recipients of biological cure—as agents of self-transformation.

This question of agency becomes a focal point in psychiatrists' confrontations with suicidal patients. Although what is most notable in the current medicalization is that psychiatrists are beginning to persuade Japanese that suicide is a psychiatric problem, clinical encounters show that this effort at persuasion often meets with much resistance. Chapter 7 describes the ways in which Japanese psychiatrists learn to bracket out disturbing moral, existential,

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given permission from the doctors in charge. With all the patients I interviewed, I first explained the aim of my research, the measures I was to take in order to protect their privacy, the form of publication it would result in, and explained they had the right to withdraw their participation 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 dissertation are also given pseudonyms.

philosophical questions about where the border lies between pathological suicide and an intentional act, and how they try to persuade patients that their suicidal desire is caused by a biological disease. Examining the cases where patients insist on their free will by resorting to the cultural idiom of "suicide of resolve," I show how psychiatrists' own ambivalence about suicide—particularly over the place of individual intentionality—creates a moral dilemma about the validity of their own medical intervention.

In Part III, I turn to the effects of medicalization beyond the walls of clinics and examine how lay people and other professionals are drawing upon psychiatry as a framework for expressing—and interrogating—social ills. Chapter 8 addresses the gender difference in depression. Despite the claim in the West that depression is a "women's disease," in Japan, men have been as likely to suffer depression as women. Through the narratives of those who have recovered from depression, I show how depressed men are provided with a public narrative of depression, which highlights their fatigue and overwork, protects them from exposing "private" issues, and portrays them as legitimate victims of social pressure. In contrast I show how women's narratives are often characterized by their struggles in even having their ailment medically and socially recognized. Lacking public recognition of their suffering, some of these women seem to have a much harder time finding—and coming to terms with—a meaning of depression. I thus illuminate how the selective social recognition of pain shapes the illness experience itself, and how this in turn structures the gendering of depression in Japan.

Chapter 9 demonstrates how claims for the social origins of depression have gained force through a series of legal victories against overwork suicide. As lawyers have successfully argued that these people are victims of the culture of

workplaces, the government has established new guidelines for measuring psychological stress at work and is encouraging overworked employees to seek out medical care. Psychiatry is thus at the heart of important social changes, at times used to urge Japanese to question the status quo, particularly where model workers who have internalized a strong work ethic are driven to suicide. I also examine, however, the potential ill-effects of adopting psychiatry as a means to demand collective responsibility, as psychiatric knowledge and treatment lend themselves to increasing psychiatric surveillance as well.

In conclusion (Chapter 10), I examine whether the societal debate about the social causes of depression may well be a product of the transitional phase of medicalization. Academic psychiatrists have disputed the scientific credibility of the local, moralized theories of depression, and pharmaceutical advertisements are promoting the de-existentialized and de-socialized language of neuropsychiatry. Amid signs of Japan's economic recovery, depression is less often seen as explicitly linked to the specific historical conditions of recession but is instead presented as an isolated mental state, whose mechanism is increasingly discussed in terms of biology and individual vulnerability. There certainly is a conceptual tension in the ongoing medicalization as it proceeds as a two-way process, whereby Japanese are being urged to reexamine their cultural assumptions about depression and suicide, while psychiatry is also being reshaped by national, legal debates about the social origins of depression. As psychiatry is expanding into new networks by linking with law and public policies, I ask what possibilities there may be for psychiatry to continue urging Japanese to reflect upon not only individual health but also how depression and suicide may be socially produced.

Part I. Depression in History

Chapter 2: Reading Emotions in the Body: the Premodern Language of Depression

> When doctors in the Neijing subsequently spoke of rising in anger, sinking in fear, sweeping away in sorrow, they weren't so much trying to explain emotions, objectively, as relating what they knew from their own bodies, describing what they felt, subjectively, within themselves. In anger, a sudden, explosive surge; in grief, a draining away. It was the intimate everyday familiarity of such sensations that made the traditional discourse of vital flux so compelling. The deepest certainties about qi were rooted in knowledge that people had of the body because they *were*, themselves, bodies.
>
> Kuriyama, Shigehisa, *The Expressiveness of the Body*, 1999:103

I. Depression as a Western category?

Japanese psychiatrists have long assumed that the notion of clinical depression did not exist in Japan prior to modernity. Scholars such as Kimura Bin (1979) have argued that unlike in the West where there is a long history of melancholia, Japanese have rarely talked about depression as an illness. He suggested that this was because Japanese were able to tolerate and even find aesthetic dimensions in the experience of depression (also see Miyamoto 1979). It may be true that the kind of philosophical and religious articulations about melancholia as a (divine) form of insanity, which occur in the West (Jackson 1986, Radden 2000), cannot be found in Japanese history. However, recent historical investigations by scholars like Kuriyama Shigehisa (1997) suggest that a depression-like notion was part of the traditional medical nosology long before the advent of modernity. This gap in the knowledge of Japanese psychiatrists can likely be explained if we consider the

following points. First of all, because Japanese psychiatrists have long highlighted severe forms of mental illness, they may have failed to examine the fact that in premodern times people turned to medical practitioners for all sorts of mild forms of distress, including feelings of dejection, lack of energy, or social withdrawal. Secondly, they have not fully taken into account that the kind of epistemological break that Foucault has described with regard to French modernity (Foucault 1973) happened in Japan with far more decisive force (Garon 1997)—particularly in medicine—because people once had to completely abandon traditional ways of understanding themselves and adopt an entirely new language,[8] a language that began to constitute the modern self. The new medical language introduced notions like nerves (which did not even exist before) and the brain as the locus of control (an organ which previously was thought to have little importance)—and also served to invalidate traditional ideas about the body and mind, of which *depression* was a part.

Building upon the recent historiography of Japanese senses and the body (Kuriyama 1992, Yamada & Kuriyama 1997; Kuriyama & Kitazawa 2004, Ôtsuka et al. 1999), I demonstrate how the notion of depression not only existed in traditional medicine but had its own distinctive developments. Indeed, the very term *utsubyô* (鬱病 or illness of utsu)—which is the modern Japanese word for depression—seems to come directly from the traditional medical term *utsushô* (鬱症). Using premodern medical texts, popular writings and newspaper articles from the advent of modernity, I first explore what kind of experience "utsu" was for premodern Japanese. I examine how this emerged as a medical concept in the 16th century, how the term became popularized during the Edo Era, and how it was adopted by modern psychiatry as a translation for melancholia. What I want

[8] The modern state officially adopted biomedicine and effectively de-legitimized traditional medicine in 1874, though the latter has certainly survived to the 21st century (Lock 1980).

to attempt here is *not* to start with a strictly defined cluster of depressive symptoms (as we understand it today) and trace how such a disease entity moved across history under different names. While such an approach is entirely plausible, instead I want to approach it via a kind of semantic historiography (Kuriyama 1997), in which I trace the term "utsu" itself and examine what meanings and conditions were implicated. In so doing, I want to illuminate how Japanese experienced the body and mind differently at different times, and ask how it is that "depression" as people talked about it in the Edo Era had become so unfamiliar, so obsolete for Japanese, that psychiatrists even assumed that such an illness experience never existed.

II. Four meanings of *utsushô*

a. A sign of qi-stagnation

Before there was the medical concept of *utsushô*, utsu as an ordinary word already had a long history. Utsu has dual meanings: first of all, as the character *utsu* (鬱) is graphically made up of trees "densely growing together," the term signifies a physiological state where things are rampant, stagnated, or densely overgrown. Secondly, utsu is also used to connote depressive emotion. Both in Chinese and Japanese literature, utsu has been used from the early time as an expression for gloominess, sorrow, and pensiveness, as discussed below (Morohashi's Daikanwa Dictionary 1984:13261-13265). What united these seemingly separate meanings was the premodern belief in the phenomenon called qi. Qi was an essential aspect of the premodern Japanese thought –the idea that not only all the living things but also the world, and the cosmic itself, are filled with this life energy (Arima 1990, Maebayashi et al. 2000). Qi was invisible and intangible, and yet it could be felt in the form of wind when it moved in the atmosphere and in the form of breath

when exhaled by the human body. As something that was constantly circulating, qi would alter and was altered by both external and internal forces, one of which was the movement of emotions. Thus when premodern Japanese talked about utsu, presumably it was qi itself that was being stagnated in the physiological sense, while the same qi—causing blockage in the human body—was thought to give rise to a psychologically depressed state. Premodern literature is rife with such words that referred to utsu in these dual meanings (see Nihon Kokugo Dictionary 2001:343). Take the word *utsumu* (鬱霧 utsu+fog) or stagnated fog, which appears in a 14th century school textbook. The expression was used to signify both an external, *physiological* condition of dense fog and a projected internal *psychological* state of gloominess (note the metaphorical link between weather and depressive experience: see Tanaka-Matsumi & Marsella 1976). Another term that often appeared in premodern literature was *ukketsu* (鬱結 or utsu+knot), as seen in the 8th century Japan's first collection of poems *Manyôshû* (Ten Thousand Leaves). One of the poems reads: "sorrow stagnating and knotting in one's heart" (Nakanishi 1995:4247), suggesting the idea that qi depressed in one's heart causes dejected emotions. The idea of qi surging in anger, draining away in sorrow, knotted and blocked in prudence, was indeed part of the common wisdom in premodern Japan, which accounted for the sensations arising both in the mind and body (Kuriyama 1999).

While the word utsu itself had these two meanings, "*utsushô*"(sign of utsu) as a medical concept seems to have started with its first connotation, that is to simply denote various sorts of pathological stagnation, before it came to acquire a predominant image of an illness of emotion. The concept of *utsushô* dates back to Tashiro Sanki (1465-1544), who brought some Chinese medical ideas to Japan and attributed the origin of the notion to a Chinese doctor called Shutankei (1281-1358). Sanki writes that *utsushô* refers to a state in which qi would lose its normalcy, become stagnated and blocked, unable to dissipate (on the blockage of

natural flow in Chinese thought: see Allan 1997). Under the category of *utsushô*, there were six different kinds of *utsu*, depending on what was stagnating. These were stagnations of qi, moisture, heat, phlegm, blood, and food: Phlegm-*utsu* would cause shortness of breath; blood-*utsu* would cause limbs to lose their energy and produce red feces (see Manase Dôsan 1979:15-17). Because such stagnation was thought to be underlying various physical pains, doctors were able to make diagnoses of what kind of *utsu* a patient had by examining the manifested physical symptoms. As suggested in Sanki's writings, *qi-utsu* was said to produce "sharp, stinging pain" in the chest, or "swelling in the auxiliary region, dense steam coming out of feces, headaches and dizziness"(Tashiro 1979:151). Sanki's disciples, Manase Dôsan (1507-1594) and Gensaku (1549-1631) (the "Restorers of Japanese medicine") helped establish this notion in medicine, using it to diagnose many of their prominent clients. Their records indicate that well-known historical figures such as Yodogimi (the infamous mistress of the ruler of Japan at the time) and Emperor Goyôzei were diagnosed with *utsushô*. Yodogimi, for instance, suffered "congested and aching chest" and "headaches" in her thirties and was unable to sleep or eat because of *utsushô*. Emperor Goyôzei's case was acute: he developed *utsushô* at the age of 28 and suffered "sudden dizziness," soon lost consciousness, and rapidly fell into a critical condition (Manase Gensaku 1979:93-94, 98). As these cases indicate, *utsushô* as a technical, medical diagnosis, was a broadly defined concept that simply indicated the internal blockages of all kinds.

b. Illness of emotion

While *utsushô* in its original form was such an all encompassing concept, at least by the late-17th century, it seems to have become a prototypical "illness of emotions." For instance, the first medical dictionary of the Edo Era written by

Ashikawa Keishû in 1686 has an entry of *utsushô*, explained here as the "illness of seven emotions" (seven emotions being the core emotions, including joy, anger, worry, pensiveness, sadness, fear, and fright). Though the dictionary cites other possible causes (such as sleep patterns and diet) for the pathological state, emotions –particularly when they are experienced intensely and/or acutely—are singled out as the primary cause of *utsushô* (Ashikawa 1982:336). Perhaps this was not surprising given the fact that qi was the most essential element of health, the very thing that transported other substances throughout the body. And because qi was also thought to govern emotions, *qi-utsu*, became the most essential feature of *utsushô* and took on both the physiological and psychological meanings. As Sanki put it, "when a man or a woman has his/her spirit knotted in pensiveness, is unable to fulfill their amorous longing, or rages in jealousy, qi in the chest would go wild, losing its order, rising in its intensity" (Tashiro 1979:40). Thus the kind of people often described in medieval literature—people who long for someone so deeply, so intensely that they would wither away, fall ill, even die in sorrow—could now be medically understood and treated accordingly—at least theoretically—as suffering *utsushô*. Despite the claims previously made by Japanese psychiatrists that Japanese people simply found depressed emotions as an aesthetic experience (Kimura 1979), such emotions, when grave, were apparently recognized as a pathological state and were treated as an object of medical intervention. This, it seems, marked the first medicalization of the Japanese notion of "depression."[9]

c. Qi-stagnation as the foundation of ill health

The notion of *utsushô* as an illness of stagnated qi was soon to go through a series

[9] It is notable that Robert Burton's famous The Anatomy of Melancholy was also published in 1621 (Burton 1932), roughly around the same time that *utsushô* was becoming a popular category in Japanese medicine.

of conceptual transformations. What helped popularize—and also diffuse—the idea of qi-stagnation was another strand of medial thought on *qi-utsu*, theorized in the 17th century by Gotô Kanzan (1659-1733). Kanzan was one of the leading theorists of Kohôha, a new school of medical thought that arose in opposition to the Manases' school of medicine. As historians of Japanese medicine have recently demonstrated (see Ryô 1997; Shirasugi 1997; Kuriyama 1997), Kanzan was an influential doctor, whose rebel spirit was expressed in the fact that he wore townsman's clothes instead of the customary priestly attire. Rather than catering to the aristocrats or the wealthy few,[10] Kanzan chose to practice among lay people and ardently promoted the idea that people can cultivate their own health. Importantly, Kanzan is recognized as one of the very first Japanese doctors to go beyond simply adopting the teaching of Chinese medicine and to establish his own theories about health. Based upon his clinical practice, Kanzan observed that in the Tokugawa Regime, when people no longer had to suffer from serious external injuries (as they did during previous wars), they were instead beginning to suffer from altogether different kinds of illnesses. This is because, he asserted, people no longer "moved their bodies" but "used their mind, seeking to fulfill their desires." What they now had was "internal torment and a hundred illnesses," which, according to Kanzan, stemmed from the condition of *qi-utsu*. Kanzan found, paradoxically in a time of peace and prosperity, "more and more people are suffering from *qi-utsu*" (Kanzan cited in Shirasugi 1997:71).

In the theory that Kanzan developed and his disciples helped establish as an influential theory of the time, *qi-utsu* or qi-stagnation was no longer limited to its former narrow definition but was now extended to signify the very precondition of ill health. As Ryô (1997) points out, Kanzan's etiology was two-layered: there were numerous causes of illness—such as climate, diet, sleep patterns, or

[10] As it may have been the case at the time of the Manases, when herbs were still being imported and were thus more precious and expensive.

emotions (certainly given much importance in Kanzan's text)—but these causes remained secondary. Instead, the foundation of all illnesses lay in the stagnation of qi: Kanzan argued that people would not develop any illness if their qi was circulating smoothly inside their body. Critical of what he saw as the excessive use of medications, Kanzan encouraged people to take care of their own bodies through healthy daily practices, such as proper diet, bathing in hot springs, massage, and moxibustion. The idea was to always maintain the smooth circulation of qi and to be aware of any signs of *qi*-stagnation in the body, which could be easily unblocked if caught at an early stage. Through Kanzan's formulation, *qi-utsu* came to represent a ubiquitous and overarching theory of health. It was also around this time that health-related books for popular consumption began to be published, from guides on hot springs to how to choose a good doctor (e.g., Ryôi Meikan 1713). Through these manuals, the prevention of *qi-utsu* and self-control of qi became a central theme in the Edo health practices (Ryô 1997).

According to Kuriyama (1997), Kanzan's emphasis on *qi-utsu* as the basis of ill heath was a significant departure from Chinese medical theories, which placed far more emphasis on depletion—not stagnation—of qi as the cause of ill health. This rising "anxiety" about stagnation, Kuriyama suggests, reflected the proto-capitalist transformation that Japan was going through in the 17th century. Kuriyama indicates how the new health consciousness paralleled the economic-political discourse on the smooth flow of goods and currency in the new economic order, coupled with the increasing demand on human labor. The work ethics born out of this so-called "industr*ious* revolution" was inseparable from the discourse of health that was being advocated by medical professions like Kanzan and his disciples (Kuriyama 1997). If *qi-utsu* had remained a technical diagnosis in the time of the Manases, reserved for the aristocrats who could afford expensive herbal medicine, then the *qi-utsu* that was beginning to be talked about

in the time of Kanzan represented the era of new health consciousness, when even lay people were able to, and were encouraged to, cultivate their own health.

d. *Qi-utsu* moralized

Under this new health consciousness, there are signs that the condition of *qi-utsu* also came to be associated with a certain kind of personhood. As Kuriyama (1997) demonstrates, Kanzan's idea of *qi-utsu* referred not only to a temporary state of illness but also to a long-term effect of the way people lived. As Kanzan argued, qi that accumulates inside the body would eventually create a blockage or even a clot, causing *qi-utsu* to become a "habit" of the body (this point is also emphasized in the later medical text of Azai Teian discussed below). Such stagnation would not be produced in a day or two but would represent the years spent in the kind of life that would produce *qi-utsu*. The presence of stubborn *qi-utsu* reflected, then, "the weight of one's past" (Kuriyama 1997:58). As to what kind of "past" that was, however, was given two opposite meanings, with gradations in between.

On the one end, there were people whose *qi-utsu* represented, in line with more traditional idea of *qi-utsu*, an illness of long-suffered emotion. As Katsuki Gyûzan (1656-1740), a contemporary of Kanzan noted, the kind of people who would develop *qi-utsu* tended to be, for example, "a formerly affluent person who fell into poverty, a woman who does not get along with her in-laws or husband, and a samurai who works dutifully and diligently" (Katsuki 1981:361). In other words, those who fell to *qi-utsu* were the kind of people whose social, moral, and psychological agonies were manifested through *qi-utsu*—an inscription of suffering onto the body—the idea that seems to have become part of the popular imagination of the Edo Era. For instance, in the famous case of attempted vengeance by Sôma Daisaku in 1822, the Shogunate issued a verdict that referred

to *qi-utsu*. Daisaku tried to murder the lord of a neighboring clan, after his own lord died from distress allegedly caused by the neighboring lord in a long standing conflict. The verdict explained that the death of Daisaku's lord stemmed from *qi-utsu* induced by enmity, which further gave rise to deadly illness (Nanbushi Rekishi Henshû Iinkai 1994:285). As well, Tachibana Nankei, a doctor and a popular essayist of the late Edo Era, cites his friend's words: "People today are suffering from the illness of utsu-qi and remain dejected even after they rest. They have poor complexion, lack qi-energy, and become thin." Nankei agrees with his friend, however, that the kind of people who do not even suffer "utsu-qi" are "generally fools" (Tachibana 1927:28), suggesting the possibility that *qi-utsu* had become prevalent towards the end of the Edo Era, when there was a general sense of stagnation among intellectuals and aspiring youths deploring the declining condition of the feudal state. In such ways, *qi-utsu* became an idiom of distress for people whose pathological condition was seen as caused by excessive contemplation and silent endurance, which in turn, carried a certain moral weight of social legitimacy for those who suffered.

Another distinctive meaning that derived from this, and became the predominant image of *utsushô* particularly in popular literature in the Edo Era was that of *utsushô* as *love sickness*. In a late 18th century bookthat collected the rumors he heard in town, a magistrate's officer called Negishi Yasumori records a story about a son of an affluent farmer, who developed *utsushô* from strong longing for a courtesan he left in the city (Negishi 1972:250). This image of a young person in *utsushô* brooding over love appears repeatedly in literature, an image that seems to have continued into modernity. For instance, an advertisement from the 1870s for a pill called *Wakyôgan* ("harmony of the heart pill"), which was an all-purpose medication reportedly used since the Edo Era, includes *qi-utsu* as one of the maladies it could remedy. The advertisement shows a picture of a woman in kimono bending over to read what appear to be love letters, representing a

prototypical *utsushô* patient as lay people understood it (see Figures 1 and 2). As well, in a satirical newspaper called *Dandan Chibun* published within a decade after this advertisement, there is also an entry about *utsushô*. The line goes: "the feeling of love rose to the point where he developed *qi-utsushô*" (Dandan Chinbun 1887:9440). Apparently, lay people in the Edo Era –and well into the Meiji period—shared the idea that unfulfilled desires, longing and sorrow, resentment and rage, knotted in one's heart and created *qi-utsu*, for which medication might bring (temporary) relief.

Figure 1: A woman in *qi-utsu* (enlarged from Figure 2)

Figure 2: An advertisement for an all purpose pill called Wakyôgan (Courtesy of Nichibunken)[11]

[11] I would like to thank Prof. Kuriyama Shigehisa for drawing my attention to the existence of this print.

On the other hand, however, *qi-utsu* also came to acquire a decisively negative connotation for the intellectuals preaching morality. As *qi-utsu* could be caused merely by lack of bodily movement, those who suffer from this were also represented to be a class of people who were unproductive, even *idle*. This theme of lack of productivity as the cause of *qi-utsu* is most conspicuous in the teachings of Kaibara Ekken (1630-1714), a scholar who is known for making neo-Confucianist ideas accessible to ordinary people through his highly popular and influential books such as Yôjôkun (Theory of Health, which is still being read today: see Yokoyama 1995). In this book, Ekken discusses *qi-utsu* as a sign of moral failure—particularly of women. Ekken writes, for instance, "Women are more prone to *qi-utsu*—and illnesses in general—because they tend to stay inside. They should make sure to use their body and labor" (Kaibara 1928:103). Certainly, earlier medical theorists such as Tashiro Sanki had already pointed out that women were more likely to develop *qi-utsu* but the reason he gave was because women were born yin by nature (Tashiro 1979:150). This seems to have changed in Ekken's argument—he says that women were more prone to *qi-utsu* not simply because of their inherent nature but because of the way they spent their days—not moving enough, not producing enough. At the time when the new health consciousness was being preached to the commoners, *qi-utsu* thus came to signify the opposite of an idealized, active, hardworking person whose qi was constantly in flux. Linked to the new ideology of class and labor, *qi-utsu* became a gender-specific, condemnable sign of idleness, which gave a different spin to the earlier ideas of *qi-utsu* as an illness of long-suffered emotions.

Thus it is not surprising that a prototypical patient of *qi-utsu* that began to appear in popular literature was a spoiled daughter of an affluent family, who lived a lethargic, life of leisure, suggesting the underlying moral economy of energy. This we can see in the highly popular writings of Ejima Kiseki (1666-1735), one of the most famous creators of *ukiyozôshi* ("Books of the Floating World") or novellas for

townspeople, which described their everyday lives and their romances. In a collection of stories in which Ejima features prototypical townswomen, he describes a young woman who becomes pregnant without her mother's knowledge and develops a condition resembling illness. Her worried mother has this to say: "An illness like this in a girl brought up with tender care must be *utsushô*; it might develop into *rôzeki* [an illness which was later equated with tuberculosis]. Take good care of yourself and get well soon" (Ejima 1989:426). In this description, *utsushô* is understood to be a state that lies in between health and ill-health, a condition whose moral connotation is also ambiguous. In other stories, he also wrote that "women are prone to *qi-utsu*", and that "if it is *qi-utsu*, then there is no need to take any medication. Go out as you would like and nurture your qi. What is important is that you do not worry about a thing" (Ejima 1989:462). Here we find a transformation of *qi-utsu* from an acute and critical condition that could make someone "lose consciousness" –as was the case with Emperor Goyôzei—to a chronic condition that could well be cured merely by "going out" and "not worrying." This is an important departure from the earlier understanding of *qi-utsu* in the Manases' time, when their clients—not infrequently aristocrats whose leisurely, idle way of being would have been simply assumed rather than condemned—were seriously treated with medication. Reflecting the influence of Kanzan's theory, the women in *qi-utsu* here are described in a kind of moral tales, whose illness state is even suspected. The failure to engage in productive life for the rising merchant class was now an object of mockery and blame, for which the medical theory of *utsushô* seems to have provided a symbolic label.

III. Transformation of *utsushô* into melancholia and to manic-depression

How was it that this notion of *utsushô*–which appears to have become not much

more than an everyday form of distress by the late Edo Era—came to be adopted as the term for translating melancholia? In order to understand this, it is important to recognize how premodern Japanese doctors—as they began to treat insanity as a kind of illness—extended their theories of qi to account for its underlying mechanism. Despite their conceptual differences and nuances, the traditional medical theorists of insanity seemed to share the belief that there was an assumed continuity between normalcy and abnormalcy, and that insanity, as a severe form of disrupted qi, represented one end of this pole.

As in many other parts of the world, in Japan there were historical shifts in the way people talked about insanity from earlier, magical thought that located the pathogenic agent of insanity external to individuals (as in spirit possession) to later traditional medical thoughts that increasingly placed it internal to individual biology (cf., Young 1976). The previous term for insanity was "tabure" (deviation from others), caused by "mono no qi" (qi of things or supernatural powers), as we see in the Genji Monogatari (The Tale of Genji), which were treated by various forms of religious chant meant to drive the bad spirit away. Such beliefs were increasingly replaced, in the Edo Era, by the notion of "qi-chigai" (qi-discord) by the medical doctors who re-defined it as a loss of balance in interpersonal relations as well as in natural elements within an individual body (Oda 1998).[12] Historians have suggested that it was in the late Edo Era that a notable specialization in insanity took shape in medical textbooks and clinical practice (Okada 2002, Omata 1998). This sudden specialization might be due, according to Hiruta (1999a) to urbanization and the development of a commerce economy that

[12] Omata (1998) classifies four types of therapies for mental illness that developed in Japan since Medieval times and notes that each was attached to a particular sect of Buddhism and its thought: 1) spirit possession rituals and folk (and later esoteric Buddhist) water therapy; 2) the Jôdô-sect's herbal medication; 3) the Nichiren-sect's prayer-reading and Zen-sect's self-introspection; and 4) more generalized behavioral therapies (such as leading a disciplined life at temples).

led people to look for a different rationale (and a more individualized approach) to health and illness. As well, the high density and oversupply of doctors in the cities (e.g., 250 doctors per 100,000 people in Edo in 1819) may have prompted some doctors to seek a new subfield (Hiruta 1999b). Thus, after Ashikawa Kashû created the classifications of insanity (such as "tenkyô"), Kagawa Shûan (1683-1755), a distinguished disciple of Gotô Kanzan, for the first time produced systematic classification of insanity (published in 1807) based upon his clinical observations, and showed how it could be explained by qi-stagnation. In 1819, Tsuchida Ken wrote Japan's first treatise on insanity, discussing more than 58 such cases out of 1000 patients he treated over 10 years. In one the cases he described, he explained that the patient's insanity was caused by the "accumulation of qi" which was "not the kind of thing that could have happened in one day." His casebook reads:

> The wife of a head monk. Age 32 or 33. She went to the capital with her husband before and developed Ten (insanity). For two years, she was unable to sleep all night, had *qi-utsu*, and was always in sorrow and grief, wanting no food. She would often try to kill herself when others were not watching (Tsuchida 1979:398).

Thus, for the Japanese doctors who were already beginning to conceptualize insanity via the notion of *qi-utsu*, it probably came naturally to understand the concept of "melancholia" in terms of *qi-utsu* when the notion was first introduced. In a text of Dutch medicine complied by Komori Touu (1782-1843), melancholia was given the name of *utsushô* (in Komori's Taisei Hôkan, published between 1829 and 1834, and is excerpted in Kaneko 1965:272-275).[13] As far as I could find, some

[13] In this text, Komori gives a detailed explanation about *utsushô*, writing that the patients would "feel woeful and agonize for no good reason" and that this illness is caused by the "inherent weakness in the brain."

variations of utsu, either *utsushô* (鬱症), utsu-yû-byô (鬱憂病: yû meaning pensiveness) or utsu-byô (鬱病) seem to have become, from this point on, the standard translation for melancholia and later "depression." Though an early detailed entry about melancholia in 1793 by Udagawa Genzui (1755-1797) –in the first translation of a Western text in internal medicine (by Johannes de Gorter)—was given a different name of zôeki haikoku byô (or illness of black bile), it is highly plausible that Udagawa as well understood this to be the likes of *utsushô*. Udagawa explained that melancholia was a pathological state in which black bile would "stagnate" (utsu) in the artery, eventually traveling to the brain where it would end up "changing the normal state of the qi-spirit (*Geist* here translated as sei-qi or "qi-spirit")." This would cause "one's spirit and perception to become illusionary, pensive, and sad." Interestingly, however, melancholia was also something that could be treated, for instance, by simply "discharging the black bile feces" (Udagawa 1995:357-360). Thus, the premodern Western notion of melancholia had, it seems, more parallels with the premodern Japanese notion of utsu than one may have assumed. Firstly, both notions referred to illnesses of sorrow and gloom. Secondly, just as *utsushô* was caused by qi-stagnation, melancholia was still, in the 18th century West, conceptualized in terms of humoral theory, and was regarded to be a sign of stagnation of the humor (black bile), for which bodily discharge could bring a cure. As these Japanese doctors understood it at the time, what was important for both *utsushô* and melancholia was to restore the balance of the mind and body by recovering the natural flow of the essential life force—albeit with their different ideas of what that life force constituted.

If Japanese psychiatrists have largely forgotten this conceptual affinity—and the certain historical continuity—between melancholia and utsubyô, it is partly because the notion of melancholia itself in the West went through a significant conceptual transformation in the 19th century. By the time Japanese psychiatrists firmly established their discipline in the 1900s, the melancholia concept had

already lost much of its premodern connotations in the West and become an incurable illness overdetermined by genetic brain abnormalcy. The change of the term from melancholia to depression was, in effect, to cut off the philosophical and existential baggage that the humoral concept of melancholia had, and instead to emphasize the physiological, pathological mechanism of the brain (the word depression was originally adopted from the physiological meaning of "lowering" or "being lowered": see Abe 1998). The humoral explanations of melancholia continued to be seen in Henry Maudsleys' textbook (translated in 1876), which was widely read among early Japanese psychiatrists. But by the time that Kure Shûzô introduced Kraepelinian neuropsychiatry as the official doctrine in academia in the 1900s, the image of depression as an inherent *brain disease*—with the central locus of control gone wrong—came to the fore, eclipsing the earlier humoral theory of melancholia altogether. After Kraepelin redefined depression as part of manic-depression, the notion of utsubyô became further separated from its earlier meanings. As psychiatrists began to widely disseminate their new psychiatric ideas, utsubyô came to signify an inherent and incurable illness, characterized by automatic recurrence of psychotic attacks (e.g., Ishida 1906). This image of the manic-depressive as incomprehensible, other-worldly, "animal-like" beings can be found in the newspaper articles that emphasize their danger (Yomiuri March 5, 1917, Yomiuri January 20, 1921) as well as a popular writing published in 1939:

> Dr. Alcotti presented his theory of periodic depression of Gorillas, causing a big sensation in academia last year... According to him, the Gorilla has a cycle of *utsu-yû-byô* (melancholia) and *kyôfu-shô* (phobia), at which point he is likely to become most violent. When agony overcomes him, he goes to lick "Hyraceum" in order to mitigate the pain (Oguri 1979:8).

Just as this author attributed the manic-depression to gorillas, the image of the mentally ill as beastly beings, who exist outside of humanity, became widespread by the 1940s, as lamented by psychiatrists at the time (e.g., Suga 1939). This stigmatized image was to continue for a long time even in the post-WWW era.

It is this radical separation between the physiological mechanism and psychological meanings that characterized the epistemological break brought about by biomedical psychiatry. As psychiatry located utsubyô in the realm of psychosis (e.g., Kure 2002), the concept of depression became stripped of its former connection to everyday forms of sorrow and gloom. Depression as such no longer evoked the image of accumulated sorrow or silent endurance that were once thought to be a cause of such an illness. The effect of this conceptual transformation via biomedicine was so broad and profound that it led Miyake Kôichi, the fourth professor of psychiatry at Tokyo Imperial University to say this in an intellectual magazine in 1924. Discussing how Japanese have come to largely disregard the effect of the mind on the body, Miyake wrote:

> Just as people used to call it the illness of qi, some illnesses are caused by the mind. The body and mind cannot be separated, and most diseases used to be thought to occur from mental causes. However, with the development of natural sciences and medicine, it was discovered that the diseases are caused by (external) agents such as germs and toxins....People have come to consider now that the mind has nothing to do with illness (Miyake 1924:336).

As utsu-byô became detached from its social, psychological causes, it became an illness that Japanese could no longer afford to suffer anymore.[14]

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[14] Of paramount importance in traditional Japanese neuropsychiatry was—and

IV. Depression in modernity

What then happened to the kind of experience that people called the illness of *qi-utsu*? Did the experience disappear entirely with the transformation of the word itself?[15] Earlier Japanese psychiatrists had tended to disregard milder forms of depression as largely irrelevant to the main object of their scientific investigations and instead to focus on severe forms of psychoses. However, during the first few decades of the institutionalization of psychiatry, there was a period in which even academic psychiatrists were vigorously promoting the idea that psychiatry can and should treat a wide range of distress—particularly neurasthenia (to be discussed in Chapter 4). The relatively easy acceptance of the notion of nerves and neurasthenia may have been because intellectuals at the time

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still is today—the idea of a qualitative discontinuity of mental illness. Depression (or endogenous depression, to be precise) has long been conceptualized as psychosis in Japan, and as such it is assumed to be distinctively and qualitatively different from a normal experience of a depressed mood. This image of depression is most succinctly expressed in the model of the "alarm clock theory," with which Japanese psychiatrists were trained at least up to the 1970s. According to this model, the depressed person is like someone carrying a psychotic time bomb, for whom depression begins when the internal clock goes off and ends after it runs its course. Depression is assumed to be endogenous, arising by itself from within, with few or no external influences, and to repeat the same process when the next cycle comes round. As we will see, this highly mechanical, biological assumption embedded in the notion of endogenous depression left little possibility for consideration of social etiology.

[15] Here we find ourselves in tricky epistemological –and empirical—questions about a history of illness. Although I do not consider depression to be a thing-in-itself, a constant biological phenomenon that is merely given different names at different historical eras, I do want to point out that the rise of certain medical ideas not only give voice to preexisting anxiety about the body but also actively cultivate it. Modern medicine de-legitimized traditional health anxieties such as *qi-utsu*, turning it into a mere metaphorical illness devoid of any real substance, and instilled the notion of a nerve disease as something to be taken seriously instead.

explicitly attempted to replace the premodern notion of qi with the new idiom of nerves.

A quick glance at the newspapers of the time suggests this transition, in which the new, biomedical concept of nerves was being used by doctors, intellectuals, and later lay people, to overwrite the traditional notion of *qi-utsu*. An 1878 article depicting an aristocratic daughter in *qi-utsu* is obviously still written within the traditional framework (Yomiuri March 23, 1878). An article appearing in the following year, however, discusses a young woman who is "shy by nature" and is depressed (*utsu*) all the time, finally developing a "nerve disorder" (shinkei-byô) and throwing herself in Shinbashi River (Yomiuri July 25, 1879). What we see here is the beginning of a conversion of the two notions—*qi-utsu* and a nerve disorder—and the penetration of the modern categories into the lexicon of lay people. Another newspaper article in 1886 even more explicitly illuminates how Japanese at the time were dealing with the transition from the old to new; it tells us that a daughter of an affluent family suffers from "*utsu-yû-byô*" (melancholia). The worried family thinks that it is love sickness and takes her to a shrine to pray, where they are told that what she really has is a "nerve disorder." The astonished family asks for prayers and exorcism, but is instead advised that simply "reasoning with her" would do to cure such a disorder. The article ends with a comic statement: "how trivial the cause of *qi-utsu* really is!" (Yomiuri September 16, 1886). Interestingly, the meaning of nerve disorder is still diffused and unknown, treated here as little more than a metaphorical illness (that *qi-utsu* had become by then) despite the fact that psychiatrists were beginning to warn at the time of the serious consequences that damaged nerves could bring. In a 1925 novel called set in the Edo Era, the kabuki writer Okamoto Kidô depicts a merchant family in torment over the mysterious illness of their daughter: "doctors were unable to give a definite diagnosis...and the family finally concluded that it was probably something like *qi-utsu*, which girls of marriageable age often suffer

from" (Okamoto 1999:252).[16] Here we find the familiar, traditional moralization of *qi-utsu*, though it had become a kind of catchall label given to an ailment of uncertain nature. *Qi-utsu* had become a metaphorical illness, a mere psychological problem juxtaposed with the Western category of the real, biological illness of the nerves and the brain.

Despite its conceptual similarities with qi, the changes brought about by "nerves" were numerous and important. Nerves were tangible, visible, and thus real, unlike qi, whose presence could only be felt but never seen. Nerves also opened the way for the anatomical worldview to take hold, serving to legitimate the dissection-based technology of biomedicine. The concept of nerves also helped establish the brain as the central governing mechanism and the location of the modern soul. Nerves were also contained within one's individual body, instead of being dispersed and flowing like qi. As such, the illness of nerves, at least theoretically, could no longer be about the discord in interpersonal relationship or one's relationship to the environment. Instead the nerve disease was increasingly coming to connote the problem within the individual body, which helped promote the idea of localization of diseases. In such ways, the rise of the nerve discourse served medical experts to denounce traditional medicine and relegate qi to the realm of superstition.[17] Through this process, qi or *qi-utsu* came to acquire metaphorical existence, increasingly de-corporealized and

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[16] Sanyûtei Enshô, a prominent figure in the classic *rakugo* (a highly stylized form of comedy), also gives a story of a tyrannical *Shôgun*, who avoids doing anything he does not want to do by claiming an illness. Withdrawn to a dark room, pretending to be ill, he really develops a "*qi-utsushô*," which, according to Enshô, "would now be called shinkeisuijaku (neurasthenia)" (Sanyûtei 1980).

[17] Note that German neuropsychiatry that Japanese psychiatrists imported at the time "made no real distinction between diseases of the brain and diseases of the mind, for they held that mental processes were always the unvarying result of underlying brain functions" (Bynum 1985:89).

psychologized.[18]

V. Psychologization of *qi-utsu*

Thus, one way in which the notion of *qi-utsu* disappeared from the modern Japanese lexicon was through this epistemological break brought about by Western medicine. Yet, it is too early to presume that it was solely the work of modern Western psychiatry that set forth this disjuncture and made the notion of qi obsolete. Indeed, one of the puzzles for the scholars of Japanese medicine is the fact that the concept of qi itself went through important changes in the Edo Era, when it seemed to have gradually lost its corporeality. Unlike Chinese who have largely retained the traditional meaning of qi, Japanese have come to regard qi predominantly as a psychological notion (Nakai 1995, Maebayashi et al. 2000). For modern Japanese (except in special contexts such as traditional medicine and martial arts), qi denotes little more than the mind or feeling, and while there are numerous psychological expressions that include qi, these are almost all understood to be little more than a metaphor (Doi 2000). When Japanese today talk about "qi ga hareru" (qi dissipating) to express feeling cheered up, qi ga meiru (qi depressed) or feeling depressed, they almost never imagine that there is a real physiological entity called qi doing all these movements – it is only in the mind. It is with this de-corporealization of qi itself that modern Japanese have also forgotten the experience of *utsushô* or the idea that it may be that their

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[18] Interestingly, nerve-related words became quickly incorporated into traditional medicine as well: e.g., "shinkeishitsu," or nervous temperament, as a personality trait that can be caused by "hereditary factors, overdiscipline and overprotection during childhood, and the institutionalized family structure and educational system" (Lock 1980:222). Psychosomatic medicine also took up and elaborated on shinkei and popularized neurosis. Biomedical psychiatry retained the ambiguity of shinkei by using notions such as autonomic nervous disorder (jiritsu shinkei shicchôshô) that simultaneously denotes both biological and the psycho-social implications.

mind—as well as the body—could be suffering from some kind of stagnation.

While no definitive studies have been conducted to my knowledge to trace exactly when this psychologization and de-corporealization of qi began to occur in Japan, I have found some materials that suggest that this gradual change may have become a serious concern among medical professionals by the late Edo Era. It is apparent that in their discussions of *utsushô*, some doctors were indeed aware of such changes and worried about their implications. Azai Teian (1770-1829) was an influential director of medicine for the Owari Tokugawa Clan: he is known for establishing a medical school and training over 3000 doctors. In his lectures on *utsushô*, Teian repeatedly criticized the "secular usage" of *qi-utsu*. According to Teian, the original meaning of *qi-utsu* referred to "things being clotted and clustered in one place" and that *utsushô* was a medical concept that referred to the "fundamentals of illness." Lay people, however, got it all wrong:

> What we here call *qi-utsu* is different from what today's people say, as in: "thinking made me *qi-utsu*." *Qi-utsu* means that *qi*-breath is in a state of *utsu*—that is, *qi*-breath is unable to stretch and has become blocked. In Japanese language, people use qi to refer to mind. They say they used qi when they mean they used their mind. They say they dispersed qi when they mean they refreshed their mind. What qi really means, however, is qi of breath. Thus these (usages) are entirely mistakes on the side of lay people (see Azai 1981:435-449).

As Teian pointed out, qi in traditional medical thought referred to vital energy that would take the form of breath, and *qi-utsu* a truly physical illness that would cause real pain. The secular understanding of *qi-utsu* not only ignored this conceptual origin but was indeed becoming a threat to its original medical

formulation. We can infer from Teian's words that people at the time probably did not envision their qi to be physically stagnated when they said they were "*qi-utsu.*" Qi no longer had the connotation of being the cosmic energy filling the universe, or the material force that circulated within the human body. Losing its corporeality, the notion of *qi-utsu* may have been increasingly conceptualized, even before modernity, as simply metaphorical.

VI. Conclusion

Further research is needed to explore exactly what broader transformation was happening before the onset of modernity, which would bring about this de-corporealization—and psychologization—of qi. But what I want to point out in the end is that another conceptual change seems to be occurring now via the increasing medicalization of depression from the 1990s. Significantly, today's medicalization is urging Japanese to think of depression not as an alien, psychotic phenomenon but as an extension of everyday distress. It is also allowing Japanese—probably for the first time in a long time—to pay attention to how their psychological distress is simultaneously a physiological process. This is an important departure from the predominant neuropsychiatric discourse of the past, which has tended to depict mental illness in the overwhelmingly negative light of genetic determinism, devoid of serious considerations about psychological (or holistic) mechanisms that might underlie the onset of depression. The emerging discourse about depression may in fact allow Japanese to imagine the internal bodily changes as linked to the psychological and social events in one's own life. If so, then, the depressed body will no longer be an isolated entity whose mechanism remains alien to the afflicted themselves. Instead the depressed body could now be regarded as essentially physiological, psychological and social at the same time. This may be too optimistic an interpretation of psychiatry, given

the biologizing and individualizing tendencies of neurobiological discourses in psychiatry. Still, making depression familiar again through this new psychiatric language may serve to remind Japanese of the ways in which they once talked about the profound connection that existed between the depressed body and mind, as well as the depressed individuals and the social environment in which they live.

Chapter 3: The Expansion of Psychiatry into Everyday Life

I. Three phases of psychiatric expansion

Rising concern over the increase of depression and suicide marks a new phase in the history of Japanese psychiatry, which had until recently rarely been used as a treatment for "ordinary" Japanese. In this chapter, I examine this transformation by dividing the history of psychiatry into three phases, each contributing to the expansion of psychiatry into the realm of everyday distress. The first (1870s-1930s) was in the prewar era, when the state introduced psychiatry as a force for modernization. The view that mental illness is a biological--and often hereditary--disease displaced the previous notion in the Edo Era that insanity was, just like any other illness, caused by a discord of qi energy (as discussed in Chapter 2). The neurobiological view of mental illness proliferated through the influence of academic psychiatry, the media, and the Social Darwinist social policies that enforced private detention of the ill. Apart from literary discussion about neurasthenia as pathology of modernity (see Chapter 4), psychiatry was used as an oppressive power of exclusion and stigmatization. The second expansion came at the time of the postwar reconstruction of Japan (1950s-1960s). Largely driven by economic rationale, the state helped establish a large number of private mental hospitals, which institutionalized those who were deemed unfit and unproductive in the new social order. Although this expansion helped solidify the infrastructure of psychiatry, the growing contradiction in the fact that psychiatry served as a gatekeeper--rather than cure-provider--of the mentally ill led to a long-lasting antipsychiatry movement beginning in the 1960s. I suggest that the attack on traditional academic psychiatry and the increasing popular attention to psychiatric discourse created both confusion in and a temporary retreat from academic, biological psychiatry and a proliferation of psychiatric

discourse as a language of resistance and a form of social critique (see Chapter 5). I argue that this transition set the conditions for the possibility of a third expansion of psychiatry (1980s to present), when psychiatry came out of asylums and, for the first time, began to focus on the mental *health* of ordinary Japanese as a national concern.[19]

II. The first expansion (1870s-1930s)

a. Modernizing Japanese Bodies: From *Yôjô* to *Eisei*

It has been convincingly argued that the modern Japanese state has used the body in inscribing the political order (Bourdachs 1997, Burns 1997, Karatani 1993, Lock 1993). The institutionalization of the new medical system in Japan was clearly the product of a top-down process, motivated by the state's goal to recreate the nation as an equal competitor among the colonizing powers of the West. The Meiji state thus took upon itself to bodily and visually modernize Japanese first by prohibiting traditional healing practices that appeared "odd" in the eyes of Westerners (e.g., the Law on Minor Offenses in 1872: Narita 1995; Kawamura 1990). Amidst regional opposition, the central government further banned sorcery, magic, and shamanism in 1873 (Ôtsuki 1998), and further suppressed traditional medicine, instilling in its place biomedicine as a new system of knowledge and practice in 1874 (Jannetta 1997).[20] Cholera epidemics between 1858-1895 became, as in Europe, a battlefield upon which biomedicine won its legitimacy over folk powers and local networks of healing (Kakimoto 1991; cf. Arnold 1993, Mitchell

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[19] For more extensive (and in-depth) historiographies of Japanese psychiatry, see Okada 1981, 1999, 2002; Suzuki 2003a, 2003b, 2005; Hiruta 1999a, 1999b.

[20] Though Western biomedicine had been imported via Portuguese traders in the 15th century and the influence of Dutch anatomy was prevalent in the end of the Edo Era, it was only after 1874 that biomedicine became the official medicine in place of traditional Chinese-derived medicine.

1988). Overcoming the recurrent local resistance, biomedicine instituted large-scale preventive measures against cholera and thereby set a model for subsequent public health interventions and urban planning (Narita 1993).[21] The success of biomedicine meant the significant retreat of traditional medicine. In 1875, most of the practicing physicians were those trained in traditional medicine; out of 28,262 practitioners, only 5247 were registered as physicians of Western medicine (Kawakami 1961:235). This situation began to change drastically after 1876, when the government passed a regulation requiring all physicians to study Western medicine (Lock 1980: 62). The Japan-Sino War of 1894-95 further helped legitimize biomedicine as the official medicine of the modern state.

In the realm of popular ideas about general health, biomedicine brought about a radical shift from *yôjô* to *eisei* (hygiene) (Shikano 2004, Narita 1993, Kitazawa 2000). The traditional idea of yôjô--developed and popularized though texts in the Edo Era--stressed the importance of maintaining balance between individuals and the environment, rest and safety, and defined heath as an absence of illness (see Chapter 2). In contrast to this "passive" concept," the notion of eisei was introduced in the 1870s as a new health principle and suggested the need to actively cultivate health, and to scientifically and systematically go about achieving it. The eisei paradigm introduced the notions that human biology is universal, that individual bodies exist independently of nature, and that individuals must learn to achieve hygiene and health by following scientific principles. Furthermore, the eisei paradigm selectively incorporated and

[21] Cholera, being the most deadly and most visible disease, caused much fear as patients were carried away to a hospital under police supervision and their neighborhoods were quarantined and disinfected. Hygiene cooperatives were set up in each municipality, and slums and poverty areas were marked. This helped give rise to a network of local governance and the scientific management of the state. As in Europe, cholera epidemics served as "proof" of the superiority of the Western knowledge and Western medicine.

strengthened parts of traditional medical thought: by reworking the idea of the "socio-organic" embedded in the yôjô concept, the eisei paradigm justified the linkage between individual health and the health of the state. Particularly in the 1890s, when German policy ideas were introduced, this vision further reinforced the idea that "individuals and society represented a part of a single, unitary organic whole in which each depended upon the other for continued development" (Kinzley 1991:23).[22] Hygiene thus became an urgent national project, in which individual effort was required in the state's drive to modernize, and modernize quickly--one ultimate goal being the production of strong soldiers who could ward off any military threat from the West. Institutions such as the Department of Hygiene in the Home Ministry and the Association for Hygiene of Greater Japan (partially funded by the state) were established, paving the way for a network of local governance and scientific management of health (Narita 1993, 1995, Ikeda & Satô 1995).

b. The infancy of psychiatry

In this politicized climate, neuropsychiatry was officially institutionalized in Tokyo Imperial University in 1879. The infancy of psychiatry was characterized by a number of state requests to have psychiatrists investigate peripheral regions of Japan where spirit possession had been occurring at an alarming rate (Ôtsuki 1998). Apparently, the Meiji state was concerned with the fact that incidents of spirit possession at the end of the Edo Period often led to social unrest and the birth of new religions, which had at times organized utopian movements against the status quo (Kawamura 1990, Garon 1997).[23] The aim of the state in installing

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[22] This vision, undoubtedly manipulated in constructing the ideology of national polity (kokutai), justified legislative and regulatory responses to social problems (Gluck 1985).

[23] This objectification and policing of the folk was followed by similar attempts

psychiatry was not to promote social welfare for citizens at large but to classify and exclude those who were deemed a threat to the establishment of the new social order (Omata 1998:232). This state project was also characteristically tied to private responsibility: the state created a system of psychiatric surveillance not by increasing public expenditure on asylums but by using the prevailing family-ideology and making the head of the household responsible for confining their mentally ill family members *at home* (Akimoto 1976, Asada 1985). In place of the massive public mental hospitals that emerged in Europe and the U.S., a tightly-knit network of private surveillance was created in the late 1870s under the supervision of the police and local hygiene committees. With the implementation of the Law for the Care and Custody of the Mentally Ill in 1900, the number of privately imprisoned mentally ill continued to increase between 1924 and 1941, at a rate that exceeded that of the growth of the population as a whole (Akimoto 1976). This pattern persisted in the postwar period, when the state continued to hold families responsible for institutionalizing their mentally ill in mental hospitals, which were almost always private.[24] As Nakazawa (1985) points out, mental illness was treated in the same manner as infectious disease: one can then suspect that private confinement was based upon a regime of fear, shame, and secrecy, images of mental illness that were to last long into the decades to come.

Such aggressive colonization of local lifeworlds by the Meiji State, however, also triggered folk resistance. Often, people resisted in silence: folk healing and shamanistic practices survived by going underground, and the ill simply

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by psychiatrists concerning the Ainu, for instance (Ôtsuki 1998). This helped constitute a form of internal colonization at the time.

[24] This system shared the same thread of thought with the much-debated "Japanese-style welfare" policy articulated in the 1980s, where the use of the family ideology enables low state expenditures on welfare (Garon 1997, Lock 1993, 1998, Takahashi 1997).

withdrew and hid themselves from government surveillance (Shikano 2004, Kawamura 1990, Eguchi 1987, Ôtsuki 1998). At other times, resistance became overt and powerful. Cholera revolts (*korera ikki*) took place between the 1870s and 80s (there were 24 revolts in 1879 alone, involving more than 2000 people at times); although quelled, these revolts provide a glimpse of the rich undercurrent of folk healing movements against the state that have continued since the Edo Period (Lewis 1990, Nakai 1983, White 1995). Scandals and controversies were revealed in the media. In the midst of psychiatric expansion, the Sôma case in the 1890s stirred public sentiment and became what was probably Japan's first antipsychiatry movement promoted via print culture (Akimoto 1985). When a servant of a former lord of the Sôma family accused the new lord of illegitimately confining his lord to a mental hospital in order to take over the family, there was public uproar against psychiatry. A book by the servant discussing the case in detail became a bestseller, being reprinted for the 17th time in 1893, while the court case lasted for 12 years. As the news was reported overseas, the Japanese government received international criticism that Japan lacked a legal system sufficient to prevent unwarranted confinement. Since this reputation significantly impaired Japan's negotiation with the West to revise the "Unfair Treaties,"[25] the state ended up tightening surveillance by legalizing, through an 1890 law, family detention of the mentally ill (Akimoto 1985:20).

c. Moving beyond confinement and the walls of asylums

As biomedicine began to shift its focus from acute epidemics to chronic illness in

[25] Beginning with the Harris Treaty of 1858, Japan signed treaties with the U.S. and European countries--under the threat of colonization--that gave the latter the right to determine tariff rates and provided extraterritorial rights for foreigners in Japan. The Japanese government struggled to revise these treaties for three decades by implementing Westernization measures in order to be accepted as an equal by the Western powers.

the early 1900s, psychiatry as well positioned itself to change from an oppressive arm of the state to a profession with an independent voice and broader appeal. Under the leadership of Kure Shûzô from 1901, the third professor at Tokyo Imperial University and the "father of Japanese psychiatry," psychiatry began to expand links both in public and private sectors (Ambaras 1998). Kure and his associates vigorously engaged with the public by providing lectures to governmental officials and intellectuals, and by writing articles and question-and-answer sections for popular magazines. Kure's contribution extended to five different domains: 1) establishing the Japanese Society of Neurology (renamed the Japanese Society of Psychiatry and Neurology in 1935) and its journal, *Shinkeigaku zasshi,* in 1902; 2) establishing Kraepelinian German neuropsychiatry; 3) restructuring hospital psychiatry, humanizing care by prohibiting the use of restraints; 4) promoting the mental hygiene movement; and 5) conducting epidemiological surveys on the plight of the mentally ill between 1910-1916 (Akimoto 1976).[26] Through this national survey, which covered one-third of Japan, Kure called attention to the misery of private detention with no medical care, particularly among the poor. Successfully campaigning for the Mental Hospital Law (established in 1919), Kure clarified the *state's* responsibility for providing medical care for the ill (65,000 of whom were deemed to require hospitalization).[27] However, in the economic and social unrest from the 1920s

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[26] Kure's survey report shows that there were three categories of patients: 1) those who were treated at private homes or hospitals, who were from wealthy families; 2) those who were privately detained without much medical care; and 3) those who received folk therapy such as Buddhist rituals and water therapy. Over 80% were men. Kure calculated that there were 23931 mentally ill (0.05%) in 1905, 41920 (0.075%) in 1916, and to 64,941 in 1917 (Kosaka 1984)

[27]Although the lack of mental hospitals at this time is usually cited as indicating the indifference of the state, we must also remember that "hospitals" as they developed in the West were not necessarily a common form of institution in Japan in the prewar period. As Fujisaki (1995:42) points out, despite the adoption of Dutch medicine in the Edo Period, hospitals remained unpopular while small clinics (kaigyôsho) remained more common. This pattern persisted until the

onward,[28] lacking financial basis, the law turned out to be rather hollow in terms of real-world consequences (Nakazawa 1985).[29]

Particularly under Kure's regime (1901-1925), Japanese psychiatry began to establish what Castel et. al (1982 [1979]) call "transinstitutionalization"--a process by which psychiatry proliferated into broader domains by making linkages in both public and private sectors, across various institutions and actors with differing interests. This took place when, from the 1890s, there was an increasing awareness in the media of "social problems" largely caused by rapid social change. A succession of wars (the 1894 Sino-Japanese War, the 1904 Russo-Japanese War, and then in 1914 World War I) sparked the Japanese industrial revolution and urbanization, and gave rise to the new middle class, but at the same time heightened class discrepancies in cities. Numerous reports were produced that informed the public about urban misery, labor movements, the plight of the working class, the problem of delinquent children, and suicide rates among workers (Ambaras 1998, Kinzley 1991). This "social problem" perspective opened up a space where experts such as psychiatrists began to collaborate with social organizations outside of academia. Particularly, the new middle class, with their desire to modernize the rest of society, helped build alliances between the state,

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1950s, when medical progress necessitated more expensive medical technologies and more staff.

[28] From the 1920s to the early 1930s, Japan went through various economic hardships, social unrest, and tightening of social surveillance: i.e., the Kanto Earthquake (1923), the Social Order Maintenance Law (1925), the suppression of communism in the first democratic election (1928), the Great Depression (1929), rising unemployment and labor disputes (1930), and severe famine (1931), while national military expenditures rose to 35% in 1932 and 47% in 1936, leading to World War II in 1939 (Asada 1985, Kinzley 1991, Silberman & Harootunian 1974).

[29] This law failed to achieve its goal of establishing three or four mental hospitals per year. The 20 years between 1926 and 1945 saw only 4 new hospitals and 7 public hospitals. This law was later replaced by the Mental Hygiene Law in 1950 (Nakazawa 1985:2).

experts, and localized networks, thereby creating conduits for social policies (Ambaras 1998). They significantly contributed to the government's success in managing Japanese society during much of the twentieth century (Garon 1997:346). Promoted by middle class intellectuals, hygiene education as well began to take on popular appeal via various media such as textbooks, pamphlets, magazine columns, children's games (cf., *eisei sugoroku*) and hygiene exhibitions, which evidently stirred much excitement (Tanaka 1992; cf. Mitchell 1988). The degree of excitement and popular support that existed at the time for the hygiene movement and the role it played in making the new health regime part of people's intimate, everyday knowledge must not be underestimated (e.g., Yoshimi 1994; Kakimoto 1991, Narita 1990).

The new science of the mind, as well, succeeded in gaining appeal in the media through discussions of abnormality and pathologies of modern life. Initially, psychologists did much to cultivate interest in problems of abnormalcy in everyday life. They gave a series of talks to general audiences from 1909 to 1913 and later published the popular journal of *Psychological Studies* (Furusawa 1998:42, Mamiya 1998). Psychiatrists as well began to write for popular magazines, featuring health advice about mental hygiene, hysteria and neurasthenia (Kawamura 1990). For instance, one of the most notable developments in popularizing psychiatry was its growing link with education. The "ignorance" of unhygenic children--and their families --under the compulsory mass education system provided the perfect opening for psychiatrists to intervene and install their medical knowledge and authority. With the passage of the School Hygiene Law in 1897, followed by the School Infectious Disease Prevention Law in 1898, children were routinely inspected for health and cleanliness. Their families as well became incorporated into this system via "home education"(Ambaras 1998).[1] The Child Study Association was established in 1902 for the exchange of information between various experts. Psychiatry was called in at this time, when the state

became concerned with the "problems" of intelligence and retardation, which required professional intervention to determine even the presence of individual deficiency. Kure and others also wrote and lectured in 1910 on German psychiatric theories about retardation, antisocial personality, delinquency, and adolescent crime. Allied with the Home Ministry, psychiatrists were commissioned to conduct a national survey of juvenile reformatory inmates using intelligence testing (Ambaras 1998:21). Despite controversy and criticism, by the 1920s psychiatric and psychological studies of intelligence and retardation became firmly established as an administrative device (Takahashi 1998:177). Psychiatric technologies were also adopted for use both in industry and the military as a tool for ensuring "adaptation" and efficiency of workers and soldiers in their respective roles (Kinzley 1991:103).

d. W.W. II, eugenics, and the origins of biological discourse

Psychiatry seems to have succeeded in expanding, if temporarily, into popular domains through nonacademic networks and financial support from the private sector. Yet prewar psychiatry, despite these links, and despite the humanistic bent of Kure (who was called "Pinel of Japan"), ended up fostering prejudice against mental illness and creating a split between scientific research and clinical practice, between the diseased bodies and suffering patients.[30] There are a number of reasons for this. First, in the tradition of university-based, academic psychiatry, medical science was conceptualized separately from humanistic care. For instance, Kure's public lectures (including at the Greater Japan Women's Hygiene Association) helped raise awareness of mental illness among upper-class women.

[30]According to Asada, whose father worked with Kure at Tokyo Imperial University in the 1910s, it was not uncommon to hear a psychiatrist say that academic psychiatry is interesting but clinical practice is unbearable. The therapies at this time centered around "insulin shock" and electric shock (Asada 1985:26; Nishizono 1988).

But there was a division of labor that seems to have been clearly gendered and symbolic: humanistic care for the ill remained in the hands of women doing private charity work, while academic psychiatry itself was defined as a men's scientific pursuit (see Kobayashi 1972). Out of 22 professors of psychiatry who studied abroad in the prewar era, Okada (1999) points out that only one studied clinical practice as well, while the rest spent time on scientific research of the brain. This is not surprising given the fact that this was a time of excitement in biological research and scientific progress. Noguchi Hideyo had just discovered the causative agent of syphilis in 1913, fueling the drive of Japanese psychiatrists to find organic causes of mental illness (Asada 1985:26). No doubt most psychiatrists saw their primary role not as clinicians but rather as scientists, helping the ill by pursuing organic causes of and cures for mental illnesses.

But perhaps most importantly, the biological bent in psychiatry was reinforced and justified by the ideology of Social Darwinism and the ideology of the nation-as-family: that is, the idea that medicine needed to contribute to making the "body of the Japanese race" competitive enough to survive the international "struggle of the fittest" (Matsubara 1998a). Herbert Spencer was translated into Japanese and 20 books on the subject were published in the 12 years since 1877. More works by Japanese eugenicists continued to come out in the 1910s and specialized journals in eugenics were published in the 1920s (Ukai 1991:126; Otsubo & Bartholomew 1998). Psychiatrists as well were drawn into the racial improvement movement that emphasized heredity over environment and biology over social conditions. In a political climate in which the family--not the individual--was conceived as the basic social unit (Kawamura 1990), a diagnosis of mental illness also meant a judgment on the whole family. Indeed, by the end of the W.W.II, the idea that mental illness is a serious deficiency, a hereditary disease, and thus a family responsibility became firmly rooted in public discourse and even legally substantiated by the enactment of the Eugenics Law in 1940.

In this social context, efforts by psychiatrists to popularize psychiatry seem to have come to a halt in 1937,[31] when they were subsumed under war effort policies organized by the Eugenics Section of the newly created Ministry of Health and Welfare.[32] This is not to say that psychiatry was neatly incorporated into eugenics and its ideology of racial hygiene, nor that there was harmonious collaboration with the state. Matsubara (1998b) discusses the complex negotiations that went on amongst psychiatrists, some of whom supported and some who rejected the eugenic discourse that defined mental illness as a hereditary aberration. Immediately before the passing of the Eugenics Law, the Ministry of Health and Welfare published a national survey report conducted on the family trees of 3000 mentally ill (1500 hospitalized, 1500 privately confined). *Yomiuri Shimbun* headlined the result as "3000 doomed families," including families with members suffering from retardation, schizophrenia, manic-depression, and other mental illnesses. Despite opposition from psychiatrists involved in the study (such as Professor Uchimura Yûshi of Tokyo Imperial University), who dismissed its scientific value, the state insisted that mental illness was "proved" to be hereditary (Matsubara 1998a, Nakazawa 1985:4). Unfortunately, the influence of this wartime "psychiatric" discourse that linked family, biology, and heredity became a lasting legacy of prewar psychiatry.[33] It is this legacy that the later antipsychiatry

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[31] Academically, however, there were a number of original research projects conducted around the 1940s. Okada even points out that this was the time when Japanese psychiatry established itself as a mature and autonomous discipline (see Okada 1999).

[32] Matsubara demonstrates that sterilization of the mentally ill under the 1940 Eugenics Law did not take place to the extent that the policy demanded, partly because of the opposition from psychiatrists but mainly because psychiatry simply lacked the institutional basis for carrying out this policy (Matsubara 1998a, 1988b). For instance, in 1941, (only) 94 patients out of 750 deemed appropriate for sterilization were actually sterilized. However, such sterilization continued to be conducted in the postwar period.

[33] Some studies have documented the extent to which--in the 1970s--fear of

movement fought against, and that present-day psychiatrists have to engage with in order to popularize the idea of psychiatry as providing care for the ordinary person.

III. The second expansion (1950s-1960s): postwar institutional expansion and the antipsychiatry movement

> "As the GNP doubles, the number of mentally ill will quadruple," predicted Takemi Tarô, the influential director of the Japanese Medical Association between 1957-1982.

There was a brief period in Japanese psychiatry in the aftermath of WWII, when the predominance of neurobiology was fundamentally shaken by the onslaught of psychoanalytic American psychiatry. In the late 1940s to the early 50s, the American model of "mental health" was disseminated through the newly established psychoanalytically-oriented university departments and the American-led National Institute of Mental Health. Popular books on neurosis were published in succession, the word "noirôze" (neurosis) became a bùzzword of the time (Satô & Mizoguchi 1997; see also Uchimura 1954), and the widespread

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mental illness as a genetic, hereditary disease still permeates people's minds in the countryside and in urban clinics (Nakazawa 1985, Hirose 1972). Nakazawa (1985) describes the predicament of the mentally ill in a rural area and suggests that people believe that mental illness is both incurable, hereditary, and the doomed fate of the family. Caution for generalization is needed, however. In a survey he conducted between 1963 and 1965 on popular conceptions of mental illness, Terashima (1969) found: 1) considerable regional difference in prejudice against mental illness and practices (hospitalization); and 2) contradiction between the strong persistence of the idea that mental illness is hereditary and the prevalence of a "remarkably optimistic view" on the prognosis of mental illness. This suggests that the psychiatric discourse did not spread evenly across Japan nor was it received uniformly (for regional variations, see also Munakata 1984, 1986).

use of minor tranquilizers for anxiety eventually came to be considered a social problem in the media. Healy has discussed the possibility that what is now called depression might have been widely dealt with as anxiety in the 1950s, the era of minor tranquilizers (Healy 2000). This may well have been the case in postwar Japan; if a national newspaper cartoon ("Sazae-san") is any indication, an ordinary salaryman seemed to be taking such pills for trivial domestic worries in the 1950s (Asahi May 14, 2005). A 1965 newspaper article that discusses the danger and horror of "casual use of minor tranquilizers" suggests that their routine usage remained a prevalent problem (Asahi November 21, 1965; Asahi September 15, 1956), until the government made them into prescription drugs in 1972. These indicate the popular receptiveness of such psychiatric medication and the flourishing of the American model of mental health (particularly neurosis) in the domain of popular discourse.

On the academic front, however, many intellectual leaders of psychiatry (who had been steeped in German psychiatry) began, from the early 1950s, to express skepticism towards the American influence, and particularly those affiliated with Tokyo University soon mobilized themselves to critique psychoanalysis and to re-establish Kraepelinian neurobiology as the official paradigm of Japanese psychiatry. In a commemorative talk for the 50th anniversary of the Society of Psychiatry and Neurology, Uchimura Yûshi, Professor of Psychiatry at Tokyo University, reflected on the postwar confusion when Japanese psychiatrists had been "knocked down" by American psychiatry. Noting how their initial responses greatly varied ("some hesitated, some averted their faces, others adopted it"), Uchimura elaborated on how psychoanalysis was "unlike anything [they] had experienced before" (Uchimura 1954:710-711). He then went on to draw on Karl Jaspers (who had called psychoanalysis an "as-if psychology"—blind to its own limitations) to criticize the epistemological basis of psychoanalysis while

admitting its potential as a therapeutic tool (Uchimura 1954).[34] Heated debates continued both within academia and in popular intellectual magazines about the nature of American "psychologism" and what direction Japanese psychiatry should take (Muramatasu 1953, Shimazaki & Ishikawa 1954, Shimazaki 1953, Doi 1954, Uchimura et al. 1957). Mainstream psychiatrists in the Tokyo area were largely successful in warding off further psychoanalytic influence. They asserted that it is psychoses and their biological mechanisms—not neurosis and its psychology—that should be the primary object of psychiatric investigation.[35] Thus neurobiology found its way again to being the supreme model of mental illness in academic psychiatry.

While psychiatrists reestablished the predominance of neurobiology conceptually, institutionally they began to expand their power through the network of private mental hospitals. In fact, the institutional expansion of psychiatry of the postwar era far exceeded what had been attained by academic psychiatry in the prewar era. The collapse of the *ie* (family) system under the new Civil Law of 1948 and the outlawing of private detention under the 1950 Mental Hygiene Law created drastic changes in psychiatric care, as the place of confinement began to shift to mental hospitals.[36] As the Ministry of Health and Welfare pointed out the

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[34] What concerned Uchimura was the multiplicity of American psychiatry (which included Freudian theories of childhood trauma, behavioral models that "overrate" the force of environment, and Adolf Meyer's holistic approach). Both Uchimura and another intellectual leader, Shimazaki Toshiki (of Tokyo Medical and Dental University) drew extensively on psychiatrist-cum-philosopher Karl Jaspers to critique the epistemological basis of psychoanalysis, translating his work and publishing in both the psychiatric and popular intellectual journal called *Thought* (Shisô) (Jaspers' lectures on psychopathology was translated in 1959).

[35] In fact, as a number of senior psychiatrists pointed out to me in interviews, "neurosis" remained marginalized and often treated dismissively as belonging to the realm of "commonsense psychology."

[36] It is important to remember that the law also paved the way for community

"shortage" of psychiatric facilities, they resorted to providing low-interest loans for building private institutions. This produced a sudden "mental hospital boom," giving rise to numerous private institutions, many with dubious medical capabilities.[37] As the number of psychiatric patients increased with the economic boom, rapid urbanization, and internal migration, the relevant clause from the 1950 law began to be flexibly applied to justify involuntary hospitalization of the "mentally ill" on the grounds of economic hardship. While most of the money from the national mental health fund was used for this purpose, there was little imperative among asylum psychiatrists to provide therapeutic treatment, or to try to return patients to the community (Kobayashi 1972; Okagami et al. 1988).

The much-awaited amendment of the Mental Hygiene Law in 1965, which was supposed to establish a policy basis for community care, was again hindered by an unfortunate incident –an assault on the popular American ambassador Reischauer by a mentally disturbed 19-year-old. The public uproar over the incident swung the pendulum back to keeping psychiatry as an apparatus of state control, as the director of the Police Agency declared in the Diet that there were "three thousand mentally disturbed people who need regulation and surveillance"(cited in Nakazawa 1985:8). This incident further led to the strengthening of the "surveillance" component of the law, thereby guaranteeing the police much broader responsibility for registering the names of mentally

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mental health by calling for mental hygiene consultation centers and family-visits, and other such normalization policies. In fact, the 1950 Law was a conceptual breakthrough for community psychiatry, as it required that each prefecture build a mental hospital and it introduced public counseling centers and home-visit treatment programs for people suffering from mental illness. These programs, mandated by law, were not implemented, however, until the amendment of the law in 1965 (Koizumi & Harris 1992).

[37] Indeed, the number of beds in mental hospitals increased rapidly (rising from 136,000 beds in 1953, 173,000 in 1965, 278,000 in 1975 to 334,000 in 1985: Okagami et al. 1988).

disturbed citizens and arresting and hospitalizing them (Koizumi & Harris 1992:1101). In the meantime, psychiatric institutions continued to expand in the 1960s as a lucrative business by absorbing the contradictions caused by rapid postwar economic growth (Tomita 1992). Psychiatrists were criticized for the way they were making a profit by keeping the mentally ill institutionalized and getting a stable income from national health insurance. In fact, Takemi Taro, the powerful director of the Japanese Medical Association, even ridiculed psychiatrists by calling them "stock farmers" (Akimoto 1976:193).[38]

By the late 1960s, international criticism of Japanese psychiatry began to be heard, which culminated in the WHO Clark Report (1968) that pointed out the mass-scale confining system, lack of specialized care, and profit-oriented management of Japanese psychiatry (Hirota 1981). With the accumulating criticisms, the antipsychiatry movement took off in the 1969 Kanazawa Conference of the Society of Psychiatry and Neurology, with a dispute erupting over the use of lobotomy by Professor Utena of Tokyo University (Asano 2000). Professor Utena was forced to retire, and the psychiatric unit of Tokyo University became occupied by students, who kept the unit under their control for the next ten years (Tomita 2000, Akimoto 1976, Healy 2002). The movement soon spread to universities nationwide, and most psychiatric societies were annihilated in the coming decade. The movement also won popular appeal through the media, with Asahi Shimbun taking the lead by reporting on the horror of psychiatric institutions and the plight of the mentally ill (e.g., Ôkuma 1973). Despite this, the profit-based structure of the private hospitals (which, due to the government policy, constituted the bulk of mental hospitals in Japan) proved resistant to change; even in 1987, over 90% of the inpatients in these hospitals consisted of

[38] In 1970, for instance, 96% of the 36.1 billion yen national health fund was used for involuntary hospitalization, and the 1975 Report by the Ministry of Health and Welfare stated that only 20% of mental hospitals had a sufficient staff.

involuntary patients (Asai 1999:14). The struggles were long and bitter, falling to petty, personal attacks, and gradually dying off as it became increasingly fragmented from the 1980s. Most Japanese psychiatrists still remain undecided about the meanings and consequences of this movement (Ôhigashi 1999). Its last signs were put to a symbolic end in 2001, when the psychiatric department at Tokyo University—which had been physically divided into different buildings for three decades—was reintegrated under a neurobiology professor.

I suggest that the antipsychiatry movement –and its dismantling of traditional Japanese psychiatry—was crucial for preparing the conditions for the later medicalization of depression. Conceptually, the antipsychiatry movement annihilated the dominance of neuropsychiatry and its hereditary-driven paradigm, even if the effect was only temporary. The antipsychiatry movement left disruption and a conceptual vacuum in its wake, which was quickly filled by the DSM-III (1980: translated in 1982), as Japanese psychiatrists, despite their unyielding criticisms against American psychiatry, had few other alternatives with which to try re-integrate themselves. Institutionally, the disintegration of the university-controlled hierarchical system initiated a move towards community mental health, as dissenting young psychiatrists left universities to open small clinics that provided outpatient care (Koike & Matsuda 1997, Sekiya 1997). As the 1985 revision of the Mental Health Law expanded the coverage of the national health insurance for psychiatric outpatients, the number of such patients began to rise. The emergence of the "psy-complex" discussed by Castel et al. (1982) can thus be said to have come about in Japan out of the antipsychiatry movement, which prepared the conditions for the later medicalization of depression.

IV. The third expansion (1980s-present): towards current psychiatric discourse on depression and suicide

The transition from asylum psychiatry to community psychiatry has been slow and gradual despite mounting criticism over the years: unlike in the West, where most mental hospitals have been public, in Japan the system of predominantly private mental hospitals has proved resistant to radical structural change (Okada 1999, Salzberg 1994). However, interest in mental health at work has come from economic concerns: the JAL airplane clash in 1982, triggered by a mentally-distressed pilot, raised public awareness of mental illness among people in the workforce (Kasahara 1991). In response to the growing public anxiety, the Ministry of Health and Welfare began implementing measures for "kokoro no kenkô zukuri" (promoting the health of kokoro), emphasizing the care of mental health and the need for stress management (albeit with little financial backing). The 1988 Mental Health Law, followed by the 1993 Mental Health and Welfare Law, set the tone for deinstitutionalization, normalization and rehabilitation of the mentally ill (Komine 1996). Since the 1990s, there have been a number of lawsuits with regards to overwork suicide, which have been won against corporations by families of deceased workers on the basis of psychiatric diagnoses (to be discussed in Chapter 9).[39]

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[39] In 2000, the Japanese government announced that one-third of the working-age population is suffering from chronic fatigue syndrome (far more than the 4-8% in the U.S.). According to the *New York Times*, these Japanese patients are being treated with antidepressants, biofeedback, and counseling. The article also notes that "in Japan, where the condition appears to be far more prevalent, the experts lean toward explanations that emphasize societal mutations far more than their American counterparts," it is foremost associated with "the stresses placed on this society since it began its dramatic economic slide more than 10 years ago." The doctor cited in the article lists a variety of changes-- from eating habits, environmental problems, housing, urban alienation, overwork, and changing family relationships--all of "which produce stress" (French 2000). The media presents the view that Japanese lack a secure sense of what kind of "society" or "tradition" the afflicted are to be returned to. It thus remains to be seen how psychiatry is going to help constitute a place of return for these people.

Given the economic imperatives (e.g., fear of legal compensation for overwork depression and suicide), combined with growing public sentiment about the lack of mental health care (Kawakami 2000), the increasing competition from other professions,[40] and the aggressive promotion of antidepressants by the psychopharmaceutical industry (New Current 1999), psychiatry in Japan seems for the first time to be preparing for a significant expansion into the domains of everyday distress. Another notable factor for change is the introduction of DSM-III and the re-Americanization of Japanese psychiatry (Okada 1999; also see Klerman 1990, Tajima 2001). At the time that I conducted preliminary research in 1997, hardly any psychiatrists I interviewed at prestigious institutions claimed that they consulted DSM regularly. In 2000, when I began my fieldwork, most depression experts admitted using the DSM alongside their traditional diagnosis but were still openly skeptical and critical. Towards the end of my fieldwork, the DSM had become a fact of everyday clinical practice, there to stay, despite the lingering criticism. The full impact of the DSM on Japanese psychiatry is yet to be known but I suspect it will be profound. Unlike the psychoanalytic American psychiatry that flooded Japan in the 1950s, the current American influence—as exemplified by the DSM's neo-Kraepelinian paradigm and descriptive approach—have been highly congenial to Japanese psychiatrists' neurological

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[40] An interest in mental health is being cultivated by forces other than psychiatry as well. First of all, rebuilding clinical psychology from the fragments of the antipsychiatry movement from 1974, Kawai Hayao and his associates created a new psychological association, which was able to establish a licensing system for its members in 1988 (Murase 1995; Kitanaka 2003). Through links with the Ministry of Education, since 1992 clinical psychologists have been going to public schools nationwide to work as school counselors, and psychologists are also negotiating with the government for a national licensing system (Maruyama 1998). Secondly, since the 1960s, Ikemi Yûjiro and his associates have been appropriating ideas from psychiatry and traditional medicine to create their own brand of psychosomatic medicine (shinryô naika). They have reintroduced and invigorated the notion of neurosis from the 1960s (Ohnuki-Tierney 1984), and have become successful in attracting people who are concerned with work-related stress but are hesitant to visit psychiatrists (Miyaoka 1999, Matsushita 1997).

understanding of mental illness (for the reaction to the DSM: see Honda 1983). At the same time, the DSM—with its "operational diagnosis"— is indirectly familiarizing Japanese psychiatrists and their patients with the idea that the vast range of what used to be mere life problems can now be regarded as manifestations of psychopathology. This seems to be achieving what American psychoanalysis tried but failed to do in the 1950s Japan; that is to say, the DSM may be breaking down the previous Japanese resistance against medicalization by collapsing the previously tightly-held boundary between normalcy and abnormalcy. Particularly through the concept of depression—which lies uneasily in between normalcy and abnormalcy—some Japanese psychiatrists are now aggressively trying to expand their influence into the realm of everyday distress.

Before we go further with the history of depression in Japan, I would like to call attention to the fact that, although psychiatry has only recently begun to expand *institutionally* into the realm of everyday discourse via depression, there was a time when it held a considerable *conceptual* influence over the way ordinary Japanese talked about their everyday distress in the popular discourse. This was during the alleged "epidemics" of neurasthenia, the risk of which was elaborated upon and widely cautioned against by not only medical experts but also influential intellectuals at the time. As this occurred just when lay Japanese were beginning to understand their ailments in biomedical terms, the neurasthenia concept helped familiarize them with psychiatry as a language of everyday experience. In the next chapter, I examine this prewar history and show how both the medical and popular discourses about neurasthenia indirectly provided a conceptual framework for the later theorizing of depression in Japan.

Chapter 4: Pathology of Overwork or Personality Weakness?: the Rise of Neurasthenia in the Early 20th Century Japan

I. The first instance of the medicalization of everyday distress

Yanagida Kunio, the father of Japanese ethnology and a prominent intellectual in the era prior to World War II, commented in *Asahi Shimbun* in 1931 on the effects of modern Westernized medicine. He said that thanks to the new medicine, a number of serious ailments that "have never been heard of" and "would have gone unnoticed" were now being successfully treated. Concurrently, however, Western medicine brought unexpected consequences. While it gave Japanese a radically new knowledge about their bodies, it had made them more anxious than ever. Japanese were now "constantly worried over the slightest changes in [their] health" and had, as a result, become "more vulnerable to illnesses." They were even suffering from something that resided in the gray area between illness and non-illness; the primary example Yanagida had for this was, *shinkeisuijaku* (literally meaning "nerve weakening" or neurasthenia) (Yanagida 1967:288).[41] The rise of neurasthenia was, indeed, the first instance of the broad-scale medicalization of everyday distress in Japan, preceding the current popularization of depression by a century. I will examine in this chapter how the psychiatric discourse about neurasthenia had many parallels with the current depression discourse, one of which is the heated debates over its causality—whether neurasthenia (like depression a century later) was an illness of overwork or of a distinctive personality.

Neurasthenia, an illness category popularized by American neurologist G. Beard

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[41] On the rather complex, earlier history of how shinkeisuijaku came to be adopted in the Japanese lexicon, see Watarai (2003).

in 1869, originally referred to a nerve weakness or nervous exhaustion, a condition which was regarded as the ill product of modernity (Gosling 1987, Lutz 1991, Clarke & Jacyna 1987). Epidemics of neurasthenia swept over America and Europe in the late 19th century (Oppenheim 1991, Gijswijt-Hofstra & Porter 2001; Rabinbach 1990); Japanese intellectuals began to discuss the notion of neurasthenia by the 1880s. By the 1910s, the Japanese media was calling neurasthenia a "national disease" (Yomiuri July 8, 1917; also see Watarai 2003). The media initially depicted it as an inevitable outcome for people at the forefront of the processes of modernization, for whom exhausted nerves even became a mark of distinction. An unprecedented number of cases of neurasthenia among elites, including government officials, company executives, university professors and artists began to be reported. Like depression today, neurasthenia was soon linked by medical experts and social commentators with "overwork" ("karô") as well as with rising rates of suicide. As newspapers began to feature daily advertisements for various pills for it, neurasthenia gradually spread among the general public and became a commonly used idiom of distress by the 1910s (see Graph 1). Its academic importance for psychiatrists began to decline in the 1910s. In the 1920s, some psychiatrists campaigned against the prevalent "abuse" of the notion of neurasthenia for explaining all sorts of everyday distress. From the late 1930s, the notion slowly began to lose its social significance, as neurasthenia came to signify little more than a weakness of personality. Though neurasthenia continued to be used interchangeably with neurosis for a while, the postwar period saw this term fade into obscurity. While neurasthenia had many vicissitudes and conceptual uncertainties, what this notion did for Japanese psychiatry was to help establish its legitimacy as an intimate language for expressing people's everyday distress.[42]

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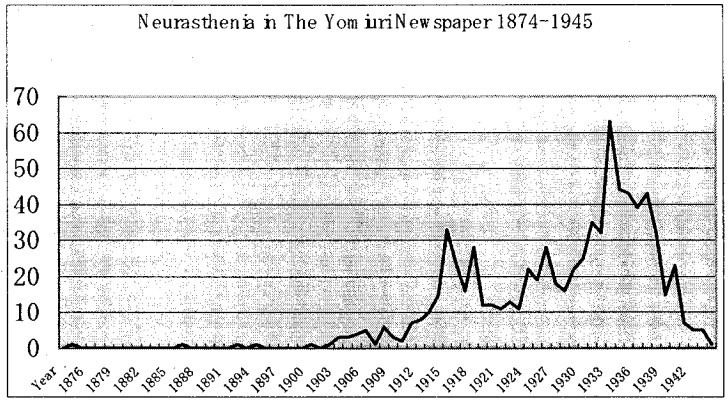
[42] The sources I use are the following. First newspaper articles were culled from the databases of *Yomiuri Shimbun* from 1874 to 1945, and *Asahi Shimbun* from 1879 to 2000. Second, popular representations in magazines were examined in an



Graph 1: The number of articles and advertisements regarding neurasthenia appearing in the Yomiuri Shimbun between 1874 and 1945 (Compiled from the "Prewar Yomiuri" Database)

II. The new language of experience—"nerves"

The success of this early medicalization is striking, particularly when we consider the fact that, only a few decades prior, Japanese could not have suffered from neurasthenia at all. This is because, as historians of Japanese medicine have pointed out, Japanese simply did not have "nerves."[43] As Sakai Shizu (1982)

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intellectual magazine, Taiyo, from 1895-1928, as well as in four popular books on neurasthenia published between the 1920s and 1940s. Third, psychiatric discourse regarding neurasthenia was examined in Shinkeigaku Zassi (Journal of Neurology) that changed its name in 1935 to Seishin Shinkeigaku Zasshi (Journal of Psychiatry and Neurology) between 1902 and 1970, and in five psychiatric textbooks published between 1890s and the 1970s.

[43] It is important to remember that, even in the West, "nerves" were not self-evident entities till the 19th century. Until the 19th century, nerves remained mysterious and were often discussed in terms of animal spirits. Electricity metaphors existed in the 18th century but it was not until the late 18th century (with the 1774 Galbano's famous frog experiment) that scientists began to understand the nerves in terms of actual electricity. It is with this conceptual change that 19th century scientists began to talk about physiological economy of nerve power (Clarke & Jacyna 1987).

writes, within the paradigm of Chinese-derived traditional medicine, there was no concept of nerves, nor was the brain regarded as an important organ. Thus when Sugita Genpaku, the first Japanese doctor to have conducted official dissection, wrote *Kaitai Shinsho* (New Human Anatomy) in 1774, he literally had to create the Japanese word *shinkei* or nerve (also see Kuriyama 1992). "Nerve" remained a highly technical term for the following century; its spread to lay people only happened after Western medicine was officially adopted by the government in 1874 (Kawamura 1990). "Nerve" being not at all self-evident to Japanese, experts of Western medicine took care to explain "nerve diseases" in detail. In a 1906 *Yomiuri* newspaper article—titled "The hygiene of nerves"—Tamura Kazaburô commented on how fashionable it was to talk about nerves, but that people had misconceived ideas. He said: "many people seem to think that nerves are invisible; they are in fact tangible, visible things"; nerves are like "white threads" whose normal width was that of "cotton thread," and they function like "electric wires" that "would make a train run."[44] Just as an electric train would not run if the wires were "exhausted beyond use," or if the wires were "cut," the citizens who were the driving force for the advancement of modernity would not function without taking proper care of their nerves (Tamura 1906). In a vision of bio-economy, psychiatrists talked about nerve diseases as triggered by a "deficiency and dysfunction of nerve power" (Sakaki 1912). And when it came to the economy of nerve power, Japanese elites, who had launched a national campaign of modernization to join the Western superpowers, had much to worry about.

[44] The idea that it is invisible possibly may suggest that *shinkei* was a transformation of qi (see Chapter 2).

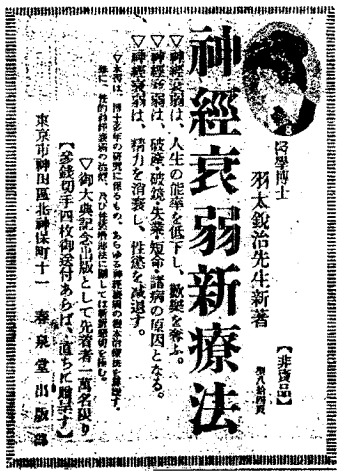

Figure 3: An advertisement for a book on how to treat neurasthenia, appearing in Yomiuri Shimbun on November 22, 1928.

The media were encouraging people to pay attention to their nerves and often provided self-diagnostic tests for the symptoms of neurasthenia. An influential intellectual magazine called *Taiyô* (Sun) featured an article in 1902 with a title that conveyed a sense of national emergency: "Neurasthenia: operators, writers, government officials, and students, read this" (XYZ 1902). The article said that government officials were known to take a leave of absence due to neurasthenia and that "one third of patients who visit hospitals for consultations today" were reportedly suffering from the disease. Such patients were mainly elites engaged in intellectual labor and thus were prone to an excessive use of nerve power. The symptoms included everything from excitability of the mind ("kandô"), insomnia, lack of concentration, decreased mental capability, over-sensitivity, irrational fears and worries, headaches, upset stomach, fatigued eyes, and abnormal sensations in the body such as the feeling that one's head was covered with a heavy pot (a common complaint among depressed patients in contemporary Japan). These symptoms were said to be caused by pathological changes in the nerve cells of the brain. The possibility of heredity was mentioned, but it was emphasized how neurasthenia affects anyone, given certain external life events. The article cited the cases of a businessman suffering a loss in stock trading, a government official

being humiliated by his colleagues, and a student experiencing heartbreak over love or failing an exam. It was also suggested that neurasthenia mostly affected "middle-aged people who are in their primary working years" (again a parallel with the depression discourse today). Hospitalization was recommended for those who received too much stimulation as a result of work or family interactions.[45] If left untreated, neurasthenia could result in full-blown insanity or suicide (XYZ 1902:134-139; also see Yomiuri July 8, 1917). Commencing in the 1900s, a relentless campaign put out in the media along these lines by medical professionals and intellectuals on the prevention of neurasthenia placed this ailment high on the list of people's health concerns (Figure 3); this no doubt created the kind of high anxiety that Yanagida was talking about.

For many Japanese intellectuals, neurasthenia was an ailment of modernity—not just any modernity, but the particular Japanese modernity. Natsume Sôseki, arguably the most important writer in Japanese modern history and also the best-known neurasthenic, asserted that Japanese were suffering from neurasthenia *en masse* because they were thrown into modernization that was not of their own choosing. In his legendary speeches such as "The Enlightenment of Modern Japan" (1911) and "My individualism" (1914), Sôseki reiterated the theme that Japanese were faced with the task of achieving industrialization and urbanization in less than half the time that it had taken Westerners. The consequence of this "unnaturally" accelerated development, imposed upon Japanese by the external threat of colonialism, will be a "nervous collapse from which we will not be able to recover" (Sôseki claimed that anyone who worked seriously as a university professor for ten years could develop neurasthenia:

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[45] A 1908 book called *Eisei Taikan* (Hygiene Encyclopedia) claimed that neurasthenia was due to a wide range of causes including heredity, mental overwork, sorrow, physical exhaustion and masturbation. The book suggests that neurasthenia was curable by "stabilizing the mind, rubbing and strengthening the body with cold water, taking a cold bath, electrification, or massage."

Natsume 1986). Writers at the time were increasingly turning inward to examine the effects of social forces upon themselves, documenting their inner torment by resorting to the idiom of "nerves." Nerves were imagined to be both physical and psychological objects that became fatigued, exhausted, sharpened, over-stimulated, or dulled, calmed, and paralyzed. Such images of exhausted nerves bombarded readers of serialized newspaper novels and magazine articles at the time. Concurrently, the media continued to feature advertisements claiming all sorts of "cures" for the damaged nerves, along with graphic pictures of the brain (Figure 4).

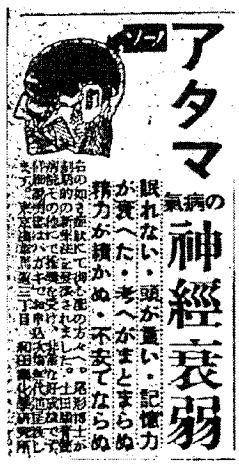

Figure 4: An advertisement for a new treatment on neurasthenia appearing in Yomiuri Shimbun on September 18, 1937.

By the mid-1900s, the epidemic of neurasthenia was being blamed as the direct cause for the rising rate of suicides. Around the time of the Japan-Russo War (1904-5), with the heightened sense of social unrest, Japanese were experiencing the first suicide boom since the rise of the modern state. Japan's first so-called "modern suicide" in 1903 was reported with much sensationalism in the media. An elite student, Fujimura Misao (a student of Sôseki), jumped over a waterfall in

scenic Nikkô north of Tokyo, after inscribing his suicide note on a tree trunk, which resulted in a phrase that became famous—life is "incomprehensible." Disputes over the meaning of his act soon erupted among intellectuals. Some intellectuals, particularly artists and writers, attributed social and philosophical meanings to suicide. Tsubouchi Shôyô, a revolutionary literary figure, for instance, wrote a long reflection on suicide and discussed it as a source of freedom for those who must contend with the impossible demands of modernity (Tsubouchi 1903).

However, some politicians, along with academic psychiatrists (most of whom were trained in German neuropsychiatry and its ideas of degeneration) strongly asserted that individuals who kill themselves do so because they have an "inborn, physical, pathological" nature (such as neurasthenia) that would drive them to "autocide." These individuals, according to this theory, were "unfit" to survive in the highly competitive modern society. Katayama Kunika, the authority in forensic medicine and a former acting chair of psychiatry at Tokyo Imperial University, wrote in *The Tokyo Asahi newspaper* in 1906 that suicidal individuals were "dispersing poison in society" and that the nation must "strengthen its body and mind so that it can eliminate such pathological molecules" (Katayama 1906; see also Kure 2002[1894-5], 1917). Ôkuma Shigenobu, a highly influential statesman of the time, was also a central figure in the mental hygiene movement, helping organize "Kyûchikai," a voluntary association for helping the mentally ill. When he was invited to a gathering of psychiatrists and lawyers in 1906, Ôkuma had this to say about the suicidal:

> These days, young students talk about such stuff as the "philosophy of life" [applause from the floor]. They confront important and profound problems of life, are defeated, and develop neurasthenia. Those who jump off of a waterfall or throw themselves in front of a train are weak-minded.

> They do not have a strong mental constitution and develop mental illness, dying in the end. How useless they are! Such weak-minded people would only cause harm even if they remained alive [applause]. (Ôkuma 1906: 616; note that the whole speech was published in the Journal of Neurology).

The surprising fact is that Ôkuma himself later confesses in this speech that his own brother is afflicted with mental illness. The fact that even the family of the mentally ill came to speak of them in such a disparaging tone shows the extent to which the degeneration paradigm permeated the intellectual's ways of thinking at the time. Kure himself wrote in the Yomiuri Newspaper in 1917 that the recent increase in the number of suicides among prostitutes (which apparently became a social concern) was the result of mental illness. He wrote that, even though lay people might think that these women were driven to suicide by despair at life's hardships, this would be "amateurish thinking." From an experts' point of view, Kure said, the cause of their suicide was that these women had "inherent, mental abnormalcy" to begin with, which (he said) would also explain why they would turn to such an immoral profession in the first place (Kure 1917). Suicide, for the leading medical experts of the time, was thus "self-destruction of the inherently weak" (Miyake 1903) and neurasthenia a manifestation of abnormal tendencies and even a precursory symptom of suicide (Katayama 1912).[46]

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[46] While a few psychiatrists later came to express cultural nationalism by asserting that the suicides of "great men" (such as that of General Nogi) should be deemed acts of courage and dignity (Nakamura 1943), psychiatrists continued to dismiss suicide as the manifestation of the diseased brain. Investigating suicide by anatomical dissection, they tried to discover the true cause of suicide, for instance, in the "unusual amount of accumulated fat in the cerebral cortex" (Itô 1928:549). With a characteristic fatalism of the prewar psychiatrists, Nakamura of Tohoku University wrote:

> There are many people placed in similar (stressful) situations, who do not

III. Psychiatric disputes over neurasthenia

In the meantime, disputes over the cause of neurasthenia—which paralleled the earlier debates on suicide—began to intensify among psychiatrists by the 1910s.[47] The first group of psychiatrists followed Beard and argued that neurasthenia was indeed an illness of overwork that anyone would experience in the increasingly complex modern world. Matsubara Saburô, who had trained under Adolf Myer for four years in New York, wrote an extensive piece on neurasthenia in 1914 and elaborated on the idea that neurasthenia was an illness of "people of culture." Emphasizing its social nature, Matsubara listed the kinds of occupation that would likely cause neurasthenia: (a) brain-power-users (students, government clerks); (b) those who "excite" their minds (doctors, stock dealers); (c) night-time workers (police officers, train officers, telephone operators); (d) those who work in a sitting position (bankers, engravers); (e) those who work in a closed room or in hot, heated places. Although Matsubara did not deny that these patients might have a certain predisposition, his emphasis was on the effects of lifestyle (Matsubara 1914).[48]

> commit suicide. Thus those who dare must have an exceptional condition in their mental state, which should be the true cause [of their suicide]. In other words, suicide is a pathological reaction of the psychotic or the psychopath (Nakamura 1943).

Thus, before the end of the WWII, there was little conceptual space within psychiatry for investigating suicide as a product of social pathology. (One notable exception is the work of Komine (1938), who examined the cases of dual suicides and suggested that these forms of suicide can be understood from a cultural perspective.)

[47] Note that the ideas about neurasthenia developed differently in different places: see Gijiswijt-Hofstra & Porter (2001) and Lee (1999).

[48] This kind of thinking was echoed outside psychiatry; the respectable Dr. Sata Yoshihisa of Kyoto Imperial University was still writing in *Taiyo* in 1924 that "neurasthenia is an inevitable condition in a society with fierce competition for

However, mainstream psychiatrists were mostly trained in German, Kraepelinian neuropsychiatry and, as a result, shared a strong adherence to genetics as cause of mental illness. Kure wrote in a 1913 *Yomiuri* newspaper commentary on neurasthenia that no one could develop mental illness from working too much—if they did, they must have a predisposition to begin with. Kure further preached the importance of recognizing what he described as the "predisposed level of talent," so that people would not push themselves beyond their limit and develop neurasthenia (Kure May 20, 1913). As well, Sakaki Yasuzaburô, who was professor at Kyushu Imperial University and brother of Sakaki Hajime (the first professor of psychiatry in Japan), stated in a book called *Kawarimono* (the Abnormal) that neurasthenics were "generally born with an inherent weakness in the brain." The neurasthenic, Sakaki wrote, was like a "poor man" who "only has half the mental capacity of a normal person" (Sakaki 1912).[49]

The theory of neurasthenia as inherited had importance for psychiatrists for two reasons. First, neurasthenia was of particular interest among forensic psychiatrists as it was regarded as a predecessor to mental illness (Katayama 1912). The Journal of Neurology featured numerous articles on the relationship between neurasthenia and crime at the time ("Neurasthenia, delusion, and homicide," "Stupor caused by neurasthenia resulting in rape," "Homicidal and suicidal explosion" of a "depressed neurasthenic," to cite a few), which mainly served to introduce the academic debates within German psychiatry. Note that, at least in the 1910s, it seems that Japanese psychiatrists were more interested in exploring

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survival; unless the life style is changed it cannot be eradicated" (Sata 1924).

[49] For the direct causes of neurasthenia, he lists weak constitution from childhood, lack of mother's breast milk or its mismatch with the baby's constitution, excessive studying, smoking, drug abuse, sexual restraint, excessive sex, masturbation, or infectious disease. For the symptoms he cites pathologically excitable nerves, easy fatigability, both mentally and physically, vulnerability to pain, and insomnia.

the *mechanism* of neurasthenia itself—that is, how those who committed crime may have acted in a mentally inhibited stated due to neurasthenia—rather than the "neurasthenics" in terms of their pathological *personality*.

Second, psychiatrists had to account for the social origins of neurasthenia as it was being linked to practical issues of legal and economic compensation. Already in the 1990s, a number of British and American residents in Japan made appeals against the Ministry of Transport, claiming that their neurasthenia was caused by traffic accidents (Yomiuri November 7, 1909, Yomiuri December 19, 1909, Yomiuri July 8, 1910).[50] Later, in the 1930s, neurasthenia became a contested illness category in a number of labor disputes. And there was even a lawsuit by the family of a neurasthenic man who had committed suicide—they argued that his life insurance should be paid as it was a "death due to illness" (Yomiuri March 21, 1931).

In fact, even before these increasing social disputes over neurasthenia, psychiatrists were contending with the issue of the scientific legitimacy of this illness category. This concern culminated in a symposium on neurasthenia held at the Japanese Society of Neurology in 1913. By this time, Beard's original formulation of neurasthenia as an illness of overwork had been largely refuted in the West (Lutz 1995). Following this conceptual change, Japanese psychiatrists began to introduce the distinction between "true neurasthenia" and "*shinkeishitsu*" or nervous temperament/disposition (discussed below). Miyake Kôichi, the successor of Kure at Tokyo Imperial University, had already made these distinctions in a *Journal of Neurology* paper in 1912 and said that less than

[50] I do not have data for the actual number of lawsuits that ensued, but it must have been enough to urge the government to issue the "First report by the research committee on traumatic neurosis" in 1927 and "Health insurance, feigned illnesses, and traumatic neurosis."

10% of the so-called neurasthenic patients actually suffered from "true neurasthenia," which was caused by "overwork" (Miyake 1912). Notably, despite the fact that these psychiatrists almost always included heredity as one aspect of their previous discourse on neurasthenia, they now claimed that "true neurasthenia" was exclusively the result of overwork.

By the 1920s, psychiatrists were lamenting the fact that too many people were casually using the label of neurasthenia and claiming themselves to be neurasthenic (again the striking parallel with the current depression discourse among psychiatrists). Miyake even suggested that most of the patients who would come to see a doctor complaining of this ailment were not suffering from neurasthenia at all: it was merely a manifestation of "*shinkeishitsu*," which was now regarded as a type of abnormal personality (Miyake 1927).[51] This general sentiment among academic psychiatrists was clearly expressed in a public lecture given by Uematsu Shichikurô, professor at Keio University (who later helped establish the Mental Hygiene Law in 1950) at a "Mental hygiene exhibition" held by the Red Cross in 1929. The Red Cross exhibition opened in the center of Tokyo with the aim of "promoting knowledge of mental illness." Held at a time when Japan was attempting to build up the health of its citizens, the exhibition sought to enlighten people about the horror of mental illness, the danger of passing it on through marriage, and the importance of hygiene of the mind and body in defense of diseases. Mental illness was presented as exotica, its horror conveyed in easy-to-digest graphs and pictures (e.g., Figure 5). In a lecture titled "Urban life

[51] Miyake points out that shinkeishitsu is too broad a category and includes those who simply worry too much, are too sensitive and meticulous as well as those who suffer (and make others suffer) from their extreme, pathological tendencies. He suggests that those pathological types can be further categories into: a) neurasthenic shinkeishitsu; b) indignant shinkeishitsu; c) melancholic shinkeishitsu; d) hysteric shinkeishitsu; e) sexually-abnormal shinkeishitsu, and others (Miyake 1927).

and neurasthenia," Uematsu pointed out that people used to believe that neurasthenia was caused by overwork but the truth was that these neurasthenics "rarely have apparent causes nor do they seem to improve with rest." This was because, according to Uematsu, these people were *shinkeishitsu*, and were merely responding to external stimuli in an "abnormal, persistent way" which gives rise to "stimulus fatigue." Addicted to material culture and tormented by deep anxiety about competition, such people had, in other words, a "weak resistance":

> ...neurasthenia is not a disease but the kind of person. Headaches, dizziness, ringing in the ear, and forgetfulness are all abnormal mental responses and do not themselves constitute a brain disease. Many lay people seem to think that neurasthenia can be cured by injection and medication. What is cured are merely symptoms such as headaches, dizziness, and insomnia. The fundamental disease—that is, the personality itself—can never be cured by medication (Uematsu 1929:17).

Though Uematsu hastily added that such a pathological personality was something that anyone might have to some extent, he concluded that the only cure for neurasthenia was a "philosophical attitude or resignation." He reiterated this position in a series of The *Yomiuri* newspaper articles in 1936 titled "Unveiling neurasthenia," and he denounced this disease category altogether in his widely used textbook (Uematsu 1948; this went into the ninth printing by 1957). As the concept of neurasthenia dissolved into that of a pathological disposition within psychiatry, and as the national call for cultivating the "spirit" rose with the impending war, the number of reported neurasthenics rapidly decreased in the 1930s. Uchimura Yûshi, who as the successor to Miyake chaired the psychiatric department at Tokyo University both during WWII and its aftermath, gave a speech at the inaugural ceremony of the Mental Welfare Association in 1943. In

front of 200 attendees, including the Ministry of Interior, he said: "The spirit of the citizens is healthy, and this is apparent in many ways. One example is the decreasing number of neurasthenic patients since 1937; the number is now half what it was before. However, we have no time to be complacent, when the various nerve wars (*shinkeisen*) are being fought" (Uchimura 1943:527). The neurasthenics apparently had no place in wartime Japan, when citizens were constantly being urged to strengthen both their spirit and body.

Figure 5: "The causes of neurasthenia": From the Mental Hygiene Exhibition in 1929

After WWII, the notion of neurasthenia was becoming obsolete in academic psychiatry, almost entirely being replaced by the category of neurosis. This was already suggested in 1942 by Shimoda Mitsuzo, professor at Kyûshû University (and the famous theorist of depression), who wrote in a book for a popular audience called *Seishin Eisei Kôwa* (Lectures on Mental Hygiene) that "there is no other disease category so widely used and abused as neurasthenia"; "Most of the early phases of mental illness are called neurasthenia; people use it as an excuse for taking time off work, and even doctors use it when they cannot find an exact diagnosis" (Shimoda 1942:88). After the war, Nakagawa Shirô of Tokyo University published a thorough study on neurasthenia, in which he examined 1914 patients diagnosed with neurasthenia and *shinkeishitsu* and found that 80% of them had a

good prognosis and most would now fall into the category of neurosis (Nakagawa 1947; Muramatsu 1953, Takahashi 1998). As neurasthenia became incorporated into the notion of neurosis, its official usage quickly declined and the term became a euphemism for insanity. In the newspaper articles of the postwar era, there were scattered references to neurasthenia in the cases of violent suicide attempts and homicides in the 1950s: e.g., a neurasthenic mother strangled her child (1951), a neurasthenic sets himself on fire (1954), and neurasthenic craftsman kills his father-in-law with a hatchet (1960). During the 1960s, the term was seldom used: one of its last appearances in *Asahi Shimbun* was in 1974 in an article about Lilly the Panda at the Paris zoo, who developed "neurasthenia" and died on a hunger strike (Asahi April 21, 1974). The word lingers on as the name of a card game (called "Melancholy" in the West), and would still be recognized as a term connoting mental illness—albeit with a sense of anachronism.[52]

Up to this point, the story of the fall of neurasthenia from an illness of overwork to a personality weakness deviated little from what had happened earlier in the West. What came after this, however, were two distinct Japanese developments. The first was the way in which neurasthenia became popularized through the rising psychological discourse about *shinkeishitsu* in the Taisho Era; the second was a new concept of depression proposed by Shimoda Mitsuzô.

IV. Transformations of neurasthenia into a personality type—*Shinkeishitsu*

Despite the official dismissal by psychiatrists that neurasthenia no longer constituted a disease entity, lay people who had come to think of their distress in terms of nerve disease continued to resort to this category. While they were left

[52] Notably in China, where the concept traveled to from Japan, neurasthenia continued to flourish and it has made an international comeback through its adoption by the ICD-10 (Kleinman 1986, Lee 1999).

uncured, one of the doctors who was able to offer an alternative to biopsychiatry was Morita Masatake, who was beginning to cultivate, against biology and Western psychoanalysis, his own theory of psychology. Morita had originally entered Tokyo Imperial University with an interest in studying neurosis, and soon emerged as an authority on neurasthenia and neurosis at a time when these notions were becoming increasingly psychologized. Writing in the 1930 *Gendai igaku daijiten* (Contemporary Medical Dictionary), Morita explicitly denied the disease category of neurasthenia, arguing that stimulus-exhaustion was a symptom that accompanied illnesses in general and that it was highly subjective, changing from person to person. Instead, drawing on ideas such as Hippocrates' theory of oversensitive constitution, and Kraepelin's of hereditary neurasthenia, Morita proposed an interpretation of *shinkeishitsu* as a disposition characterized by "self-reflexivity and intelligence."[53] Morita argued that the key to the cure was to simply encourage patients to "realize" that what they were suffering from was not really a disease but simply the way they were (Morita 1930:83-85; Watanabe 1999). Morita said that 60% of his *shinkeishitsu* patients recovered in less than 40 days through this therapy, and his disciples such as Kôra Takehisa were able to claim that the "conventional idea that chronic neurasthenia is based upon hereditary predisposition and is incurable has been refuted." According to Kôra, because *shinkeishitsu* patients could return to their normal state by the psychological changes induced by Morita Therapy, they should not be regarded as suffering from an abnormal personality (Kôra 1938). This marked the birth of a new psychological theory in Japan, in which the meaning of *shinkeishitsu* changed from merely a sign of incurable abnormality to an *excess of self-reflexivity*, which was supposedly brought about by the disruptions caused by modernity.

These striking reports of cure by the Morita Group went largely ignored by

[53] Morita contrasted this with the "hyper emotionality" of a hysteric.

mainstream psychiatrists who were only interested in the "real" (that is, biological) diseases and moved away from neurasthenia in contempt of its dubious scientific status. However, intellectuals of the time took a keen interest in Morita Therapy and began to form a kind of therapeutic movement, which helped form a kind of psychology boom beginning in the Taisho Era.[54] Morita himself energetically promoted his idea through the publications of his books, *Shinkeishitsu oyobi shinkeisuijakushô no ryôhô* (The treatment for shinkeishistu and neurasthenia) in 1921, and gained a wide audience through his national radio talk on neurasthenia in 1926. At the same time, prominent writers such as Kurata Hyakuzô, known for works like *The Priest and his Disciples* (1916), published accounts of their own recovery from *shinkeishitsu* through Morita Therapy (Satô et al. 1997:198). Most notably, Nakamura Kokyô, the editor of *Hentai Shinri* (Abnormal Psychology) was an ardent Morita supporter. A former disciple of Natsume Sôseki, Kokyô had lost his brother to mental illness and himself suffered from neurasthenia. Critical of modern medicine from his own experience and arguing that its "materialistic" treatment "disregards the depth of human psychology," Nakamura became a well-known therapist in his own right, publishing numerous case studies that explained in depth—from his perspective—what overcoming neurasthenia was all about (Nakamura 1930; Oda 2001).

In serial articles Nakamura originally published in the magazine *Shufu no tomo* (Friend of housewives), which was later published in a book called *Shinkeisuijaku wa dô sureba zenchisuruka* (How to fully recover from neurasthenia) in 1930, he discussed the life stories of neurasthenics who finally found a cure in Morita

[54] A 1954 outcome study on neurasthenic patients at Tokyo University found that 82 out of 286 formerly neurasthenic patients said they were cured by (bio)medical care, and 15 out of these 86 patients said they recovered because of Morita Therapy (Nakagawa 1954).

Therapy after a long quest. In one of Nakamura's articles, for instance, a 37-year-old graduate of Tokyo Imperial University had needed to take a year off from his government work because of his neurasthenia. He had been feeling depressed, with no sense of judgment or desire to interact with others; his head would become heavy and fogged, and he would suddenly feel pessimistic. But he had fully recovered with five sessions of hypnotic suggestive therapy and was now "successfully working as a governor." Another patient was a 26-year-old graduate of a vocational school, who claimed to have suffered from neurasthenia since grade school. He had seen numerous doctors, most of whom simply prescribed medicine and vitamin injections. His illness history illuminates the range of treatment that was available for neurasthenics at the time: he had received electric therapy, hypnosis, willpower treatment (kiaijutsu), the Great Path to Spirit (daireidô), and thought-projection therapy (nensha ryôhô)—but all in vain. (Other kinds of treatment that Nakamura's patients had tried were also far ranging and included massage, self-control therapy, deep-breathing, exercise, abdominal respiration, chiropractic, water therapy, and more ordinary treatment of vitamin shots and hormone therapy by medical doctors.) In desperation, the patient even resorted to a "special medicine" that would make "part of his brain paralyzed" in order to "create changes in the brain encephalon" but it failed miserably. Convinced that "it is natural law that the weak must perish," he decided after all these treatments and "wasting his last twenty six years" that the "only contribution [he] can make to society" was to "leave this world." Nakamura's advice was that the weak person would only exhaust himself if he wished to be stronger than he was capable of. The cure was to simply recognize who he was: "He has to be resigned to his own weakness, be satisfied and grateful" (Nakamura 1930:42-53). Despite this unflattering fatalism, Morita Therapy won popular appeal, probably because it apparently provided a much-needed cure where biopsychiatry had failed.[55] At the same time, however,

[55] The idea of neurasthenia and *shinkeishitsu* penetrated into society by the 1920s,

Morita's interpretation of neurasthenia may have served to remove the question of social etiology from its original concept, instilling its own distinctive process of psychologization in the Japanese soil that did not accept psychoanalysis.

V. A new illness of overwork: localizing depression

In the meantime, as the medical category of neurasthenia was beginning to be dismissed by academic psychiatrists, another illness "resembling neurasthenia" emerged on the horizon of Japanese psychiatry –that was depression.[56] As I will discuss in the next chapter, this notion was formulated by Shimoda Mitsuzô who noted a group of patients who shared not only neurasthenic symptoms but a certain type of personality. Arguing that they were in fact suffering from depression, Shimoda further illuminated how these patients shared the personality traits of those who are diligent, thorough, highly respected members of society. As if to revive the earlier discourse about the overworked neurasthenics, and to save those from the quickly degrading implication of neurasthenia itself, Shimoda's theory of depression established a new category of person whose

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creating diverging interpretations. Compared to the Tokyo-based Nakamura, the case reports of Usa (1925) from Kyoto, another disciple of Morita, are of a more working-class clientele and show a strikingly different picture of neurasthenia as being continuously *physical* in nature. Usa, originally a Zen priest, became a disciple of Morita and his article on the neurasthenic and *shinkeishitsu* patients treated between 1923 and 1925 appeared in the *Journal of Neurology and Psychiatry* in 1925. The patient population varied remarkably in terms of their occupations, suggesting a spread of neurasthenia in the 1920s well beyond the intellectual circles of the 1900s. They included a potter, fabric store clerk, farmer, policemen, chirographer, fisher monger, dye shop worker, oil container seller, goldsmith, photographer, pharmacist and a dentist, among others. What is intriguing is the range of physical symptoms that Usa's patients commonly talked about, including stiff shoulders (a predominant symptom among them, it seems).

[56] By this time, depression was mainly classified as part of manic depression. Unipolar depression was rarely discussed in Japanese psychiatry until Shimoda proposed this theory (see Chapter 5).

illness was not necessarily of a morally degenerate kind. Shimoda's theory of personality developed just when Japan was plunging deeper into the war effort, and was explicitly trying to produce more and more "model" workers.[57] As we will see in the next chapter, the moral ambiguity of the neurasthenia concept is also inherited in Shimoda's depression concept. While this later came to aid psychiatrists to discuss the pathology of Japanese social structure, this new notion of depression also left unanswered the question of where the real causality lies—whether the blame should be placed on the society that produces the demand for overwork or on the individuals whose personality drives them to such overwork—a question that Japanese psychiatrists are again having to confront with regard to the rising rates of depression and overwork suicide.

[57] Though Shimoda himself did not emphasize this point, his theory was later used by other psychiatrists to illuminate the hidden pathology behind the otherwise serious, diligent, hard-working people, whose seeming normal devotion could lead to their own self-destruction.

Chapter 5: *Typus Melancholicus*: a Theory of Depressive Personality

I. *Typus Melancholicus*

Like neurasthenia a century ago, what is distinctive about the current medicalization of depression in Japan is the fact that depression is being explained as an illness of social origins. What has long underlined this argument is the theory of Typus Melancholicus or melancholic premorbid personality (Tellenbach 1980; cf., Shimoda 1941) a widely popular idea in Japan that both lay people and experts seem to assume is a universal, scientific theory,[58] when in fact it is rarely heard outside of this country (in Germany, this has reportedly become an obsolete notion). The theory asserts that depression is likely to affect those who have a serious, diligent, thorough, and caring personality, and this image of the depressed personality has significantly helped de-stigmatize depression (Suzuki 1997). For instance, psychiatrists and lawyers involved in overwork suicide cases have used it to emphasize how the deceased workers were not deviants but normative Japanese. Some psychiatrists-cum-social critics have even gone so far as to claim that Typus Melancholicus is what embodies the Japanese self and that the reason why there have been so many people with depression of late is because Japanese society has been facing fundamental structural changes (Shiba 1999; Takaoka 2003; also see Doi 1966, Iida 1978, Iida et al. 1980). However, the theory also poses a certain ambiguity, as it has been used both to point to the biological, individual vulnerability to depression, and to demonstrate how depression is socially produced. In this chapter, I will examine the conceptual history of this personality theory and show how the two competing perspectives—the biological

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[58] This notion is featured in most psychiatric textbooks, including the ones medical students have to study for their licensing exam.

and the social—have played out in the making of "depression" in Japan today.[59]

II. From manic depression to Shimoda's notion of depression

Depression had remained a minor disease category in Japanese psychiatry until rather recently.[60] For most of the 20th century, the German neuropsychiatric concept of "manic depression" (sôutsubyô)—with its strong link to the idea of heredity—predominated and overshadowed "depression" (utsubyô). Originally, for the early Japanese psychiatrists trained with Henry Maudsley's textbook (published in 1872 and translated into Japanese in 1876: Maudsley 2002), melancholia served as an all-encompassing category for insanity (see Okada 1981: 76-78). Melancholia's importance soon waned, however, particularly after Kure Shûzo instilled the Kraepelinian nosology as the doctrine of Japanese psychiatry. Noting in his clinical lectures the ingenuity of the Kraepelinian notion of manic depression, Kure emphasized how the seemingly unrelated diseases—mania and depression—are in fact two sides of the same coin (Kure 1914,1915). The term manic depression began to replace melancholia when it was discussed in the widely used psychiatric textbook by Ishida Noboru (1906), who also cited the German statistics that established its cause to be 80% hereditary. As with other diseases that were then of primary importance (such as general paralysis or epilepsy), psychiatrists seemed only interested in manic depression for its peculiar symptomatology and its genetic makeup (see Tatsumi 1975). Clinically, manic depression did not seem to attract much attention either, because, unlike dementia praecox, it was assumed to abate by itself after a certain period of time

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[59] The materials I draw on are: 1) articles from the Journal of Psychiatry and Neurology [formerly the Journal of Neurology] from its inception in 1902 up to the present; 2) representative Japanese psychiatric textbooks of the 20th century; and 3) newspaper articles on depression from the 1900s onward.

[60] As David Healy points out, depression, as we know it today, did not exist as such before the discovery of antidepressants (Healy 2000:395).

and to leave few aftereffects in terms of personality deterioration. In the era of biological determinism, when psychiatrists regarded the mentally ill as "degenerates" (see Chapter 3), it was not surprising that most of the manic depressive patients brought to their attention were those suffering from conspicuously violent mania attacks, and rarely depression per se (e.g., Kure 1914).

Because of the predominance of "manic-depression," Japanese psychiatrists continued to express puzzlement over the patients who only manifested depression. While most seemed content to simply describe these cases, Shimoda Mitsuzô, professor of psychiatry at Kyûshû Imperial University went further by creating his own model of depression in 1932. Shimoda's group found a significant number of patients with what he originally called "senile depression," who never developed mania even under a long-term observation and thus clearly deviated from the classic Kraepelinian description of manic depression (Naka 1932, Shimoda 1941, 1950). Shimoda's group particularly emphasized the fact that these people were not feeble degenerates but rather socially adaptive people—many from the upper class—who developed depression only later in their otherwise successful lives (the fact that the 20% of the patients were doctors was noted).

What characterized these patients, Shimoda argued, was that they shared a common personality. Drawing on the work of Ernest Kretschmer who proposed in 1921 that manic-depressives have a constitution called cyclothymia,[61] Shimoda

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[61] Shimoda's theory of personality was a product of a dialogue with an entirely different strand of German intellectual thought that had been newly introduced to Japan in 1925. Up to that point, German psychiatry meant Kraepelinian neuropsychiatry. What Japanese psychiatrists seemed not to realize was that this kind of biological reductionism was in fact a reaction against the previously dominant Romantic psychiatry in Germany, and that the two currents continued

argued that Kretschmer's description still remained within the realm of normalcy, and instead proposed that his own patients possessed what he called immodithyme (cohesive) personality (junkan kishitsu). Shimoda believed that this personality, which he conceptualized as a kind of genetically based constitution, would also explain the pathological mechanism of depression itself:

> The essence of this personality is the abnormalcy of its emotional processes. That is, for those with this personality, an emotion that once occurs does not cool down after a certain period as it would in a normal person and instead persists for a long time at a certain level of intensity, which can even grow stronger. People with this abnormal personality are enthusiastic about work, meticulous, thorough, honest, punctual, with a strong sense of justice, duty, and responsibility, and unable to cheat or be sloppy. They are the kind of people who gain trust of others by being reliable, who are praised as model youths, model employee, and model officers. (Shimoda 1950: 3)

When these people develop "neurasthenic symptoms" from overwork such as sleep disturbance, they cannot calm their excitability and rest, as a normal person would, but remain active until they fall into depression at the height of their exhaustion. Depression is then an "escape into illness," or a "biological response for self-preservation"(Shimoda 1950:2). The cure Shimoda provided was "continuous sleep therapy" (jizoku suimin ryôhô), which basically made patients

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to interact and develop with one another within Germany itself. Thus when Kretschmer's theory of constitution and mental illness—which was heavily influenced by the Romantic thinking that linked depression with geniuses (such as Goethe and Humboldt)—was introduced to Japan by Ishikawa Sadakichi in *the Journal of Neurology* in 1925, there was considerable excitement among psychiatrists and other intellectual figures (Ishikawa 1925). The Japan-Germany Culture Association, whose aim was to "promote mutual understanding of the national spirit of the two nations," also gave praise to Ishikawa's "distinguished work" of translating Kretschmer's complex ideas into lucid concepts.

sleep for days on end (Nakao 1988).

Though largely conceptualized at the level of physiological response, Shimoda's idea of immodithyme personality was one of the first Japanese attempts to go beyond a simplistic biologism, and to explain the mechanism by which the pathology arises in a seemingly normal person (Kasahara 1976). Largely neglected at the time, Shimoda's personality theory was reappraised in the 1960s, when it was re-interpreted through the lens of existential, phenomenological psychiatry that revived the notion to emphasize the social cause of depression.

III. Depression existentialized and the rise of antidepressants

In the era immediately following WWII, depression continued to be conceptually subsumed under the category of manic depression, and as such rarely attracted popular or scholarly attention.[62] Perhaps the most important change during the 1950s and early 60s in light of the later depression discourse was the emergence of a field called psychopathology (seishin byôrigaku) and its new depression concepts. Psychopathology emerged in part as a response to American psychoanalytic influence in the 1950s, when Japanese psychiatrists began to

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[62] With regard to depression before the advent of antidepressants, see Chitani 1957. Also note that Healy writes: "Depressive disorders, at least in Europe, were restricted to the melancholias, with or without delusions, and severe depressive personality disorders that led to admissions to hospital at a rate of approximately 50 per million of the population. These early figures need to be set beside current estimates for depressive disorders which run at 100,000 per million. It follows that conditions currently described as primary care depression or community depressions, and thought to be in some way continuous with hospital depression, before 1950 must have been subsumed within the general pool of community nervousness and as such must have been viewed as discontinuous with melancholia. These non-hospital nervous conditions were more likely to attract a diagnosis of anxiety or mixed anxiety depressive disorder or 'nerves.'" (Healy 2000:395)

attempt descriptive, phenomenological, and even psychoanalytic investigation into the "lifeworld of the psychotics" (Nishimaru 1954; also see Uchimura, Kasamatsu & Shimazaki 1957).[63] While most attention was given to schizophrenia, some of the psychiatrists affiliated with Kyoto University turned to depression. They began to introduce the concepts that were emerging out of postwar Germany, where psychiatrists were being faced with the occurrences of "depression" among the victims of the Holocaust (see Omata 2002). Introducing the German debates and trying to go beyond the rigid dichotomy between psychosis and neurosis, Japanese psychiatrists such as Hirasawa Hajime (1959) and Fuse Kuniyuki (1960) imported such notions as "uprooted depression," Hafner's "existential depression," Lorenzer's "loss depression," Volkel's "neurotic

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[63] It is important to note that around this time, Japanese psychiatrists began to engage with the positive aspects of mental illness as well through a new field of pathography (byôsekigaku), a study of the relationship between madness, creativity, and art. This intellectual atmosphere may have been fostered by the fact that some of the leading psychiatrists came from families of writers and thinkers. Uchimura Yûshi, the Professor at Tokyo University, for instance, was the son of Uchimura Kanzô, an ardent non-Church Christian evangelist and an intellectual leader of the time (whose extremities of personality Yûshi later wrote about from a psychiatric perspective). Yûshi also translated in 1953 Kretschmer's work on the psychology of geniuses and reflected on the question of where the border lies between normalcy and abnormalcy. As well, Shimazaki Toshiki, Professor of Tokyo Dental and Medical University, and his brother Nishimaru Shiho, Professor of Shinshu University—both of whom were intellectual leaders of humanistic, phenomenological psychiatry—were related to a revolutionary novelist, Shimazaki Tôson, who wrote a family saga about his father's failing political visions and the subsequent insanity (on Tôson, see: Bourdachs 1997). Then there was the family of the Saitôs, who have produced a number of psychiatrists-cum-poets and writers, including the renowned poet Saitô Mokichi and the novelist Kita Morio, who has also written extensively about his family and the history of their insanity as well as a series of highly popular comical essays on his own experiences of manic depression. These psychiatrists helped popularize the idea of mental illness as something that can exist in the midst of normalcy by reflecting on the interplay between genetics and social environment. This duality—where psychiatrists saw no contradictions between their firm basis in biology and their social and existential perspective—can be seen in the later theorizing about depression.

depression," and Kielholz's "fatigue depression" (which came to be adopted in the arguments made for overwork suicide: see Chapter 9). These psychopathological concepts became the basis for the new understandings of depression in Japan.[64]

What directly liberated depression from the narrow confines of asylums was, however, not so much these existential concepts of depression but the discovery of antidepressants in the 1950s. Antidepressants created a much larger basis for outpatient psychiatry, and established depression apart from manic depression as an independent clinical entity. Journal articles on depression mushroomed from 1958, while popular articles on depression began to follow less than a decade later. In works that marked the beginning of Japanese interest in mild depression, Hirasawa (1966) noted how there was an emerging population of patients who clearly deviated from the classic Kraepelinian description of manic depression, and (unlike traditional manic depressives) how their symptoms were mild enough to be treated in the community. With the availability of a cure, psychiatrists were now trying hard to de-stigmatize depression by emphasizing its physiological basis.[65] Shinfuku Naotake, who had earlier conducted a

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[64] The social perspective brought by American psychiatry also helped some Japanese psychiatrists to question the prewar biological paradigm when they encountered the "suicide boom" of the 1950s. While the nation grappled with the question of why so many young people—who had just survived the devastating war—were being driven to kill themselves, psychiatrists began to engage more closely with the existential experiences of those who attempted suicide. Young psychiatrists such as Katô Masaaki (1953), who went on to become a leading social psychiatrist, examined the life histories of 35 people who attempted suicide, and argued how psychiatrists should be "cautious in stressing the genetic cause" (also see Katô et al. 1955). While the debates continued on genetics versus environment, new socio-cultural perspectives on suicide also began to grow out of works such as *Suicide in Japan* by Ôhara Kenshirô (1975), which demonstrated how suicide is shaped by the forces of culture and society.

[65] In a newspaper Q & A column in 1967, for instance, Shibata Shûichi of Tokyo Women's University discussed depression, which he said would be "naturally

community survey on the elderly, found high rates of depression among them, and became one of the first scholars to rejuvenate Shimoda's personality theory for understanding the depressed (Shinfuku 1955), and also became one of the first psychiatrists to promote Kral's notion of "masked depression"(Shinfuku 1969). Masked depression referred to the kind of depression with physical symptoms but without depressed mood itself, and psychiatry's promotion of this idea of depression also coincided with the rise of psychosomatic medicine (shinryô naika) among internists in Japan. The Society of Mind-Body Medicine (later Psychosomatic Medicine) was established, and the first psychosomatic department was opened at Kyûshû University in 1960, by Ikemi Yûjiro. These changes helped cultivate a public interest in mind-body problems, for which antidepressants were being promoted as a cure (Okada & Kinoshita 1995).

Notably, antidepressants, which seemed as if they might cement the dominance of the biological paradigm, actually served to diversify psychiatric perspectives. Despite initial optimism, psychiatrists soon had to confront the fact that antidepressants did not always cure patients, and that it even seemed to produce relapses and protracted depression (Takahashi 1974, Kasahara et al. 1992). This led psychiatrists to turn to the two etiological concepts of depression—namely, the personality cause (seikaku-in) and situational cause (jôkyô-in). Just as Shimoda noted the socially adaptive personality of the depressed in the 1930s, Hirasawa (1966) drew on Hubertus Tellenbach's notion of Typus Melancholicus (1961) to illuminate how the depressed are the ones who most embody ideal "Japanese" values—that is, their love of order, caring for others, and a dutiful identification with a collective (Hirasawa was the one to point out the similarities

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cured" within half a year and would "leave no defects." He also added, however, that it would be better treated by an expert with medication or injection and wrote: "Apart from paying attention to the meaning of patients' bodies our psychiatric consultation little differs from that of an internist. Please feel free to come to see us"(Shibata 1967).

between the two concepts of Shimoda's and Tellenbach's: also see Shimazaki & Yazaki 1963). In the reputable book titled *Clinical care and the prognosis of mild depression,* Hirasawa illuminated the experiences of the 573 patients he saw over five years from 1958-63, and showed how depression can be understood as both a biological and psychological reaction to a stressful social situation. Closely examining patients' life histories, psychiatrists began to turn to the subjective experiences of depression that can be approached through a closer therapeutic engagement with the afflicted (Kasahara 1976). A number of veteran psychiatrists trained at Tokyo University emphasized in my interview their initial shock when encountering Tellenbach's work in the 1960s, at a time when they were struggling to find a way out of the rigid biological determinism that was still the dominant, singular model of mental illness.[66] Drawing upon his humanistic approach, psychiatrists began to reconceptualize depression as an existential—if pathological—reaction to the particular social conditions of the postwar Japanese society (see Katô 1999a).

Such perspectives helped psychiatrists turn their discourse about depression into a form of social critique, a theme that was extensively developed in the series of workshops held on manic depression in the 1970s and 1980s (e.g., Kasahara 1976, Miyamoto 1977, Kimura 1981).[67] The notion of "social personality"—as

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[66] One of them, Moriyama Kimio, who went on to become the most influential leader in the antipsychiatry movement, illuminated in an award-winning paper the dialectics of depression. He drew upon existential philosophy in depicting how depression arises from the individual desire to rise above oneself (both socially and psychologically), and the tension that it creates because of the rigidity of personality structure of Typus Melancholicus (Moriyama 1965, 1968).

[67] It is notable that some psychiatrists began to question the notion of Typus Melancholicus just when it was beginning to proliferate in popular discourse. Particularly during the antipsychiatry movement, most anti-psychiatrists influenced by RD Laing and Thomas Szsaz focused on dismantling the concept of schizophrenia, but there were others who tackled manic depression (under which category depression was still included). In a Society of Psychiatry and Neurology

exemplified by Erich Fromm's works (*Escape from Freedom* was translated in 1951)[68]—had already been discussed in various symposiums of the Society of Psychiatry and Neurology since the 1950s. Now faced with the sudden increase of depression from the 1960s on, psychiatrists were asking why it was those with a socially adaptive personality that were falling into depression en masse (Kasahara et al. 1971, Takahashi 1974, Ôhara 1973). Some psychiatrists ventured to explain how the social change was affecting not only individuals' biology but their psychology as well. Psychoanalysts such as Doi Takeo (1966) argued that the epidemic of depression was caused by the disintegration of traditional communities and the transformation of the work style, and such changes were destroying people's "illusionary identification" with the collective. Iida Shin (1973) similarly argued how the rise of industrialization and nuclearization of families were causing alienation for melancholics, whose strong desire for a sense of belonging made them particularly prone to "uprooted depression." Paralleling social critics such as Norman O. Brown in the West, who had discussed how the industrial capitalist order has instilled and rewarded an "anal" personality (Brown 1959), Nakai Hisao (1976) traced the historical production of the work-obsessed melancholic personality in Japan to the rise of the 17th century

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symposium on manic depression in 1972, Naka questioned whether there really was such a thing as a depression-prone "personality." This was a striking comment coming from one of the disciples of Shimoda, who was also the principle author of the first article on immodithyme personality in 1932. Naka argued that personality was not something that could be objectively measured, and demanded that the "notion of endogeneity be abolished altogether." While Ôhara Kenshirô, the suicide expert, defended the notion of endogenous depression by saying that "[this] had always been taught this way," the chairperson ended the disjointed session with characteristic rhetoric of the time—that they needed to overcome the psychiatric conceptualization that "rendered patients as passive beings"(Naka 1972:328). The debate over the social etiology of depression continued, though it remained largely at the level of rhetoric and was rarely backed up by empirical research.

[68] *The Sane Society* was also translated in 1958 by Katô Masaaki, the aforementioned suicide expert.

Agricultural Revolution. He showed how the work ethic that began to permeate Japanese society, reproducing a certain collective personality type, was no longer rewarded in the emerging economic order. Through these explorations, psychiatrists elaborated on how Typus Melancholicus—and depression itself—are socially and historically produced.

IV. The rise of depression

Expanding on the social theme, psychiatrists during the era of the long-lasting antipsychiatry movement (see Chapter 3) were also becoming more interested in depression as a clinical object, as they noted the steady growth of depressed patients from the 1960s on. In 1971, Kasahara et al. contrasted the stable ratio of schizophrenics and the growing ratio of the depressed during the 1960s (Kasahara et al. 1971). At the outpatient clinic of Jikei University, the ratio of depression rose from a mere 7.1% in 1964 to 18.5% in 1971 (Shinfuku et al. 1973). In a survey at Kyoto University, depression also increased from 10.8% (1958) to 19.2% (1968), to 29.3% (1978). In 1973, Ôhara Kenshirô, the suicide expert, conducted a questionnaire survey of 200 psychiatrists and confirmed the commonly held impression at the time that depression was on the rise (73.8% of these doctors answered yes to this question) (Ôhara 1973). This trend continued in the 1980s, when depression increased by 3.17 between 1980 and 1990 (whereas the increase was only 1.54 for schizophrenia) (Matsushita 1997:32).

Given the therapeutic urgency, Kasahara and Kimura Bin—two of the most reputable scholars of psychopathology and phenomenological, existential psychiatry—created in 1975 Japan's first diagnostic criteria for manic depression (Kasahara & Kimura 1975). This has been widely used as a manual for training new generations of psychiatrists (Makino 1997), and undoubtedly helped

establish the idea of personality cause as part of the official psychiatric knowledge nationwide. Kasahara and Kimura employed multi-axis criteria, combining premorbid personality, the situation of the onset of illness, symptoms, and a prognosis for diagnosing depression. Most importantly, this nosology broke away from the traditional premise that had long relegated depression to the ranks of psychosis and officially separated out depression from manic-depression (Hirose 1998:11; cf., Arieti 1974). Its use of multi-axis criteria also preceded the DSM-III by five years, and probably made Japanese psychiatrists more comfortable with the DSM-III's criteria when it was introduced in 1980 (its translation coming out in 1982). Thus, while most of them continued to criticize the DSM notion of major depression as being too wide to be therapeutically useful, these new notions of depression have significantly helped psychiatrists to broaden their criteria and extend the pool of patients (Kubota et al. 2000; Nikkei January 11, 1984).

From the late 1990s, Japanese psychiatrists found themselves increasingly called upon to deal with a sharp rise in suicide rates, which the government was now actively linking to depression. Calling it the "cold of the heart" (kokoro no kaze), bio-psychiatrists (who had again become influential after the introduction of the DSM-III and the new neuropsychiatry) as well as social psychiatrists, began to emphasize that depression is a common illness found in society at large (Landers 2002). The introduction of SSRIs, approved by the Ministry of Health, Welfare and Labor in May 2000, created a depression boom that was far more expansive than that which Japanese psychiatrists had experienced with the first generation of antidepressants in the 1960s. Yet the rhetoric remained the same as they promoted through the media the idea of Typus Melancholicus, and explained that it was hardworking Japanese that were particularly susceptible to depression at a time of social change. What was different this time was that there was an even more aggressive promotion of the notion of social etiology, and an attribution of the high rates of suicide and depression to the long lasting economic recession.

In an ironic twist from the antipsychiatry era (when critics would have scorned any attempts at medicalization) some left-leaning psychiatrists have promoted the depression concept as a way of establishing social responsibility of employers and the government for the suffering of overworked workers. The number of successful lawsuits along these lines has led the Ministry of Labor to even change their diagnostic criteria for depression. Abolishing the notion of endogeneity altogether, the Ministry has recently established the stress-diathesis model[69] of depression and the ICD-10 criteria as the new standard (to be discussed in Chapter 9). The current medicalization of depression thus seems to be made possible by its assertion of not only biology but also social etiology, and in this sense significantly departs from the traditional model of medicalization that has often been criticized as a way of treating social ills as a matter of diseased individuals.

At the same time, however, there has continued to be certain tension in the fact that psychiatrists use personality theories as a way of placing "blame" on individual vulnerability. Already from the 1970s, some psychiatrists have noticed the growing number of "treatment-resistant" patients, who deviated from the traditional types of depressives. Hirose Tôru argued in 1977 that there was an increasing number of patients with "escaping-type depression," by which he referred to a group of young patients who shared certain characteristics with Typus Melancholicus (such as perfectionism and thoroughness) while differing from it in that they tended to easily withdraw when faced with a difficult task and

[69] This is the idea that mental disorders are not necessarily direct results of underlying predisposition but are what become manifested due to environmental stress. By emphasizing the relationship between genetic aspects and the effects of environment, this model of depression arguably serves to bring more attention on the environment than what the Japanese, traditional endogenous model of depression allowed for.

seemed able to enjoy non-work related activities even when they were on sick leave (Hirose 1977). Miyamoto Tadao also proposed "immature-type depression," referring to patients around age 30, whose characteristics included being dependent, selfish, self-centered, attention-seeking, and quick to lose energy when encountering "trivial" stress (Miyamoto 1978:68). These notions clearly place the moral blame on individual personality and coexist uneasily with the popular discourse that depicts the depressed as the victims of society. For the time being, the psychiatric discourse on social etiology proves useful for psychiatrists, who seek to overcome the long-lasting stigma of the earlier biological paradigm. Just as German psychiatrists have remained un-reconciled over the social etiology of depression among the WWII survivors (Omata 2002), Japanese psychiatrists might soon have to face the fundamental question of what level of causality they will admit to account for the incidence of depression (see Chapter 9).

Part II. Depression in Clinical Practice

Chapter 6: Containing Reflexivity:
the Interdiction against Psychotherapy for Depression

> [P]sychoanalysis helps promote in the minds of those who engage in it the precious illusion of control over fate, that is, the sense of autonomy.
>
> Doi, Takeo. "The Cultural Assumptions of Psychoanalysis." 1990: 269

I. Interdictions against psychotherapy for depression

I chose to do my fieldwork in the psychiatric department at JP Medical School because of its emphasis on psychopathology (seishin byôrigaku). Psychotherapy is a subfield of clinical psychiatry developed by scholars who have drawn upon phenomenology and psychoanalysis. They have promoted distinctive theories about melancholic premorbid personalities (see Chapter 5) and established most of the commonsensical ideas about depression both in professional and popular discourses in Japan. Psychopathologists have also critiqued biopsychiatrists' disregard for the subjective meanings of mental illness and have thus provided the main opposition to the predominance of the biological perspective in Japanese psychiatry since the 1960s. Headed by Professor Higashi, a psychopathologist who is also the grandson of a pioneering social psychiatrist, the psychiatric department at JP has nonetheless created a congenial balance between its smaller, American-trained biologically-oriented staff and the more dominant, European-trained psychopathologists. Though they use the DSM-IV and ICD-10 alongside more conventional nosology, the psychopathologists maintain a sceptical attitude towards American psychiatry and occasionally critique it when articulating their own clinical perspectives. This contributes to an intellectually vibrant atmosphere in the department, which is reflected in the wide range of interests discussed in the weekly departmental seminars. While I was doing

fieldwork, the presentations included, for instance, a lab report on serotonin syndrome by a neurobiologist, a linguistic analysis of schizophrenic delusion with a reference to Wittgenstein, and the exploration of anorexic narratives in light of the philosophy of Simone Weil. However, their apparent interest in the *meanings* of mental illness seems curiously confined to backstage, intellectual discussion. In their daily clinical practices, the psychiatrists at JP emphasize a straightforward pragmatic, biological approach, which seems to differ little from those at the few other, more biologically-oriented psychiatric institutions where I had done observational research. Contrary to their interest in narrative-based perspectives, they remain particularly "biological" with regards to the treatment of depression, and they even proclaimed to me: "Psychotherapy is taboo when it comes to depression."

This seemed puzzling not only because of the doctors' intellectual disposition but also because psychotherapy has long been regarded as an effective cure in North America even after the advent of Prozac. In fact, the increasing dominance of the biological cure has attracted much criticism there, where intellectuals have been concerned that such a simple cure may impoverish people's ability for self-reflection (for a review of this debate, see Kramer 1992, 2005). Politically-conscious critics have even worried that biologization of depression may serve to numb people's critical insights and impose conformity (Elliot & Chambers 2004); thus the fact that in Japan it is the psychological cure for depression—and not the rise of antidepressants—that seems to have created discomfort, even explicit prohibition, among psychiatrists, is an intriguing difference. When I asked these Japanese psychiatrists why they would go so far as to disclaim psychotherapy for depression, the responses varied. Generally they pointed out the overall unpopularity of psychotherapy, and the lack of institutional and economic support for it. Under the current system, the reimbursement for "psychotherapy" remained a set fee, which meant that

psychiatrists would receive the same amount for doing fifteen minutes of so-called therapy as they would for an hour. Yet the lack of economic incentive alone did not explain why some of these psychiatrists occasionally engaged in extensive talking cures for other types of patients (such as anorexics) but rarely for the depressed. When specifically asked about depression, they emphasized that this was a biological disease, for which antidepressants should be the primary therapeutic tool. Then they would point me to Kasahara Yomishi, an authority in psychopathology who also established, together with Kimrua Bin, the first comprehensive nosology for mania and depression in 1975. (Note that Kasahara is also known as one of the fierce critics of biopsychiatry during the antipsychiatry movement, who introduced R.D. Laing's work through his translations: see Chapter 5). In his widely read papers, Kasahara has asserted that depression be treated first and foremost with medication and rest. He suggests supportive listening and giving advice on practical matters but strictly warns against the kind of psychotherapies that seek to promote psychological insight in depressed patients (see also Hirose 1979, Yoshimatsu 1987). He writes that the Japanese approach—with its focus on bodily recovery—is more "holistic" than the North American approach, which he says concentrates "too much on cognition" (Kasahara 1978; see also Suzuki 1997). Should their interdiction against psychotherapy be understood, then, not as just a matter of biologization but as a cultural articulation of holism of some sort (cf., White 1982, Kirmayer et al. 1998, Kirmayer 1998)?

Drawing upon anthropological analyses of psychiatric encounters, I want to examine how these Japanese psychiatrists provide the depressed with a language with which to express and mediate the disruption in their lives (Lock 1988, Young 1995, Corin 1998a, Kirmayer 1992). My aim is to examine how they construe the biological understanding of depression in lieu of psychotherapy. Does their psychiatric language, as some critics of biopsychiatry have argued, serve to

silence patients, suppressing their reflexivity? Or as Kasahara seems to insinuate, is it an attempt to promote a culturally "holistic" reflection upon the nature of their alienation? Alternatively, do these psychiatrists have another way of construing the reflexivity over the biological—and psychological—nature of depression? Japanese resistance to psychotherapy has long been noted (Lock 1980, 1982, Ohnuki-Tierney 1984, Ozawa 1996, Ozawa-de Silva 2002; Doi 1990), yet there have been few ethnographic investigations into how Japanese psychiatrists, particularly more psychotherapeutically-oriented ones, actually treat their patients in everyday clinical practice (except for Breslau 1999). This chapter attempts to fill this gap.[70]

II. Diagnostic interview

JP Medical School, located in a city outside of Tokyo, attracts patients from across the demographic spectrum. The waiting room fills up quickly in the morning, and each psychiatrist sees anywhere between thirty to sixty patients per day. There is a general animation in the air as doctors, nurses, a few psychologists, and a social worker busily move around in white coats. Consultation rooms are minimally furnished, containing an examination bed, a desk and perhaps a couple of chairs. From the outside, the psychiatric unit differs little in appearance from other unites in the university. Yet its waiting room—which is segregated from the corridor by a closed door—has an atmosphere that is always a touch more tense than other units. When I looked at the anxious faces of the patients, and later heard them talk about how they took pains to avoid a chance encounter with an acquaintance, I realized that the media campaign for depression that has increasingly brought more patients to this university had yet to fundamentally diminish the stigma

[70] The discussion below draws upon the data from 40 individual consultations, 128 case conferences, and 14 group therapy sessions that I observed at JP Medical School.

associated with psychiatry.

What seemed to most strongly characterize the patients' initial encounter with a psychiatrist was their heightened feeling of uncertainty. This is partly because, unlike in internal medicine where patients have basic familiarity with the kinds of diagnostic questions to be asked, psychiatry is alien territory for most patients. The questionnaires they have to fill out before the consultation—Zung's depression scale and the department's own questionnaire—might add to this sense of unfamiliarity. The latter includes the usual medical questions, such as the patients' demographic data, illness history, and current symptoms. It also includes, however, apparently *psychiatric* items such as an extensive list of personality traits to choose from, and a family tree (suggesting hereditary factors) in which patients are supposed to fill in the illness histories of close relatives. Such pre-diagnostic questions indicate that psychiatrists are concerned not just with the physiological symptoms but also with what kind of person a patient is. Patients' unfamiliarity with the psychiatric framework was evident in the pre-diagnostic interviews that I observed conducted by less-experienced residents, with whom some patients seemed lost as to where to start their narratives or exactly what constitutes "psychiatric" symptoms. I was occasionally surprised to see how their narratives changed quite drastically when they were later being interviewed by a senior psychiatrist. It is against this uncertainty of the patients —and the malleability of their narratives— that psychiatrists attempted to first establish a solid framework for understanding their distress via a biological model of depression.

Victor Turner has demonstrated how a therapeutic ritual serves to contain chaos by providing a name for the affliction (Turner 1967). The diagnostic interviews I saw certainly strived for this goal, where psychiatrists approached the patients' emotional chaos with the calm assurance of a medical authority. For instance, one

morning in the outpatient clinic, Dr. Ota and I were looking over the questionnaire that patients fill out, and called in a man whose ailment Dr. Ota suspected to be depression. Takayama-san, a well-dressed, fifty-six year old businessman, came into the consultation room looking haggard, restless, and preoccupied. After Dr. Ota introduced me as a research student (Takayama-san nodded to me) and asked him what seemed to be the problem, he began to pour out the stories about the recent incidents at work that had been distressing him. Ever since he had become promoted to Sales Director, he had been feeling both overwhelmed and isolated in the office. He thought about work all night and could not sleep. And he was deeply resentful about the treatment he was receiving under the new position: "I think the company is dumping more work on me than I deserve, and my colleagues are not taking any responsibility." As he talked on, he seemed to grapple with his own anger, whose intensity I could feel as it seemed to fill the room. After he talked on for a few minutes, Dr. Ota, who had been quietly writing down the details, looked up and said: "You have gone through a hard time" (taihen deshita ne).

At this moment, Takayama-san's shoulders fell, his face visibly relieved. As I have since witnessed many times, psychiatrists' simple words of recognition seem to produce in patients an effect that is reminiscent of religious or psychotherapeutic affirmation: "You have suffered" (cf., Levi-Strauss 1963b). As patients revealed in my later interviews, a surprising number of them had had their worries dismissed by their families, even by other doctors. They thus found great relief in meeting someone who has even an inkling of what they were going through. Perhaps it was because of this that patients talked about the acknowledgement from a psychiatrist to be a defining, transformative moment. As one woman said to me: "I knew, at that moment, that he understood, that I could entrust myself to him." Establishing this moment of connection was, for doctors as well, important for ensuring diagnostic accuracy and therapeutic efficacy. Psychiatrists pointed out to

me how some patients go home without saying what was really troubling them because they were afraid of being labeled as mentally ill or because they could not trust the doctor enough to reveal themselves. Beneath the verbal exchanges, there was much that went on, as the patients were deciding whether or not to disclose their deepest fears and yield themselves to the power of psychiatrists.

This psychological, cathartic moment of connection was kept brief, however, as the psychiatrist swiftly moved onto the diagnostic questions. Changing the tone and the pace, Dr. Ota began with the basic symptoms: "You said you have been losing sleep. What about appetite?" Takayama-san: "Come to think of it, I have not been eating much. I've lost some weight." Asked about the sleeping patterns, Takayama-san told us how he had been waking up regularly at two or three a.m. and laid awake for the rest of the night. Dr. Ota asked about the level of concentration, energy, and changes in the mood. Takayama-san pointed out how he felt intensely depressed in the morning but that this would recede in the afternoon (a distinctive sign of depression that psychiatrists call diurnal variation). Robert Barrett (1996), in his ethnography of Australian psychiatric practices, demonstrated how psychiatrists make patients understand the biological nature of their experience not through overt persuasion but through a subtle process of repetitive questioning and evading what they regard as irrelevant information (also see Atkinson 1995, Osborne 1994). This is also what was happening here to an extent, as the psychiatrist began to translate the patient's highly emotional, psychological torment into a set of biological signs that were beginning to form a pattern and then into the definite shape of a *disease*. The psychiatrist's focus on the bodily aspects of depression here is not really an expression of cultural holism (a way of engaging with the patient's emotions through somatic symptoms); rather, it appears, at this initial stage, to be simply an expression of their biological reductionism, whereby psychiatrists treat the bodily symptoms merely as the indices of the underlying biological disease.

Only after the psychiatrist has clearly extracted the biological contours of depression does he move onto situating the patient's distress in the social and psychological context of his life. Dr. Ota began to ask Takayama-san about his daily routines, particularly around the [time of the] onset of depression, in order to determine how the biological symptoms appeared independent of other factors (social and psychological). Inquiring of Takayama-san about his family situation and seeing no problem there, Dr. Ota then asked him how his life changed before and after the promotion. Takayama-san reflected how, under the increased workload of the new position, he had recently begun to get up early and come home late at night and how he had felt chronically tired. Then Dr. Ota moved on to asking about the longer life history to see if he had experienced anything like this before. Takayama-san recalled that ten years ago, he had barely survived a critical case of an ulcer, when he was put in charge of a major project and his boss fell ill before the project deadline. Previous episodes of physical collapse (particularly ulcers), such as this, were not uncommon among the depressed patients I met. These histories of illness served for the psychiatrists as a way of understanding patients' patterns of response to a socially stressful situation.[71] Lastly, Dr. Ota asked him about his personality, to which Takayama-san said he was probably a "serious" (majime) type. Dr. Ota, content with this further indication of underlying depression (based on the theory of Typus Melancholicus discussed in Chapter 5), seemed certain that what Takayama-san had was endogenous depression.

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[71] In a society where psychiatrists also practice under the banner of (much-less stigmatized) psychosomatic medicine (shinryô naika), psychiatrists and patients seem to naturally share the assumption that stress can be manifested differently—both over the mind and the body—at different times. Readers may be reminded of Henry Maudsley's words: "The sorrow that has no vent in tears makes other organs weep"(cited in Littlewood & Dein 2000:14).

The inquiry about biological changes, when done effectively, serves to symbolically disconnect the patients' (normal) self from the disease (Estroff 1981, Luhrmann 2000). As Takayama-san concentrated on mapping out all the physiological symptoms that had been happening to him, he appeared as if momentarily lifted out of the uncontrolled emotions that had seized him. This must have had the effect of making him recognize anew the serious changes that were occurring both in his mind *and* his body, which he might have been too preoccupied to notice or too frightened to admit to himself. Notably, after he had been bitterly expressing his resentment towards his colleagues, he suddenly broke down and said: "I don't know what is happening to me. I can't show gratitude to the people I'm close to. I can't even say hi to the people who have been good to me." This burst of self-confession illuminated how genuinely scared he was of the mysterious changes that were happening to him, and of the intense emotions that were spinning out of control. Assuring him that this was a "disease," Dr. Ota told Takayama-san that taking medication—as well as an immediate leave of absence from work— would ensure recovery. By the time Takayama-san left the room with an appointment in two weeks' time, he seemed calm, liberated, at least momentarily, from the alarming sense of the incongruities he was experiencing about himself. Dr. Ota believed that Takashima-san's emotional confusion would eventually dissipate as the biological depression itself lifted. He would not deny that certain events might have happened or psychological conflicts exist and might even have served as pathogenic factors. But his plan was to first test the medication out to see if the patient might change his *interpretation* of such events and recover his innate power to cope with life's difficulties. It is for this reason, first of all, that psychiatrists place the priority on the bodily aspects of depression.

The power of such biological language lies in its ability to temporarily suspend patients' search for social meanings for their emotional confusions, and place them firmly under biological management. On another morning, Dr. Satô and I

met a thirty-year-old housewife, Yamanaka-san, who complained of experiencing dejection and strong anger. She thought her emotional torments were initially caused by her husband's infidelity, but said they had since grown much more intense. Sobbing nonstop in the consultation room, Yamanaka-san recounted how she felt a surge of rage every morning and wondered aloud why she could not control her emotions. She emphasized that she was "no longer [her]self" and asked Dr. Satô if she was suffering from a "personality disorder or something." Listening quietly to her account, Dr. Satô, as he told me later, was focusing on two alarming signs of depression. First, the intensity of the emotion that she was exhibiting, which even the patient herself seemed to think was disproportionate to the stressful event (her husband's affair). Second, the time lags between the stressful event and the onset of her depression, as she said it began months after her reconciliation with her husband. Suspecting that her depression was more endogenous (a biologically-rooted anomaly) than psychogenic (a reasonable response to a stressful event), Dr. Satô gave her a set of diagnostic questions in order to ascertain its endogeneity. He asked, for instance, when the anger was likely to occur ("Always in the morning") and if it stopped at a certain time ("it usually lasts till about ten o'clock"). Continuing with this line of inquiry, Dr. Satô elicited the intensity, durability, and periodicity of her "anger," which began to appear as if it had a life of its own. By shifting her attention from the psychological *content* of her anger to the biological *form* it took, Dr. Satô seemed to successfully persuade the patient that she was a victim of forces beyond herself.[72]

These cases illustrate how the biological model of depression prevails in initial psychiatric encounters as it is used to temporarily suspend patients' uncertainty. Professor Higashi often emphasizes that depression lies at the "limit of language." That is to say, depression in its core represents a psychotic experience, which

[72] For alternative interpretations of "anger," see Hochschild 1983, Boddy 1989, Holmes 2004.

creates a fundamental disruption in the sense of self. The psychiatrists' sensibility about the psychotic aspect of depression also means that they implicitly placed mere psychological torments lower in their moral hierarchy of mental illness. They carefully differentiated endogenous depression—which is presumed to have biological etiology—from neurosis, and often referred to the latter in a tone of dismissal. They even called the first "true depression" to distinguish it from the DSM-IV's concept of major depression, which they think has carelessly expanded the boundary of depression to include neurosis and is thus quite useless in clinical practice. This implicit moral hierarchy means that patients who are judged to be suffering from psychological problems are at times told that there is nothing medically wrong with them and that there is not much doctors can do (except to refer them to a smaller clinic).[73] Still, there were ambiguous cases which call this simplistic version of the biological model into question.

III. Hospitalization

While the biological model of depression predominates throughout clinical encounters, psychiatrists often carefully introduce approaches beyond the purely biological perspective (including what one may even call "holistic" approaches) as well, particularly after patients come out of the initial, acute phase of depression. This was evident in the ways in which these psychiatrists treat those who are hospitalized. In a society where long-term hospitalization is often used as an opportunity for rest, particularly for salarymen who tend to be provided with generously paid sick leave, this is a preferred method of treatment for depressed patients who do not promptly respond to medication. Psychiatrists structure

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[73] In such cases, patients are often told not to worry about it or referred to a smaller clinic. Psychiatrists themselves were split on the issue of what to do with "neurotic" patients but they clearly saw them as outside of their main responsibility and only dealt with them when time allowed.

hospitalization for these treatment-resistant patients in a way that allows them to explore what factors are inhibiting their recovery; if the matter is purely at the level of the biological (the mismatch between the symptoms and the antidepressants), or alternatively rests more on psychological and social factors (such as stressful family/work situations). In terms of the biological inquiry, hospitalization undoubtedly provides an ideal, quasi-laboratory setting for the psychiatrists, who closely monitor the patients at three levels. First, they give patients a battery of tests to scan their *physiological* condition,[74] while checking the daily reports (kept by the nurses) on the patients' temperature, weight changes, blood pressure, sleeping and eating patterns, urination and bowel movements. Secondly, they observe patients' *behavioral* changes, examining the level of energy and what kinds of activities they engage in. Third, psychiatrists monitor *affective/cognitive* changes in patients through individual consultation and note their facial expressions, tone of voice, and other signs of angst, agitation, anxiety or dejection. The way these psychiatrists commonly talk about patients as "going up" (meaning "turning manic") or "going down" (turning depressed) on varying doses of antidepressants does illuminate the extent to which they rely upon the biological model of depression. Listening to them talk in this way, I initially wondered if the psychiatrists saw patients as little more than passive vehicles upon which depression left its mark.

However, the psychiatrists never let patients hear them talk in these technical terms, and instead use, when they interact with them, another kind of language, or what we may call, *a language of the body*. Here they try to construe a common understanding by urging patients to reflect —phenomenologically— upon how depression is experienced as a "physical disease" (karada no byôki). At the initial stage of hospitalization, they encourage patients to leave aside their emotional,

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[74] These tests may include X-rays, electrocardiogram, echocardiogram, head CT, MRI, electroencephalogram.

psychological torments and instead to focus on recovering through rest. And it is through bodily changes that patients begin to recognize how thoroughly fatigued they had been and how unaware they were of the dysfunctions that were happening inside their bodies. I was often surprised at how much psychological meaning patients gave to the physiological symptoms, as they talked about the burden of responsibility they suffered as they discussed stiff shoulders (kata ga koru), heaviness in the head (atama ga omoi), and lead in the chest (mune no namari) (cf., Kirmayer 1999). Perhaps it is here that the kind of holism that Kasahara discussed as the strength of the Japanese approach is most evident, where psychiatrists try to get patients to see the link between the psychological torments and their bodily changes. Through such phenomenological talks, patients began to share the idea that—as Dr. Kanda put it—depression creates profound "alienation of the mind from the body," and that the recovery is a matter of restoring this connection. Without delving into the question of which is the cause and the effect –the body or the mind—psychiatrists usually succeed in persuading patients how depression affects their whole being, for which the biological treatment presents one path to recovery.[75]

Thus it is important to note that these psychiatrists do not use biological language in a totalizing way. That is to say, they do not lead patients to think that depression occurs in the absence of other, psychological or social factors. In fact, they emphasize that such simplistic models of depression belong to the past, when traditional psychiatrists believed in genetic determinism and assumed that

[75] Compare this with the more explicitly biological, Kraepelinian approach, which introduces a sharp division between the subjective and objective (or behavioral). Radden characterizes this approach as follows: "The subjective captures what is able to be introspected, that which we alone know directly from our privileged and exclusive access to our own mental and psychological states. The behavioral is that which may be known from the detached perspective of third-person observation, without the subject's cooperation or verbal report" (Radden 2000:29).

depression happened "for no good reason." Instead, they emphasize the interplay among biology, personality, and environment and create ample opportunities for exploring non-biological aspects of depression. For instance, as patients began to recover at the physiological level, the doctors usually encourage them to join one or two of the many weekly group therapies that the department offers, which include undirected discussion, painting, collage-making, pottery, calligraphy and music. Psychiatrists use their observations of these activities for understanding the aspects of depression patients might not (or cannot) readily talk about. For instance, I observed that they would compare the same patient's art works from different weeks and discuss the changes in the themes, colors, overall moods, and levels of energy that these works exhibited; the more psychotherapeutically-oriented staff would even venture to make comments on patients' unconscious desires. Sometimes they would exhibit these art works in case conferences (discussed below) and analyze the patients' personality structures, hidden psychological themes and conflicts. It was unclear to what extent they used these art works in their individual consultations (I had the impression that very few did) but many of the psychiatrists regarded art therapies to be a distinctive strength of their psychopathological tradition and pointed out its value as a non-verbal, non-intrusive therapeutic tool.

Patients themselves seemed to find doing art therapeutic and talked about themselves as they did these activities. And because of the way hospitalization was structured, away from families and work, some patients came to reflect intensively upon themselves in a way they said they had never done before. The patients often shared such insights with psychiatrists (who mostly simply listened) and their fellow patients. Thus, psychiatric hospitalization undoubtedly provides a *refuge* from the outside world, where patients experience an unusual level of introspection. This, no doubt, contributed to creating a special environment, where the biological remained the most prioritized, official

language, but where other, diverse languages of depression were also actively cultivated and coexisted at different levels.

IV. Case conferences

> (Referring to what Kretschmer said) "A depressed person is essentially like a river with a dangerously low level of water. Because the water (=energy) is so low, the rocky river bottom becomes exposed. The psychiatrists' job is not to try to remove these rocks (=personality flaws) but simply to let the water level return to normal."
>
> Dr. Kondô Kyôichi, a depression expert;
>
> for Kretschmer's citation see: Tolle 1991

Given that I observed how the hospitalization period was rife with psychological talk, it was interesting to see how psychiatrists and patients came together at the end to create the official narrative of depression through the discharge case conferences. Professor Higashi, who interviewed each incoming and departing patient in front of thirty or so staff members, regarded this as an important function and required all the doctors to attend. After the resident-in-charge handed out a summary of the patient's illness history and held a brief presentation and a discussion, they called in the patient.[76] Most patients, after

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[76] The case conference serves many purposes at once. It is a system of training residents (who usually report the cases as doctors-in-charge), of negotiating and coordinating different viewpoints among the psychiatrists, and of establishing the agreed-upon professional standards within the department. Thus there is a bit of lively discussion after the resident-in-charge hands out a case summary of the patient in question and goes over the symptoms, illness history, test results, treatment outcome, final diagnosis (one according to DSM-IV or ICD-10 criteria plus the one based upon the Japanese "conventional diagnosis"), and future treatment plans.

being greeted by Professor Higashi and taking a seat, seemed to gradually overcome their initial nervousness and recount their story (which usually lasted from fifteen-minutes to half an hour). At one level, the case conferences served as a means of quality control, whereby they ensured the departmental standard of diagnostic validity and therapeutic efficacy. More importantly, however, the conferences—particularly the discharge conferences that are the focus of this section—provided a platform upon which patients could tell their stories. Because the structure of the interview paralleled that of diagnostic interviews, I often found it striking how patients were able to provide a psychiatrically coherent narrative, which suggested the extent to which they had mastered—if not necessarily internalized—the language of psychiatry (cf., Saris 1995).

Here, psychiatrists strived to help patients reach what they called "narrative integration" (katari no tôgô). The interview often began with the Professor leading the patient to demarcate the chronology of their depression in terms of its attendant etiology, course, and prognosis. Patients would describe the physical symptoms they suffered and reflect upon when and how they began to feel not quite themselves. Then they were urged to narrate the social circumstances that led to their gradual breakdown. Usually the last question—in which Professor Higashi asked what kind of personality patients thought they had—was given to not only validate the theory of melancholic premorbid personality but also to legitimize their depression as an illness that was borne out of their hard work and their consideration for others. Professor Higashi referred to these encounters as a place where psychiatrists can serve as secretaries for recording patients' testimonies of suffering. Though this view downplays the power that psychiatrists wield by determining the order and the length of the interview, it does suggest how he saw this as an opportunity for acknowledging how patients have overcome their difficulties. In these ways case conferences served as a place where psychiatrists tried to bring a symbolic sense of closure and returned the

authorship of their narrative to the patients themselves (cf., Kirmayer 1994, 2000).

The point of the case conference was thus not to gruelingly scrutinize the patient or even to establish a solid consensus about the nature of depression (cf., Light 1980). Patients offered their interpretation, and at times said things that contested psychiatrists' understanding of their illness. Psychiatrists would not dispute patients' versions at such times, however, as long as the basic facts about biological symptoms largely remained in place. This was evident in a conference with a fifty-five-year-old businessman, Sataka-san, who had been hospitalized for the second time for depression. Prompted by Prof. Higashi's questions, Sakata-san recounted a number of physiological symptoms with utmost fluency –apparently, he remembered what kinds of questions would be asked from his previous hospitalization. He then elaborated on his long commutes, difficult work situation, and frequent business-related drinking, as well as his "serious" personality, all of which he presented as contributing factors for his depression. It was notable how he particularly stressed that his depression began "for no good reason." This was not necessarily unusual (some patients found no apparent stressful circumstances behind their depression) but the firm, determined tone he said it in seemed to imply that he would rather end this inquiry sooner than later. After Sakata-san left the room, psychiatrists began to examine what it was that triggered his second depression, which they suspected might have non-biological causes that needed to be examined in order to prevent a further relapse. Dr. Kanda, a veteran psychiatrist in charge of Sakata-san said that he was facing complex family problems he did not seem to wish to discuss. Psychiatrists then halted further exploration in this direction and left the patient in the care of Dr. Kanda. It was obvious in this case how the patient used the biological language of depression to construe a public narrative, which left the potentially threatening, psychological problems in the realm of the private.

On other occasions, psychiatrists themselves explicitly drew on biological language to keep from having to deal with underlying psychological issues that patients insisted on. In one instance, a forty-two-year-old civil servant, Miyao-san, had protracted depression, which seemed to have improved but again became suddenly worse before his scheduled discharge. Miyao-san himself told Prof. Higashi that he did not want to go back to work (where he faced demotion) and dwelled on how thinking about work made him depressed. Professor Higashi, however, impressed upon him that what was beneath all this was *depression*, that he had a "hardworking" personality, and assured him that he would be feeling differently once medication began to kick in. After Miyao-san left the room, however, some psychiatrists pointed out that Miyao-san's workload seemed not necessarily heavier than that of his colleagues and that there might be certain vulnerability in his "personality structure." As they began to discuss how psychology—more than biology—might be at work, Dr. Satô, who was in charge of him, instead emphasized how utterly bureaucratic and un-supportive Miyao-san's boss had been, and how difficult it was to intervene in his work situation. The discussion then shifted to solving the practical issues of how to support Miyao-san's return to work, how to help improve his relationship with his boss, and how to monitor his changes carefully as the level of his exposure to (social) stress would gradually increase. As was usually the case, psychiatrists did not hesitate to intervene in the social aspects of patients' depression, giving their families and supervisors advice about how best to treat the patient, even inviting the company people to the hospital for consultation, if necessary. When the biological model alone failed to work, they mostly concentrated on adjusting social relations rather than examining possible psychological reasons behind protracted depression.

Though in-depth psychological excavation in front of the patient was apparently off limits, in the case of a young depressed patient, an enthusiastic young resident

explicitly went against the general interdiction. Shima-san was a twenty-six-year-old businessman, who was hospitalized with what appeared to be a straightforward case of a salaryman's *overwork depression*. He had been working long hours and on weekends for months, routinely coming home at two or three in the morning. After his request to be transferred to a different section was turned down, Shima-san became severely depressed and suicidal. It was apparent that his work conditions were to blame, as his own boss had already become depressed from the heavy burden and was seeing a psychiatrist himself. Despite his situation being typical among depressed inpatients, what made Shima-san stand out was his persistence with the "big questions" of life. He kept asking why he had become depressed, what the meaning of his life was, and why he should continue living at all.

Other psychiatrists would have waited to see such psychological conflicts pass with the biological recovery. They would, as a senior psychiatrist told me jokingly, rather "impose the biological explanation on the neurotic and provide a generic narrative" than let the psychological take hold. Dr. Mori, however, who seemed to generally have a good reputation among the patients because of his devotion and sincerity, reciprocated Shima-san's existential ponderings by spending many hours listening to him. Under this doctor's care, Shima-san made a brisk recovery, while elaborating on the meaning of his collapse and understanding the patterns of his relationships at school and at work. All seemed to be going well, until Shima-san, with a prospect of soon returning to work, began to again suffer severely from various physical symptoms. At the same time, he began to express strong emotions—particularly anger against his company—which he started to redirect at Dr. Mori himself, who was, in Shima-san's eyes, now failing to resolve his problems. Though Dr. Mori and his supervisor tried desperately to set the treatment course straight, Shima-san's "aggression" became more intensified.

His anger seemed to affect other inpatients, as it soon came to transform one therapy group that had been tranquil (if rather uneventful), into a highly emotional, explosive outlet for dissenting patients. Some of them began to raise doubts about the effect of medication, demand more psychotherapy, and express their concern that they "need to be taking more control" of their own illnesses. This turbulent situation, which lasted for weeks, ended abruptly when Shima-san—who seemed to have mostly recovered on the physiological level by then—decided to transfer to another hospital. The subsequent case conference, held without the patient himself, had a feel of soul searching for the psychiatrists involved. They labored to determine exactly what the patient's biological depression was and how the psychological problems ("neurotic components") had begun to take over. Professor Higashi pointed out how the doctor must have become, for Shima-san, an omnipotent being, who he expected would be able to provide the ultimate meaning for the magnitude of the suffering he endured. Yet, as the Professor said, such a grand expectation for a unifying meaning would be hard to fulfill (also see Kleinman 1995). While one psychiatrist raised the issue of Shima-san's vulnerability and suggested "personality disorder," Prof. Higashi immediately cautioned against the use of this notion. He pointed out how this diagnosis would label him with the ominous implication of being incurable and implicitly place the blame on the patient. Without resorting to the notion of personality disorder, senior psychiatrists discussed how those with melancholic premorbid personality had embedded in them such "hidden aggression" (Kasahara 1976, 1978; see also Yokoyama & Iida 1998). They had pointed out, in discussing this among themselves, how *essentially endogenous* depression could *turn neurotic* through such (genuine but misguided) psychotherapeutic intervention.

As it became clear from their discussions over the weeks, what lay behind their interdiction against psychotherapy seemed to be their particularly localized,

historically-situated, understanding of depression. The senior psychiatrists brought out the examples of the 1970s and 1980s, which they nostalgically talked about as the time when their supervisors were engaged in intensive psychotherapeutic endeavors—when some would "spend all night in a locked room with an acutely psychotic patient." This was the height of the psychotherapeutic zeal among psychopathologists, who began to regard depression as a kind of cultural alienation, caused by the breakdown of the old Japanese values (Iida 1978). As discussed in Chapter 5, these psychiatrists illuminated how the people with a melancholic premorbid personality—who have been taught selfless devotion to the collective good—were most prone to depression in the emergent social order. While some psychiatrists emphasized at the time the importance of changing their value system (Yazaki 1968), what others began to reveal was how threatening such psychological probing turned out to be for these patients. The literature from this era notes how depressive patients react strongly when their internalized social norms or their identification with the collective become questioned (Kasahara 1978, Hirose 1979, Yoshimatsu 1987). Such probing can also lead to expand and diffuse the nature of their depression, furthering their sense of vulnerability, producing dependency. Psychopathologists such as Kasahara (1978) instead emphasized that the depressed were well-adapted people to begin with, and the aim of the treatment should not be to question or change their way of being but rather to help them return to the way they were.[77]

V. Containing reflexivity

Thus psychiatrists' reliance on biological language stems not from their belief in

[77] The aim was to provide a secure sense of order, even if this meant on the part of the psychiatrist to consciously reproduce the hierarchical work relationship by playing the role of the superior (Suzuki 1997).

some timeless, cultural holism (although their practice certainly has an aspect of this: cf., Ozawa-de Silva 2002) but rather, it seems, is a historically-situated sensibility about the potential danger of their own power. Psychiatrists at other institutions also told me that the only thing still standing after the vehement antipsychiatry movement was neurobiological psychiatry, as all the others—including psychotherapy and psychopathology—were thoroughly criticized as intrusive, even insidious tools for colonizing thought, which might even end up "emptying out the patient." Thus some psychiatrists talked about the importance of letting the patient determine the terms and the extent of their psychological reflexivity. Even if they seemed to engage in extensive psychological reflection over the meaning of their depression—and even if such depth intrigued psychiatrists intellectually—they believed that it was important, therapeutically, to try to "place a lid on it" (to keep it contained) (Yokoyama & Iida 1998). This also meant that even for the patients whose depression had a dubious biological basis, psychiatrists maintained a policy of minimum intervention. For instance, I observed a case conference for a twenty-four-year-old hairdresser, who was, as psychiatrists came to conclude, hospitalized with a mistaken diagnosis of depression when in fact he only had neurosis. After the interview in the case conference, the doctors agreed that this patient's biological symptoms never really "deepened" or attained the clear shape of depression, and his complaints (low energy, sleep disturbance, and despondency) were only an extension of the way he had lived his life. Judging that his problems were of the kind that lay beyond psychiatrists' control, these psychiatrists agreed that it was better to immediately discharge him rather than let him develop "hospital dependency." Their general sentiment was summed up by Dr. Kawano, who said at the end of the conference that it would be better "not to psychiatrize him" (seishin-iryôka shinai). This sentiment was also repeated in a training seminar, when another senior psychiatrist made an explicit warning to the residents about the danger involved in the intricate power relationships of psychiatry. He said: "Do not turn the

patient into an object of your own desire. A mere human being cannot change another, and such a desire would only produce a perverted relationship." Such an act, he declared, "belongs to the realm of magic." For these psychiatrists, the distinction between the "biological" and the "psychological" serves to demarcate the boundaries of not only what is "true depression" but also where they see their jurisdiction and their responsibility end.

What emerges from these practices is also a different vision of what recovery means. Emphasizing the danger of colonizing the patient, these psychiatrists define clinical encounters more in terms of a crisis management than inward exploration for self-enlightenment (they may think that such a self, construed through psychiatric encounters, may risk fostering an "illusion of control" as Doi put it). Some psychiatrists were explicit about the differences between their ideal model of the therapeutic and the American psychoanalytic model. As Dr. Eguchi Shigeyuki put it, North American psychotherapy adheres to a *dialectic* model of recovery, where an increased awareness of the accumulating contradictions in one's life inevitably leads to a confrontation that allows the patient to reach a new self-awareness "in a moment of epiphany." In the Japanese clinical practices I observed, patients' claims for having made such a dramatic transformation—particularly via psychological insight—were received by psychiatrists with concern, even skepticism, in terms of the genuineness of their recovery. Instead, they urge patients to reflect upon their bodily changes, thereby implicitly demonstrating the historical continuity between traditional medicine and current practices in terms of the belief in the interconnectedness of mind and body (see Chapter 2; also see Lock 1980, 1981, 1982). Their attempts to downplay patients' excessive psychological reflexivity is thus based not on a simplistic belief in the power of the biological but rather on their concern about deflecting patients' deeply internalized sense of self-responsibility and protecting patients' fragile sense of the self. At the same time, however, their actual clinical practices

might come to resemble, ironically, those of the biological reductionists, who bracket out the social and existential questions about depression. In the next chapter I turn to suicide as a problematic issue in Japanese psychiatry, where the confrontations between psychiatrists and patients who insist on the existential nature of their ailment becomes most intense.

Chapter 7: Diagnosing Suicides of Resolve

> Suicide cannot be comprehended as merely a "psychiatric problem," yet it is central to a psychiatry that asks questions.
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> R. J. Lifton, *The Broken Connection*, 1979:239

> Suicide... the act of intentionally destroying one's own life. ...Its existence is looked upon, in Western civilization, as a sign of the presence of maladies in the body politic which, whether remediable or not, deserve careful examination. It is, of course, impossible to compare Western civilization in this respect with, say, Japan, where suicide in certain circumstances is part of a distinct moral creed.
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> *Encyclopedia Britannica*, 11th ed., 1910-1911[78]

I. Suicide of resolve

Under the expanding power of psychiatry in Japan, few subjects have so thoroughly resisted medicalization as that of suicide. Early 20th-century Japanese psychiatrists adopted the biological view of suicide then dominant in the West, and proposed that it should be understood as a matter of a diseased brain or a genetic predisposition to suicide (Kure 1900, Miyake 1903). This biological determinism provoked a heated debate in Japan for a few decades, but since has had little persuasive power over lay people beyond the narrow circles of biological psychiatry. This may be because Japanese, according to Maurice Pinguet in *La mort volontaire au Japon*, have never criminalized suicide as a matter of principle, and have even granted suicide an aura of legitimacy (Pinguet 1993;

[78] Written by Henry Harvey Littlejohn, Professor of Forensic Medicine at the University of Edinburgh: cited in Shneidman 1976.

also see Takahashi 1994; cf. MacDonald & Murphy 1990, Gates 1988). This cultural logic dictates that, far from being pathologically driven, those who choose to take their own lives are in full possession of their senses and act with intentionality (Takahashi 2003). This image of suicide has prevailed in the postwar period, and has been reinforced in the media (e.g., Asahi February 6, 1960) and in various art forms, such as the annual broadcasting of the legendary drama of *Chûshingura* (a suicide pact of samurais) and school-recommended modern novels about suicide like Natsume Sôseki's *Kokoro*. The endurance of this cultural logic was recently demonstrated in the way Japanese responded to the suicide of the postwar literary giant Etô Jun, in 1999, who left a note stating: "I've decided to do away with what remains of me." Admiration from fellow intellectuals flourished in the media, with the Asahi newspaper running a commentary that stated Etô's death embodied "first-class aesthetics." Few commentators questioned the normalcy of Etô's state of mind at the time of death or the intentionality of his suicide and the voices of a few psychiatrists who dared to suggest that his suicide might have been caused by depression went largely ignored (e.g., Oda 1999, Katô 1999b). Etô's suicide, for many Japanese, seemed to embody the continuation of the cultural logic that defines suicide as the ultimate expression of personal will, or what Japanese often refer to as: *kakugo no jisatsu*, or "**suicide of resolve**."[79]

The cultural legitimacy of this idea is, however, being challenged today by some psychiatrists, and their influence is being felt on an unprecedented scale. Amidst public concern about high rates of suicide in Japan, psychiatrists are increasingly appearing in the media to stress the link between suicide and depression. A series of lawsuits concerning "overwork suicide" (karô jisatsu) has also given

[79] While the Japanese have recognized different degrees of intentionality in those who commit the act—from a reckless desire for escape from an unbearable reality, to a fully premeditated act—suicide of resolve represents the ultimate expression of intentionality.

psychiatrists a public platform from which they argue that those who take their own lives under tremendous social pressure might also have been victims of depression. Following these lawsuits, the Ministry of Health, Welfare, and Labor have adopted new criteria for diagnosing suicide, which has had the effect of significantly expanding the domain of what is called "pathological" suicide. Under the new system, the kind of suicide that would have been automatically labeled as suicide of resolve –such as the death of someone who left a note stating their intention to die—can now be regarded as caused primarily by "major depression." Being more than policy revisions, these changes have increasingly brought the subject of suicide under wider psychiatric scrutiny. The current medicalization of suicide is helping create an important conceptual shift in the way Japanese think about the normalcy and intentionality of those who take their own lives.

For those who question this medicalization, the cultural logic of suicide of resolve apparently serves as a point of reference, as the term keeps appearing in popular writings on suicide, government records about overwork suicide, and in everyday conversations in the clinical practices that I observed. Also, such resistance to medicalization is not totally absent from the opinions of the psychiatrists themselves. On the one hand, there are certainly many Japanese psychiatrists who are enthusiastic about diagnosing and treating a wider range of suicidal cases. Some of them even claim—echoing the early 20th century Japanese psychiatrists—that most suicides are caused by mental pathology.[80] While they genuinely believe in what they think of as essentially humanitarian attempts to intervene, they also cast doubt on such ideas as "suicide of resolve." As a

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[80] However, this idea is far from being shared beyond psychiatry. For example, the suicide statistics complied by the Police Agency give the reasons for suicide in the following categories: family problems, sickness, economic hardship, work-related problems, relationship problems, problems in school, alcoholism or mental disorder, other, and unclassifiable.

forty-eight-year-old suicide expert said in an interview with me, "I know some people bring up the issue of free will [when discussing suicide]. But our job is to save lives, and not to be bogged down in a philosophical debate." On the other hand, however, there are Japanese psychiatrists who express ambivalence about the underpinnings of increasing medicalization and wonder where that kind of pathologization might lead. When I began asking the then-current director of the National Institute of Mental Health about "depression and suicide," he frowned in visible disapproval and poured out his criticism of the "new idea" that directly links suicide and depression. His stance originates in the suicide boom of the late 1950s, he told me, when he became a psychiatrist in order to investigate why so many of his own friends had killed themselves in a time of peace, especially puzzling after they had only recently survived WWII. He implied that explaining away their suicides in terms of "depression"—which, to him is a matter of biological pathology—was to dismiss their existential angst and the determination with which they took their own lives. His strong reservations about the expanding power of psychiatry in dealing with suicide was shared by many of the younger psychiatrists I interviewed, and also seems to remain strong in Japanese society in general (Kayama 1999; Okajima 2005).

Given these opposing views, what I want to examine below is how Japanese psychiatrists actually medicalize suicide in practice. Here, I draw upon my two years of fieldwork at the JP Medical School, where I talked to suicidal patients, discussed these cases with psychiatrists, and observed how the suicidal are treated. I draw upon data from 48 case conferences that I observed, where patients' attempted suicide(s) were discussed and their suicidal ideation was explicitly an object of medical intervention (out of 48 cases, 37 patients were diagnosed with depression, 3 schizophrenia, and 8 with other categories such as eating disorder and neurosis). I also draw upon my interviews about suicide with 25 psychiatrists at other psychiatric institutions. First, I show how psychiatrists

deal with suicide not by expanding but by carefully limiting the object of psychiatric intervention. Second, I illustrate how psychiatrists treat the suicidal patients who do come under psychiatric care and examine, specifically: 1) how they attempt to persuade patients to see their suicidal acts as pathological in nature; and 2) how they engage with those patients who resist these persuasions and insist that their failed suicide attempts be understood, instead, as attempts at suicide of resolve. These everyday clinical practices expose the limits of psychiatric logic, while at the same time raising questions about the shades of intentionality that are left largely unexplored in the cultural logic of suicide of resolve.[81]

II. Determining the objects of psychiatric intervention

The psychiatrists at the JP Medical School say that suicide in itself is not a pathology and that their task is to treat only those who are suffering from a mental illness (i.e., depression, schizophrenia, or personality disorder). In this regard, they are certainly not descendents of J.E.D. Esquirol, who once declared: "I think I have proved that no man takes his own life unless he is in delirium, and that all suicides are deranged" (cited in Pinguet 1993:23; on Esquirol's theory of suicide, see Goldstein 1987). Pressed further, these Japanese psychiatrists even go so far as to state that the decision to die, for people without mental pathology belongs to the realm of free will (jiyû ishi), where psychiatrists have no right to intrude. However, this seemingly clear-cut principle—with which they appear to support the cultural logic of suicide of resolve—easily breaks down in the reality of the clinic. Unlike the idealized notion of suicide of resolve, people's intention to die is notoriously difficult to determine, and varies significantly in degree. What

[81] Note that: "death can be the scene of many an intention. Revolt or renunciation, aggression or sacrifice, cry for attention or flight from it, exaltation or despair" (Pinguet 1993:27).

psychiatrists soon learn in their practice is the malleability of people's intentionality, and uncertainty as to how to determine agency in a suicidal act.

At the JP Medical School Hospital, psychiatrists are now involved in the care of all the patients who are brought to the Emergency unit after a failed suicide attempt. (This in itself is a new system, which suggests a growing awareness in Japanese medicine that suicide might be considered as a psychiatric problem.[82]) After the emergency medical treatments are provided, psychiatrists are called in to determine the cause of the suicide attempt and decide what psychiatric intervention, if any, is necessary. If the patient is still in critical condition, psychiatrists first gather information from the family and/or the police. There are a number of questions they ask first in order to determine whether the attempt was fully intentional, and if so, whether the patient's mind was influenced by mental pathology. First, they ask about the presence or not of a suicide note. Second, the method employed and its lethality; for example, what kind of knife was used, how deep was the cut, or how many pills were taken.[83] Sometimes patients choose a deadly method, such as swallowing hundreds of pills with alcohol or slashing their own throats; in such cases, their suicidal intentions appear unquestionable.[84] Other times patients may have swallowed (only) ten pills or made several minor cuts on the wrist, leaving the degree of seriousness of their intention to die rather ambiguous. The third question psychiatrists ask is the situation in which the patient was discovered. For instance, was he found at 2:00

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[82] Previously, unless patients exhibited apparent signs of mental disturbance, they would have been let go without a psychiatric examination (also see Igarashi & Ishii 2000; Sakurai et al. 1998; Suzuki 2000).

[83] Common suicide methods are by overdose, cutting wrists, throat, evisceration, jumping from buildings etc., as well as hanging, poison, drowning.

[84] The knowledge of how to kill oneself has been disseminated through websites on suicide that have been mushrooming of late, and best sellers such as the *Complete suicide manual* (kanzen jisatsu manyuaru), which has sold more than 1,500,000 copies.

am on a wooded mountain having taken an overdose of sleeping pills, where no one would likely pass by, or was he discovered having hanged himself at home around 8:00 pm when his family was expected to arrive at any minute? Lastly, psychiatrists try to gather information on the possible reason(s) for why the person had attempted suicide. From this circumstantial evidence, psychiatrists make a tentative diagnosis. Such a diagnosis is only an early interpretation, however, which psychiatrists know can be easily contradicted later by patients' own subjective accounts.

According to the psychiatrists who have worked in Emergency, a considerable number –about half—of the patients who have attempted suicide, are released directly after being given a brief psychiatric consultation. This is because these patients are deemed to be more or less in control of themselves—that is, they can logically explain the act, show repentance, and are judged to be in no immediate danger of repeating a suicidal attempt. Some patients say that they had no lethal intention and only acted in the heat of the moment. Others say that they really meant to die but somehow taking the action "cleared away" their deadly intention. While interviewing these patients, psychiatrists carefully look for any signs of gaps, strangeness, or breakdown in the coherence of their narratives, and any disconnection between the given reasons and the act committed. If psychiatrists are satisfied that there are no signs of mental illness, patients are let go, and provided with a referral to outpatient psychiatry. Thus it is important to recognize that, for the time being, the medicalization of suicide in Japan remains selectively targeted at a small portion of the potentially suicidal.

There are two types of patients whom psychiatrists regard as requiring immediate psychiatric care. The first group is the patients who still remain suicidal after the first attempt. Some of them appear totally "out of control" –that is, restless,

agitated, and possessed by an urge to die. As a man who checked himself into the hospital aptly put this state of mind: "It isn't that I wanted to die; it was more than I didn't know what I would do if I were all by myself." This split between the self (or intention identified by the self) and the pathology is one of the key pieces of psychiatric knowledge that these doctors learn before entering emergency psychiatry. These patients are kept under close watch, even tranquillized, for fear that they might wander out into the corridor and jump from a window. While almost all of these patients are immediately diagnosed as suffering from a mental illness, there are a few who cannot be diagnosed as such. This presents psychiatrists with a serious dilemma, as we will see below. The second group is the patients who appear under control and now regret the act, but whose suicidal behavior leaves some mystery to be accounted for. That is, neither the patients themselves nor the psychiatrists can fully explain why they tried to take their own lives. Fearing the possible risk that these patients will make another impulsive suicide attempt, psychiatrists try to place them under close monitoring to attempt to discover and treat what they suspect is an underlying pathology.

III. Treating pathological suicide

The dialogues between psychiatrists and patients provide us with a glimpse of how psychiatrists try to persuade patients of the pathological nature of their suicidal acts, and how patients respond to such medicalization. The dialogues we see here between inpatients and Professor Higashi took place at a weekly case conference held both at the time of patients' admission and at their discharge from the hospital. In one admission conference Professor Higashi invited into the conference room a patient in an acute phase of depression, a sixty-year-old retired worker, Kimura-san, who appeared visibly agitated and restless. Soon after sitting down Kimura-san told Professor Higashi: "I can't describe it in words. I feel like

I'm being driven to die." Professor Higashi, in an attempt to determine exactly what was generating this urge, asked him:

H: The feeling that you are driven to die, is it stronger in the morning?

K: I feel it more in the morning.

H: How does your head feel when you wake up? Do you feel like you've slept well?

As we have seen in the previous chapter, the priority in the diagnostic interview is given to discerning the presence of an endogenous depression that has taken over the patient's body and mind. Having detected in Kimura-san the typical signs of endogenous depression—such as diurnal variation (with which depressive mood moves with regularity) and disrupted sleeping patterns—Professor Higashi moves on to examining his life history. Kimura-san seemed to calm down a little as he began to discuss his life after retirement and his gardening hobby. Shifting to the subject of his future concerns, however, he again became agitated and too preoccupied with his suicidal thoughts to talk of anything else. Seeing that his urge seemed to be welling up from inside him, Professor. Higashi assured him:

H: For now, leave it to your doctor. If you try to think, your thoughts will only be circular.

K: I can't prevent these thoughts from coming into my mind. I try to tell myself that I shouldn't think about death but the thoughts keep coming back to me.

H:...We will make sure to treat your anxiety. Your doctor will see to it.

Here the psychiatrist tries to tame Kimura-san's suicidal thoughts by translating them into "anxiety," a de-existentialized, pathological condition (and a symptom

of depression) that can easily be controlled by medication. (Professor Higashi later instructed the resident in charge of Kimura-san to "reduce his anxiety level.") His suicidal urge also being a mere symptom of depression, it is supposed to go away as the depression "lifts." Based upon this belief, psychiatrists caution patients not to dwell on their suicidal ideation because their thinking under the influence of depression will likely be circular, repetitive, making it impossible for them to understand their situation based on calm reasoning. Struggling to reason logically while depressed only ends up exhausting the patient (and no doubt the psychiatrists as well).[85] I remember a morning round in which a petite elderly woman with "delusional depression" suddenly grabbed the sleeve of Professor Higashi's white coat and insisted that she was going to die anyway and that there was nothing they could do. (She later wondered aloud in the case conference how she could have believed that.) As they become used to this way of thinking, patients themselves talk about the uncontrollable impulse, as a force external to their sense of "self." "I always try to watch a movie around four o'clock because I know that the suicidal urge always happens around then," said a forty-five-year-old businessman, who had taken a long sick leave from work. For many psychiatrists, then, the *biological* impulse for self-destruction lies at the core of the suicides they deal with, and, as such, leaves little room for *psychological* exploration.

At times, even when patients dwell on external reasons and psychological motives that drove them to attempt suicide, psychiatrists retain their focus strictly on the internal, biological mechanisms. This has an effect of conceptually shifting the agency—the locus of control—away from the suicidal patient. For instance, a

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[85] Professor Higashi also noted that Kimura-san had just gotten a haircut and cautioned the psychiatrist to keep an eye on him, noting that a few patients he had seen had attempted suicide immediately after a haircut (probably as an act of cleansing before death).

thirty-three-year-old factory worker slashed his stomach and hanged himself both in one night, only to survive these deadly acts. In the case conference, he talked about how he had been recently promoted in the labor union but that he felt he was not meeting other people's expectations of him. Failing to manage the workload and despairing about his lack of ability, he came to believe that he was better off dead. As he talked on, however, the psychiatrists were puzzled by the light-hearted and even sometimes humorous manner in which he discussed what he had done to himself. Also, the magnitude of the violence seemed like an aberration in his life history and personality (described by him as "serious and responsible"). The only time the psychiatrists saw this patient become emotional during the interview was when he was asked if he had "hesitated" before the suicide attempt: "I did, and that is why I didn't succeed." He was diagnosed as having suffered depression, which, they speculated, had turned into a milder form of mania after the rescue (and which in turn would explain the way he behaved during the interview). The psychiatrists remained alarmed by his emotional disconnection from his suicidal acts, however, and some even worried about the possibilities of organic disturbances in the brain, which could again trigger further impulsive behavior.

In the hospital where I carried out my fieldwork, such biological concerns were always given priority over other possible explanations. Though psychiatrists would occasionally mention hidden intentions and unconscious desires behind such an act, they would rarely elaborate upon them, nor would they ever hint at them to patients. In another case, a thirty-nine-year-old lawyer was rescued after being found having tried to hang herself. Seeing that she had no memory of the incident or what had happened prior to it, Professor Higashi tried to determine if she had committed the act in a state of dissociation or if it was a retrograde loss of memory. She said she did it after one of the usual quarrels with her husband; she discussed the ongoing conflicts that she had with him because of his lack of

consideration for her work and her desperate attempts to balance marriage and work. She also expressed her fury at the psychiatrist for the fact that she was the one, not the husband, to be given medication "for [her] anxiety." Apparently, there were long-standing psychological issues that went into her thinking as she was driven to the suicidal act, and at one point she even muttered, seemingly more to herself than to doctors: "I wonder if I'm better off if I do not recover my memory." After she left the room, Professor Higashi mentioned how this particular case made him "want to think about her psychological background." But the discussion which followed hardly touched on such issues, while the psychiatrists examined in depth the level of her agitation, signs of psychomotor retardation, and the precise nature of her dissociation. The heightened sense of risk and uncertainty of her possibly being seized by another suicidal urge lead psychiatrists to give stronger emphasis to impulsive and biological forces rather than deliberate, intentional aspects of suicide.

In the final step of the treatment, psychiatrists make sure that patients are able to distance themselves from their formerly diseased, suicidal selves in their recovery narrative. They consider it an important aspect of the treatment that patients can reflect upon their suicidal acts and integrate them into their life history –or what some of the psychiatrists referred to as *narrative integration* (see Chapter 6). In one case conference, a forty-four-year-old businessman explained how he had been so driven to the edge by accumulating debt and the fear of being prosecuted, that he became determined to pay the debt off with his own life insurance.[86] Asked if he had made the decision calmly, he denied it firmly and said: "No, I was exhausted and I wasn't myself. I kept thinking how my life was not what it should have been." When Professor Higashi asked him if he was happy to be alive, he nodded

[86] As the economic recession has dragged on, many men have taken their own life for the sake of leaving their life insurance for their family. This has become a social problem.

and said: "I didn't imagine that I would be feeling better like this again. I'm truly thankful for what you've done."

Such psychiatric persuasion—and the patient's adoption of psychiatric thinking—is at times so thorough that it seems to suppress all other possible interpretations of patients' suffering and behavior. I once witnessed a humorous exchange between Professor Higashi and a forty-one-year-old patient, who had taken a massive overdose of antipsychotic drugs after being "ordered by divine forces" to kill herself. Schizophrenia was first suspected but in the end this patient was diagnosed with hypothyroidism, which had caused the psychotic symptoms. After listening to her discuss the spectacular visions she saw of the struggles between God and Death, Professor Higashi, who has written on creativity and religious themes in psychotic experiences, appeared impressed and asked what she would call that experience, "Doesn't it sound like a mystical experience?" he said. The patient's response was blunt:

> P: No, I do not think it is. It's simply a disease. (Laughter from the attending staff.) Well, the doctors told me that it was.
>
> H: (with an amused, embarrassed smile) Well, I think that you had a rich experience, very religious, I'd say.

Other times, however, the existential pondering that went into the suicidal act seems too painful to reflect upon, the suicidal urge so apparently frightening for the patient, that psychiatrists try to tame the experience by biologizing it. An eighty-one-year-old woman asked Professor. Higashi not to ask her to recall the time leading up to her suicidal attempt: "My son and I agreed that it would be best to forget it and never speak of it again." So psychiatrists try to direct the recovery narrative by stressing the discontinuity between the diseased, suicidal

self and the recovered, normal self. Another patient, a seventy-year-old retired worker, discussed how he had thought that he would be better off dead, as his memory was fading in his old age and how he, serving as the chair of a local community meeting, felt "ashamed" of what he perceived to be his poor command of things:

H: You said before that it was no use being here.

P: I wanted to die. I thought it would be of no use receiving any treatment.

H: You no longer feel that way?

P: It must have been a disease....I kept thinking about jumping in front of a train or being hit by a car then.

H: (empathetically) You couldn't sleep then.

P: No, I couldn't sleep.

Psychiatrists in such ways empathize with the patients' struggles, highlighting how natural it might have once seemed—from the patient's point of view—to take their own lives. Professor Higashi often uses such expressions as "*For you*, it was a calm decision" or "There's no denying that you went through a lot," as a way of acknowledging patients' suffering and existential concerns that cannot be simply reduced to mere effects of biology. He then gradually shifts the agency to the pathology by reminding patients how they were driven to the edge by a force they had no control over. In the end, patients are induced to regard their act not as a product of personal will and they were more willing to accept it as a result of mind-affecting psychopathology. To highlight this point, Professor Higashi frequently posed the question more dramatically, drawing a contrast with the culturally pervasive idea of suicide by asking: "Was it a *suicide of resolve*?" Patients' flat out denials—as usually was the case—allow psychiatrists to ascertain that the treatment is now complete.

IV. Resistance stemming from the cultural logic of suicide of resolve

a. Psychiatrists' own ambivalence and doubts

Not every patient accepts this medicalization, however. When patients refuse to be convinced that their suicidal urge was a product of mental illness, Japanese psychiatrists are compelled to examine their own stance towards the cultural logic of suicide of resolve. It is important to recognize that these psychiatrists are not only biomedically trained practitioners, but are products of local cultures, just as patients are, and thus it is not surprising how often they talk about suicide with a certain sense of romanticism. In my interviews, some of them discussed suicides of their friends and the influence these acts had on their decision to go into psychiatry. Others talked about the suicides of their favorite writers, citing passages about suicide that had left an impression on them.[87] Many of them explicitly stated that they had chosen psychiatry as a profession expecting to have a glimpse into the depths of the human mind. Probably it is because of this initial expectation and romanticism that many of them stated somewhat cynically that it was rare to encounter a suicide of resolve in the true sense of the term. In a widely read text on this topic, suicide expert H. Inamura drew on the work of German psychiatrist P. Feudell (1952) to express similar disillusionment: "Relatively speaking, I find it surprising how petty people's reasons for suicide tend to be and how casually they considered it. We often approach the bedside with an initial feeling of intense expectation, only to be betrayed. Instead of encountering depth,

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[87] For instance, Dr. Satô cited a passage from a novel by Dazai Osamu (1936): "I was thinking about killing myself. But somebody gave me a New Year present of a piece of material for a kimono. It's linen, with fine grey stripes. For a summer kimono. I told myself that I might just as well go on living until summertime" (also cited in Pinguet 1993:267).

what we find is the vulgar imperfection of the human mentality" (translated from the Japanese translation of Feudell's text cited in Inamura 1977:61). As Dr. Ota said, "Most of the time I cannot help but wonder why the patient has attempted suicide for such trivial reasons. I have rarely encountered anyone who has carefully contemplated the act beforehand." (Though the question remains as to how much patients would allow that kind of self-revelation in a medical setting.) Thinking along these lines, psychiatrists I have talked to seem to have grown used to the ubiquity of "petty" suicide attempts, and some talk wearily of the patients who phone the doctors on call at night to talk persistently about their plans to kill themselves. As psychiatrists repeatedly witness people's minds altered simply by means of medication accompanied by rest, they begin to think primarily in terms of the biological model of suicide, while leaving other questions unasked.

b. Suicide of resolve by a mentally ill patient

Doctors' cynicism—and the biological model—come to be most dramatically questioned in their confrontation with a *suicide of resolve* by a psychotic patient. In fact, this is the topic that brought about one of the most important conceptual shifts in Japanese psychiatry after the first postwar suicide boom of the late 1950s. Questioning prewar biological determinism, some psychiatrists began to explore the notion of Japanese suicide as a product of society and culture (Katô 1953, 1976; Ôhara 1975). This new generation of psychiatrists fundamentally challenged the traditional view in Japanese psychiatry that automatically assumed the suicide of the mentally ill to be an expression of psychotic symptoms, and set the stage for later discussions on the existential and humanistic perspectives on suicide. Moriyama Kimio, a leader of the antipsychiatry movement of the 1970s, told me in an interview that his starting point for questioning the established knowledge of biological psychiatry was his encounters with psychotic patients who had

attempted suicide. In his dissertation on this topic, he discussed how these patients had tried to take their lives after contemplating the gravity of their own illnesses. To dismiss such acts as impulsively driven biological symptoms, he argued, is not only to fail to recognize the existential nature of their suicide attempts but also to do further harm to their human dignity. A number of investigations inspired by this humanistic stance were conducted in the 1970s. Takemura & Shimura (1977), for instance, carried out a survey of the suicides among institutionalized psychiatric patients and found that a significant number of such cases had "comprehensible reasons" for their acts (Takemura & Shimura 1977, 1987). What characterized this psychiatric approach was the psychiatrists' commitment to the patients' own subjective accounts, and efforts to bring agency back to patients by granting the possibility of normalcy and intentionality in their suicide attempts.

Given that the JP Medical School is an heir to this humanistic tradition, it is not surprising that one of the most striking cases I encountered, where the psychiatrists failed to—in fact chose not to—explicitly medicalize the suicidal intention, was an attempted suicide by a schizophrenic. A forty-three-year-old worker, who had been previously treated for hallucinations but had long lived a seemingly stable life, was brought into Emergency after drinking insecticide. The life history he told us in the discharge conference illuminated an increasing deterioration in his relationship with his family (his wife had left him taking the children with her), his difficulties in holding a steady job because of the illness, and his persistent worries and despair about his future. Assuming that his suicide attempt was nonetheless a product of schizophrenia, Professor Higashi asked what the reason was for his attempt:

P: I was at a dead end. I knew my existence was causing my family trouble.

Taking my life was the best choice for everyone. I would leave the insurance money and the house to my wife and kids. It would be the best thing to do; that was the conclusion I came to.

H: So you had given much thought to it.

P: Yes, I had.

Later, Professor Higashi came back to the same question, this time asking explicitly if the patient was "being induced by a voice." The patient lifted up his face, looked at him squarely and declared: "No, doctor. It was a *suicide of resolve*." Here, by inserting this cultural expression, the patient was bluntly resisting the psychiatric framing of his act, thereby insisting on the personal will with which he tried to determine his own end. Though I doubt that he implied any criticism of the doctors, his utterance also attested to the psychiatrists' own failure to cure his illness, a factor in his increasing desperation. Professor Higashi fell into a respectful silence and did not further pursue other questions on this point.

Here might lie a troubling question posed by the patient's assertion of a suicide of resolve: what if it appears "reasonable enough" that one should want to choose death? Though the commitment to exploring in depth such subjective "reasons" for suicide once characterized the humanistic approach in psychiatry, many psychiatrists said in my interviews that they have learned during the years of their practice to bracket off such unsettling questions. This was because, they said, the consequences of being drawn into considering patients' "reasons" and having any doubts about the possibilities (and the legitimacy) of their medical treatment can be dire. Many of them stressed that suicidal ideation, "unlike delusions and hallucinations" from which they remain detached, is so "easy to imagine and get emotionally drawn into." As many of them pointed out, "The more you listen, the more you begin to see the logic that the person has for wanting to die."

Psychiatrists certainly meet many patients who have unusually difficult life histories, some for whom, as a suicide expert pointed out, "suicide would even begin to seem as if it were a natural conclusion to their life" — an extremely dangerous mindset for a psychiatrist to hold. As a cautionary tale, a number of psychiatrists brought up the case of Ellen West, the famous patient of existential psychiatrist Ludwig Binswanger. Faced with the possibility of her committing suicide, Binswanger nonetheless discharged her, believing that "in the death chosen with freedom, she was able to break the vicious circle" and "came to the true realization of herself" (translated from the Japanese translation of Binswanger's *Schizophrenie* cited in Ishikawa 1962). Binswanger's philosophical stance—and his therapeutic negligence that led to her death—has been much discussed by Japanese psychiatrists, many of whom see it now as representing the danger of existentializing and aestheticizing a patient's suicidal intention. A well-known expert in personality disorder emphasized how treating the suicidal was a constant struggle in which it was important to stand firm. He said that he had "no doubt" about the rightness of medicalizing suicide, and added: "That's what we are here for. If they try to bring you onto [their] existential ground, you might get swallowed up in it. And if you begin to have any doubts yourself, I think you'll lose."

Thus psychiatrists at times intentionally medicalize suicide not because they cannot see beyond pathology, but precisely because they see the boundary between pure biology and existential angst begin to blur. A thirty-seven-year old psychiatrist became tearful as she recalled the first patient she lost, a young man who was referred to her by her colleague with the warning that he had "more of a personality problem (than depression)." Seeing that he was steadily getting better under her care, she gave him permission to stay out at his home one night, only to find the following morning that he had hanged himself at home. Dazed and devastated, she hardly remembered how she spent the following days, only that

she had lost her wedding ring amidst the confusion that morning. "I still wonder if he committed suicide of resolve or if it was depression and I made a misjudgment. Since then, I never forget the equation: 'Depression Equals Suicide.'" While she hung on, other young doctors are known to have quit psychiatry, or seriously contemplated it, over such intense experiences. Discussing such a time in his life, a thirty-three-year-old psychiatrist talked about having lost three patients in one week—one in a murder and the other two to suicide: "It was like going through a massacre– I was too busy and had too many responsibilities by then to stop and absorb what had happened" (for research on American psychiatrists' reactions to the suicides of their patients, see: Hendin et al. 2000). Suicide apparently leaves a strong mark even on experienced psychiatrists and is certainly something that they "never get used to," as a sixty-nine-year-old depression expert stated. I know a few psychiatrists who have repeatedly gone back to the files of the first patient they lost to suicide during their residency in an attempt to think over what they could have done differently. And I met a number of veteran psychiatrists who recited the minute details of letters they had received from patients who later committed suicide. The aforementioned personality disorder specialist, who talked in depth of the three patients he had lost during the decades of his practice, still uses the appointment organizer file that a patient's father gave him as a keepsake after the patient's suicide; he said that he keeps it as a reminder to himself. For them, the danger of contemplating the existential meaning of suicide, or normalizing it through a philosophical stance, can create a kind of therapeutic distraction that may prove too risky.

It is clear that psychiatrists regard a strict diagnostic differentiation to be a solution for resolving this dilemma. They keep away from these disturbing questions by focusing on treating the patients whom they know they can help with biological treatments and social interventions. They do an extensive amount of social work by trying to bring about changes in workplace conditions, creating

a rehabilitation plan for a patient's return to work, and talking to patients' families. And hospitalization does seem to work as a temporary shield for suicidal patients, nourishing their desire to live; at times bringing about dramatic transformations. But these same psychiatrists strictly stay out of intervening in the "reasons" for the patients' suicidal intentions. They might quietly listen to patients talk about death, but rarely urge them to elaborate upon its meanings or try to make them confront themselves through psychological and verbal confrontation. (A young resident who tried to do this kind of cognitive intervention was much criticized by his colleagues as misguided.) Their skepticism about psychological intervention, as we have seen in the previous chapter, means that their involvement with the suicidal revolves around biological and social care, where they hope —and almost always succeed— in seeing patients lose their suicidal ideation as a result of medication and rest in a supportive environment. But, I found, it takes only one case with a bad outcome to make psychiatrists confront the limits of their perspective.

d. Can there be suicide of resolve?

During the entire course of my two-years of fieldwork at JP Medical School, there were only a few patients, who believed—even after the treatment—that their act was fully intentional.[88] One case stood out because of his insistence that his act be regarded as an attempted suicide of resolve in the traditional sense of the term. Furuta-san, a sixty-four-year old former civil servant, was brought into Emergency after he took an overdose at night and was found by his family unconscious in the morning. Diagnosing him with depression, the psychiatrists in charge soon found out about his foundering family business and tax problems, on

[88] The rarity of this was in part due to the fact that the psychiatrists were extremely careful to hospitalize only those whom they diagnosed as suffering mental illness.

top of a tragic family history. Treatment with antidepressants began immediately and his mood seemed to improve. To the psychiatrists' puzzlement, however, Furuta-san persisted in saying that his was an attempted suicide of resolve, and that his only regret was that he had been saved. A few months into hospitalization, he walked out of the hospital (there is no locked ward at this psychiatric department as a matter of principle). He took a cab to a mountaintop, and again attempted suicide only to be rescued by the cab driver, who went back to find him after sensing that something was wrong. After the second attempt failed, he promised that he would not try again as long as he was in the hospital ("I do not want to cause trouble for the staff who have done so much for me," he said), but he made it clear that he still intended to die, after an appropriate interval, upon going home. Despite the intensive treatment he received, and occasional fluctuations of his moods, Furuta-san's suicidal desires remained constant throughout his 18 months of hospitalization. He often drew upon the legendary suicides of General Nogi (who followed his master, Meiji Emperor, to his grave) and Ôishi Kuranosuke (the samurai hero of the *Chûshingura* suicide pact in the Edo Period) to talk about his own sense of honor and asserted that it was with his "aesthetic of death" that he was determined to complete the "suicide of resolve."

Psychiatrists could not tell why Furuta-san never "recovered," and suggested that I, a medical anthropologist, talk with him as well (to which Furuta-san agreed). Thus began my weekly hour-long meetings with him, in which I tried to simply listen to him talk about whatever was on his mind that week. While having worked as a civil servant, Furuta-san also reigned as the head of a prestigious family of landholders with a history dating back two hundred years, that owned several tree-covered mountains in the area. Furuta-san was intelligent and had a sense of humor, and I enjoyed listening to him discuss everything from paintings (he was an art collector) to forestry (his family business, which has been hard-hit by the recent global competition). But the theme he kept coming back to was his

family and his estrangements from his daughters. He had lost a daughter to suicide years ago, after she was treated for a mental illness at this same psychiatric unit. He had severed all ties to his eldest daughter, whose secret marriage to a man he could not accept had so infuriated him that he refused to accept her child as the heir to the family. Because his youngest daughter –after seeing all the family tragedies—renounced any intention of marrying, Furuta-san faced the discontinuation of his family lineage. Though he discussed with me his complex relationship with his now-deceased father, who had been a prominent figure in local politics, and for whom a statue had even been erected, he never seemed to reflect on the parallel difficulties that he had with his own children. Furuta-san often wondered why he had to continue suffering more than he already had, a sentiment exacerbated by the lack of significant improvement of his mental and physical condition – a heaviness in the chest, overall lack of energy, and the dejection that was apparent in the air he brought to the consultation room every week. The psychiatrists and I often discussed the Shakespearian weight of his family tragedies but we never urged him to cultivate psychological "insight." This was because the psychiatrists believed that what they were dealing with was an endogenous depression with strong neurotic components, and, in their view, such psychological intervention would be ineffective, if not harmful.

Seeing the limits of their biological intervention, however, the psychiatrists continued to debate what the purpose of their treatment should be. First, they were clear that they were treating clinical depression and had no desire to intrude into the irresolvable aspects of Furuta-san's life. In one of the early case conferences for Furuta-san, Professor Higashi thus told the attending staff: "It is our responsibility to cure depression. Once his mental illness is treated, the remaining decisions will lie with him." Confidence was behind his statement that their biological cure would eventually lift his suicidal intention. However, as Furuta-san's hospitalization dragged on to an unusual length of time, with no

change in his insistence on suicide of resolve, psychiatrists began to wonder what they were dealing with. All forms of treatments (including electric and magnetic therapies) had failed, and his family situation was deemed too complex to intervene. In an interim staff meeting specially called for this case, Dr. Satô, who specializes in medical ethics in terminal care, opened the discussion by asking if Furuta-san's insistent wish to die was a mere symptom of depression or if they should really consider the possibility that it constituted "free will." Dr. Kanda, the veteran specialist of depression who was in charge of Furuta-san, replied: "We have no power to change his thoughts or his family situation. He feels there is no way out and we can see no way out." His comment served to articulate the feeling of despair prevailing among the staff, but also to caution against the potential danger inherent in pursuing this line of existentialist argument. The room fell silent for a while. Eventually, other psychiatrists tried to redirect the course of discussion back to biology by pointing out how Furuta-san's mood fluctuated with the varying dosages of antidepressants, which also affected the frequency with which he talked about "the aesthetics of death." Other staff tried to find in Furuta-san's statements some signs of his desire to live: "Remember how he once said that he wanted to die surrounded by his grandchildren?" With this, the staff ended the conference—somewhat inconclusively—by renewing their sense of legitimacy as caregivers. But what the discussion also exposed was the fragile basis upon which psychiatrists intervene in the lives of those patients who proclaim themselves determined to a suicide of resolve.

This case seemed to raise disturbing questions for psychiatrists about whether they have the right to treat patients against their will. Japanese psychiatrists are granted the legal power to confine those who are deemed a danger to others and to themselves. While they do not hesitate to forcefully institutionalize the first group, in the case of the latter, they can be highly indecisive about taking the same measure if being a danger to oneself means being (simply) suicidal. The irony is

that the ultimately "humanistic" attempt to grant agency to someone who is suicidal might result in the patient's death. This ethical dilemma was brought up in the departmental seminar, and in one of the ensuing discussions in the departmental lounge, Dr. Satô pointed out; "After all, we have no philosophical grounds upon which to justify why we stop suicidal patients from killing themselves." Dr. Ota added that the fact that the patients are telling their stories to a psychiatrist—who has the medical and ethical responsibility to save lives—"already suggests their implicit desire to live." The group agreed that this was the only rationale they had to treat the suicidal. Dr. Satô continued: "It's a perverted relationship, I think. They keep telling me that they are going to die and I keep telling them that I will do everything in my power to stop them. But somehow that seems to calm them." That was what Dr. Kanda did, to keep assuring Furuta-san that what he had was indeed depression and that it would eventually lift by itself. Furuta-san recovered after the 18 months of hospitalization, partly because the treatment finally began to take effect, but mostly because his family situation unexpectedly turned for the better, making it possible for him to be reconciled with his daughters. Not long before his discharge, Furuta-san said to me with a mischievous smile: "I told the doctors it's all thanks to their care and their medication that my depression got better," and we all went along with this story. But as Dr. Satô and Dr. Kanda reflected on the case, they wondered if this was in fact a highly unusual case of suicide of resolve, or if there were "others like him out there that they simply did not know about."

Psychiatrists hung onto the thin thread of his desire to stay under their care of his own "free will" as the justification to keep treating a determinedly suicidal patient like Furuta-san. This suggests that the only time that psychiatrists grant the cultural logic of "suicide of resolve" is when patients successfully hide any desire to die while in their care. The fate of Terada-san, a sixty-four-year-old woman, who was hospitalized around the same time as Furuta-san, was in sharp contrast

to his. On the one-year anniversary of her husband's death, she took an overdose of antidepressants and was found unconscious the next morning. She surprised the psychiatrist in Emergency when she begged him to help her die, literally suggesting physician-assisted suicide. In my interviews with her after her recovery, Terada-san told me about the hardships she had gone through; divorcing after her husband's infidelity, she brought up two sons on her own by working as a medical clerk, a job she kept for thirty years. Meeting her second husband gave her happiness and comfort, until they were thrown into an uphill battle with the cancer he developed. The memories of the numerous trips they made to mountain shrines to pray for his recovery were still fresh in her mind, and she was proud of having done everything she could to ease his pain and nursed him at home till the very end. Soon after his death, she began to experience mysterious symptoms including being drained of energy, shivering, rashes, and high blood pressure, that none of the doctors she visited were able to diagnose. Even after she finally met a psychiatrist who prescribed antidepressants for her, she spent many nights sleepless, worrying about gradually turning into an "invalid." Once hospitalized in the psychiatric unit, however, she was amazed by her own brisk and dramatic recovery: "I started feeling better after ten days!" she said. Terada-san soon regained her cheerful former self and made many friends in the unit. She told me repeatedly how the doctor had saved her life, and how she had complete trust in him. The only concern she still had at the time of her discharge, it seemed, was if her married son would live with her to keep an eye on her fragile health. Before the hospitalization, he had offered to do this himself, but she had kept being indecisive, possibly because she was under the influence of depression but also because she incessantly worried about becoming a "burden" on others.

A few months later, I was told by the doctor in charge of Terada-san that she had taken her own life on the morning she was supposed to enter a nursing home. The

doctor was visibly distressed. He could not comprehend what had driven her to it. Could it be that her depression was not fully cured, as doctors had assumed? Could it be that she chose death because she did not wish to be a burden on her sons? She emphasized that she felt satisfied with her life, and proud of having taken care of her sons and her late husband. Did she want to end it with a sense of pride as a caregiver while she could, rather than becoming an "invalid" – an existence that she had so feared? Or did she die in resignation, possibly even protest, feeling abandoned by her family and by medical professionals? As these thoughts rushed through my mind, the doctor told me that he had not predicted this outcome at all. Though it was apparently a planned act, Terada-san had shown no signs of her suicidal intention that the psychiatrist could detect in the last few times he had seen her in the outpatient unit. Then he added: "This must have been a suicide of resolve."

V. The limit of treating the suicidal mind

These clinical vignettes from Japanese psychiatry illuminate the way in which, despite their initial ambivalence early on in their careers, psychiatrists grow accustomed to suspending the uncertainty they once held about treating suicide. By limiting their object of intervention to what they understand as mental illness, Japanese psychiatrists seem to effectively transform suicide into a product of biology. They achieve this in three steps: First, they "extract" the underlying depression. Second, they de-existentialize suicide by illuminating how the mind of the suicidal patient changes with biological interventions. Third, they urge these patients to accept that their suicidal intention was a break from their "normal" self, thereby shifting the locus of agency—and intentionality—to the realm of pathology. As they repeatedly witness patients denounce their suicidal intention through this process, they begin to wonder if there really is such a thing

as suicide of resolve. The triumph of the technological rationality anthropologists have discussed prevails here, whereby moral –and cultural—questions that cannot be easily answered by biomedical routines are bracketed and left unexamined (Lock & Gordon 1988, Good 1994). Psychiatrists come to operate mainly with the biological model of the suicidal mind, assuming a sharp dichotomy between the normal and the pathological.

Despite their cultural and clinical sensibilities, psychiatrists are constrained by the model of the human mind that they draw on from participating in a dialogue with those who assert their act be understood as an attempted suicide of resolve. Cultural logic blurs the psychiatric border of the normal and the pathological, and raises disturbing questions about the ethical boundaries of the work of psychiatrists in treating people against their own will. And psychiatrists' failure in the end to provide a cure—as in the case of Terada-san for whom medication was apparently successful in changing her outlook, but whose effects seemed to last only within the walls of the hospital—reminds them that there is a vast domain that the biological cure does not reach. Aware of their limitations in altering the social conditions that have produced patients' desperation, psychiatrists nonetheless carefully stay away from intervening in the realm of people's own reasons and intentions for attempting suicide. While this non-involvement suggests, on the one hand, their concern over the abuse of medicalization, on the other hand, it implies that they might be ill-equipped in terms of having a language with which to capture and attest to the ephemeral nature of intentionality or the contradictions of the suicidal mind. Psychiatrists thus remain silent about the contradiction whereby cultural discourse about suicide provides so few clues as to how to bring the suicidal back onto the side of life whereas, traditionally, the idea of the right to die voluntarily has been passionately defended in Japan as an acceptable expression of free will.

Part III. Depression in Society

Chapter 8: The Gendering of Depression and the Selective Recognition of Pain

I. The gender of depression

Japan has been a statistical anomaly when it comes to the gender of depression.[89] While in the West women are twice as likely as men to suffer from depression, in Japan, until recently, men have been equally or even more prone than women to depression. Throughout the 20th Century, numerous Japanese psychiatrists commented on this statistical anomaly, while showing (mainly from their hospital data) that the depression ratio between males and females in Japan is slightly more among males than females (Hirasawa 1966); others have shown that it is three to two (Naka 1932, Shinfuku 1973).[90] Indeed, Japan was the only one out of the twelve countries that participated in the 1973 WHO cross-national survey on depression, where slightly more men than women suffered depression (Nakane et al. 1994; Lock 1993). Since even as early as the 1930s, however, some have speculated that Japanese women's depression is merely hidden, and not attracting social –or medical—attention (Naka 1932). In other words, it may be that Japanese men have suffered more; another possibility, however, is that women have suffered as much as, if not more than, men, but their suffering has remained largely – socially and medically—unrecognized.

The fact that the latest epidemiological study shows a gender ratio of depression akin to that suggested by the Western data (Kawakami et al. 2002, 2005) hints that the latter may well be the case. Indeed, a number of veteran Japanese psychiatrists I talked to pointed out that their model of depression has traditionally been based

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[89] On gender and mental illness, also see Suzuki Akihito's excellent historical work on the asylums in the early 20th Century Japan (Suzuki 2005).

[90] Similar gender ratio can be found in the statistics on manic-depression as well: see Kure 1914, Takase 1922, Matsumura 1937.

on men's depression. Given this psychiatric representation, perhaps it is no surprise that male depression– particularly that of middle-aged workers—has been given the spotlight in media discourse accompanying the rise of depression since the late 1990s. Psychiatrists have given powerful descriptions about the plight of these depressed men – how, for instance, their self-sacrificing devotion to a company is no longer rewarded in the crumbling system of life employment. In the popular discourse about "overwork depression (karô utsubyô)," psychiatrists—together with lawyers and journalists—have elevated male depression to a symbol of the collective misery that Japanese people face in the continuing long recession (Shiba 1999, Kawahito 1998, Kamata1999). There seems to be no such master narrative for female depression. While psychiatrists certainly point out the depression of housewives and the increasing number of young female patients, they remain much less eloquent about the plight of these women, as if they cannot quite grasp or explicate the nature of their suffering. This reminds me of an unforgettable scene I encountered at an international conference on depression in 2004. After a series of typical talks on depression by Japanese psychiatrists, where they emphasized how hardworking salarymen are often the victims of depression, a French psychiatrist stood up and asked with a dramatic gesture: "Can a homeless person become depressed in Japan?" Despite the laughter which followed, his comment effectively drew out the implicit morality embedded in the Japanese psychiatric representation of depression, where certain kinds of suffering—more than others—may be more readily recognized and legitimized (cf., Micale 1995, Metzl 2003).

In her work on menopause in Japan and North America, Margaret Lock (1993) illuminated the irony of the circumstances in which Japanese "menopausal" (kônenki) women largely escaped medicalization because of the relative lack of Japanese doctors' recognition of these women's distress. Furthermore, Lock has shown how women themselves tended to belittle kônenki as an illness of the idle

few. While such a medico-moral discourse may have kept women out of doctors' offices and encouraged them to seek out other cultural resources, it also had the unfortunate result of making them believe in the hegemonic discourse that de-legitimized their pain even against—at times—their own subjective experience. Drawing upon this interplay between medical and social recognition and subjective experiences, I examined the narratives of 23 Japanese who were recovering from depression (12 male and 11 female). I asked six psychiatrists to introduce me to their patients, whom they considered as more or less "typical" cases of depression, and I also participated for a year in a depression support group, the only one in existence in Japan that I could find in 2002 (though the group was open to both men and women and it once had some female members in the past, it was exclusively male for most of its history and certainly during the year that I participated).[91] What emerged from these interviews is that men and women suffer differently because of the particular gendering of depression in Japan.

II. Male Depression

> Job security, recognition for long service, a system of rewards, company accommodation, social backup: under Japanese capitalism the firm neglects no measure which can further the integration of its employees, and assumes a large part of the welfare role which in the West was once played by the Church, and now devolves on the state. Employer and employee are bound not by a precise and dissoluble contract for the sake of working capacity, but by a personal

[91] With regard to the women, I focus here on those who had work outside the home because I wanted to examine what kind of experience might lie behind the dominant image of the depressed – the middle-aged working men – and their female counterparts.

commitment involving total participation in the life of the company.

Pinguet, Maurice. *Voluntary Death in Japan*. 1993:30.

a. Depression as overwork

Male depression both in popular and psychiatric discourses has often been represented as an illness of overwork. Ever since Shimoda Mitsuzô formulated the Japanese theory of depression as a product of physical and mental fatigue, Japanese discourse about depression has revolved around the centrality of work. Even psychiatrists have reflected on why it is that work has attracted so much attention as the cause of depression in Japan (Nakai 1976, Suzuki 1997) –not just any kind of work— domestic labor is not usually included in this formulation—but the kind of work that salarymen are engaged in. The first narrative we hear from Kobayashi-san, who works in the central government, allows us to look into what might go through the minds of some Japanese men, who risk literally working themselves to death.

In a consultation room at a private mental hospital in Tokyo, I was introduced by Dr. Koyama to Kobayashi-san, a fifty-one-year-old civil servant working for a Ministry. After we exchanged our business cards, I explained that I was interested in the subjective experience of depression, and Kobayashi-san agreed to the interview. Chronologically recounting his experience, Kobayashi-san recalled what he thought was the initial episode of depression. Ten years previously, he had been working in Kasumigaseki (the part of Tokyo where most governmental offices are located), and was engaged in an intense negotiation with the Ministry of Finance over the annual budget for his Ministry. The computer system for compiling the budget was then being introduced, but Kobayashi-san did everything manually and took leftover work home at night. (The reason for this,

as it turned out, was characteristic of Kobayashi-san; he did not wish to hurt the pride of his computer-illiterate boss.) Sleeping for only three hours each night and working on weekends, Kobayashi-san suddenly found himself one day feeling suicidal.

> I was in the office on a Sunday, when my mind went blank: then the thought occurred to me that I might throw myself out of the window. I had heard about people jumping (from high rise buildings) in Kasumigaseki. I wondered if I might just do the same. ... I simply wanted to escape from it all.

At the time, mental health was not something people talked about in his office: "We would habitually exceed 100 extra hours of overtime per month. If someone happened to drop dead, then superiors would consider providing the deceased's family with workers' compensation, but that was it." Kobayashi-san said he did not think his problem was depression and thought that he was simply "weak," lacking the ability to carry out the job. Similar to the illness histories recounted to me by other depressed patients, Kobayashi-san soon developed a duodenal ulcer and had to be hospitalized.

His initial encounter with a psychiatrist began with what Japanese psychiatrists commonly refer to as: "promotion depression" (shôshin utsubyô). At the time, Kobayashi-san had been transferred to the Southern part of Japan as a stepping-stone to his next promotion. The job proved to be highly stressful, however, as he had to constantly negotiate with the strong labor union there. Kobayashi-san recounted with apparent chagrin that he was yelled at by the union people during an important lecture he was giving to new trainees. After eight months of drinking with union leaders (despite his dislike of alcohol) and trying to smooth things out, Kobayashi-san felt thoroughly exhausted and one

day simply could not go to work anymore. His worried wife took him to an internist, who then referred him to a psychiatrist. The psychiatrist, who diagnosed him with depression, seemed to know exactly what to say to convince Kobayashi-san to take a sick leave: "I don't remember exactly what the doctor said, except that even a departmental chief from the local government [higher ranked than Kobayashi-san] was coming to the clinic. I was surprised to learn that it happened to my superiors as well." The hospital hid the fact that their diagnosis was depression and kept out all visitors. Kobayashi-san "slept as much as [he] wanted for the first time in a long time" and found himself recovered in two weeks' time. Depression, for Kobayashi-san, was apparently a case of work-related exhaustion or "burn-out."

Kobayashi-san's narrative is typical of men's accounts of overwork-induced depression. Their stories are strikingly uniform, characterized by an increasing amount of work, fatigue beyond limit, eventual collapse, and recovery through simple rest.[92] This is the basic form of depression that Shimoda had already illuminated in the 1930s, and the mold in which Japanese psychiatric understandings of depression have been cast. As with cases which lawyers involved in overwork suicide litigations have successfully argued, there seemed to be little doubt that work stress was a crucial factor for the depression of almost all the men I interviewed. For instance, Narita-san, a thirty-seven-year-old computer engineer, explained to me how he became depressed right after being promoted to section chief. He was exhausted from the added responsibility of

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[92] I often thought that the uniformity of their narratives in itself is interesting, considering how utterly confused and confusing most of the narratives I heard from the people in diagnostic interviews were, people who were visiting psychiatry for the first time for their depression. By the time they have gone through the psychiatric treatment, there emerges a certain sense of uniformity, a structure, in the way they come to share a certain narrative line with a beginning, middle and end. Their narrative is certainly a co-product of their own reflection and psychiatric encounters (see Barrett 1996).

managing employees and keeping up with the ever-accelerating pace of the computer industry. As his boss had suffered depression himself, Narita-san was urged to take a sick leave and rest, which led to recovery after a few weeks. A fifty-five-year-old entrepreneur, Watabe-san talked about how he was driven to a suicide attempt after his once-successful chain stores began to fail in the bursting of the bubble economy. Watabe-san said he was driven to the edge while scrambling for funds, worrying about the imminent risk of bankruptcy and spending many nights sleepless. Such narratives attested to the increasingly difficult working conditions under which Japanese men are placed in the long recession, and suggest how depression may be understood as a work hazard. While straightforward "overwork depression" dominated the male narratives I heard, I also encountered some men, particularly those who had battled with chronic or repeated forms of depression, who spoke of how their work stress came to be closely entangled with problems beyond the workplace. Kobayashi-san did not hesitate to bring this up himself.

As Kobayashi-san saw it, depression was an embodiment of the growing contradictions in his life. He said that at the time that he became depressed, he had just found out that his wife had joined the Jehovah's Witnesses. "I hadn't realized how distressed she had been about everything, especially about how to bring up children. I was far too busy with my work to notice her distress, and when I found out, I was thrown into a panic." His wife now insisted on new ideas about child rearing, and refused to tend to his family grave (regarded as an important act for preserving the continuation of the family). As his life began to crumble both at work and at home, Kobayashi-san was forced to confront the fact that his personal aspirations were causing strain in his life. He recounted how as a young man, his family had been too poor to send him to college, but that he got his B.A. through night school after joining the Ministry. While this placed him in a higher position than he might have hoped for, he still had to work as an

intermediary between the top elites in the central Ministry and the (equally proud) directors of local governments. Kobayashi-san felt he was always "trying to cover up [his] lack of ability" by maintaining smooth relationships on all sides. He would, for instance, write five hundred New Year's cards every year: "I used to do it naturally but I now find it a bit exhausting." Kobayashi-san even worried about the careers of the people who had been replaced or pushed aside by his own promotion. His reliability in work and unfailing consideration for others had certainly won him many supporters (his former boss was sketching out his next promotion and he had recently been chosen as the only candidate from his Ministry for a special personnel training session). But Kobayashi-san had come to realize how this way of being had thoroughly exhausted him. What went through his mind when he imagined himself jumping out of a window, he said, was the fear that he would make an irreversible mistake on the job and would be "destroyed" (tsubusareru).

> When I was hospitalized, I really wanted to talk to my father. I went back to see him at the end of the year, and he said: "I understand." He wasn't at all surprised that I had become depressed. My father was only a farmer but had also served on a village council so he knew [what it was like] ...He told me not to worry about getting ahead of others and to take it at a slow pace. I was so relieved. .... He never told me to try harder (ganbare). To tell someone to try harder often means driving him to take his own life.

For Kobayashi-san, recovering from depression meant critically re-examining the meaning of his life. Through his struggles, he came to feel gratitude towards his wife, who kept telling him not to worry about promotions, saying that that was not what she married him for. Watching her do volunteer work every week and bringing up their children with care, Kobayashi-san became reconciled with her

religious belief: "I came to realize how she also needed a purpose in life (*ikigai*)." While he still debated taking the exam for the next promotion, he was now also trying not to spend his days worrying about "what [he] could otherwise do tomorrow." Kobayashi-san's dream was to quit work after staying with the Ministry for another decade and go back to his hometown to take up farming: "I want to do another budget compilation as my last service, and leave [the Ministry]...I don't think I would have become depressed if I had been a farmer all along."

Like other male patients, Kobayashi-san thrived on the protective relationship that the psychiatrist offered him. He said, "Dr. Koyama listens to me well. When I have three days off and I don't feel like going back to work, he says: 'I feel just the same.' That kind of thing makes me feel so much better." If psychiatrists consciously reproduced the work-relationship for the depressed, implicitly taking up the role of their superior, ordering them rest, determining when to return to work (Yoshimatsu 1987, Suzuki 1997), then these men seemed to find a sense of comfort and security in such a relationship. They recovered by readily yielding themselves to the power of psychiatrists, whose benign shelter helped them nurture their impaired sense of self.

b. Depression as a product of work relations

The depressed, as Japanese psychiatrists say, are often the most desirable types of workers for organizations. They are known for their self-sacrifice and are devoted, disciplined and responsible. They are, in the well-known dictum of Shimoda Mitsuzô, "model (male) youths, model employees, model officers" (see Chapter 5). Because these men become so united with their work, and work occupies most of their waking hours, the slightest discord with the workplace seems to open up an

abyss that could destabilize their sense of self, even threaten their existence. Depression lies in that dangerous, liminal space, where excessive self-questioning into its cause and meanings could lead one out of the orbit of well-ordered company life. No one else elaborated upon this sense of impasse as eloquently as Takashima-san, a forty-nine-year-old banker.

When Dr. Nakata introduced me, Takashima-san bowed and smiled courteously, and seemed gentle, which remained irreconcilable in my mind with the images of violent suicide attempts he later described. After he discussed the book he was carrying upon my asking about it (it was on the history of the agricultural revolution in England), Takashima-san began telling me about his formative years in a private junior high school, where he received the lasting influence of his liberal-minded teachers. Takashima-san recounted how they read books like *Silent Spring* to learn about pollution, and watched *The Grapes of Wrath* to accompany discussion of the Great Depression. When he went on to the university affiliated with his high school and began studying Marxist-oriented economics (which was predominant at the time), the impact of the student movement then sweeping the country could be felt even on his bourgeois campus. Though the socially-conscious Takashima-san dreamed of becoming a lawyer, he gave in to his parents' plea that, not being physically strong enough to study for the competitive bar exam, he instead do something else, and opted for a job at a local bank. At work, Takashima-san came to be in charge of arranging loans for small firms attached to what is known as a "publishing hub," in which hundreds of small subsidiary factories cluster around a few publishing houses. This was the time, he said, when Japanese industry was going through a fundamental restructuring after the oil shock, and Toyota's strict production control was being acclaimed as the model for the new era. The tiny factories that he would visit were in turn controlled by a few mega publishers; each shop specialized in a single process of book production such as binding or page trimming. Their livelihood

was entirely dependent upon the whim of the big corporations.

> As I took charge of these small firms, I started reading more books on economics than I ever did in college. You know how much these small companies get paid for binding? It's a matter of sen [a smaller unit than a yen, now obsolete], for thousands of books they do. Big companies demand a rebate on top of that! ...I felt I was seeing real life exploitation.

This stratification was, it seemed, very familiar to him, as he talked about the place of his own bank in the hierarchy of the Japanese banking system. "Being a credit association, we provide the last resort for small businesses –our status is determined by the banking laws. I myself found it good to know that we are the ones who do everything possible to try to save them." Making rounds to these small places and building trusting relationships with his customers, he came to find his work meaningful. At the same time, Takashima-san remained uncomfortable with a certain culture of toughness at the bank, where being able to turn down a loan request was regarded as a sign of manhood. It was stressful, he said, when he was unable to grant a loan to a person with whom he had come to cultivate a close relationship. That was why, he said, he began to "go wrong": "I cared too much about my relationships with my customers. I must have chosen the wrong vocation."

The first time he became depressed, Takashima-san was at the height of his career. Being a graduate of an elite university with a promising future, he was temporarily transferred to the Bank of Tokyo in his ninth year to be trained to launch a foreign currency section. Back at his own bank, he was placed under a new boss, who came from a powerful bank known for its Spartan culture. Takashima-san began to leave home at six-thirty a.m. and work till two a.m. to

keep up with the new work demands. However, the boss did not take to Takashima-san and would criticize him in front of others. Takashima-san recalled how the boss would bang the desk with the document Takashima-san had prepared, and disparaging him, would toss the paper into the air. "I can't forget that sound of the paper hitting the desk, 'bang, bang.' I totally lost confidence and began to wonder what I was doing."

> He imposed his own style on me. I felt like I was beginning to not be myself. Then all at once, I could not go to work anymore. I lost confidence; I wasn't sure what I was doing. Tears would start and would not stop. Then I met Dr. Nakata. It's been almost ten years now.

Just when I thought I had grasped the cause of his depression to be a product of overwork and alienation in the workplace, Takashima-san said his "wife was another reason" for his depression. Their ideas about child rearing were incompatible, he said, and, after she had an affair, she was living upstairs and he downstairs in the same house. Living with his mother—to whom Takashima-san seemed strongly attached–led to a constant war between the two women. As his wife refused to divorce him, he found himself in a limbo: "I love my children. I can't stand it when my wife yells hysterically at them. My mother and my wife fight all the time. I can't stand it." For him, contemplating the technical problems of the act of committing suicide was when he felt "most alive." The time he hanged himself, he temporarily lost consciousness, which, he said, relieved his mind. I was shocked to hear that it was his younger child's noticing a strange smell coming from the garage (he had defecated from hanging) that led to the rescue. Worried about the effect on his child, I asked him—somewhat timidly—how he thought the child must have felt about it. Takashima-san, who had talked about his children with apparent affection, simply said that they

would eventually get over it as they grew up. It left me wondering if this was the effect of "depression," or if he was so utterly exhausted that he could no longer care. He said he wanted to achieve peace of mind by "finding the absolute meaning for [him]self," and talked feelingly about an old woman he saw on the train, a peddler carrying an enormous bundle on her bent back. Wondering how she could persevere in life despite the apparent hardship, he said:

> I can think of the reasons and solutions [for my depression] but I can't actually carry them out. I'm forever analyzing my plight. You know how the hardest working people are not necessarily the most rewarded. ...There were many folks who went through tough times in the rise of the agricultural revolution or the industrial revolution. How did they find the strength to survive that?

His dream was to go to graduate school to study the history of the English working class after retirement: "I'm just hoping that I can hang on for the rest of my time—thirteen years and six months before retirement."

Even with the marital problem, Takashima-san's agonies appear so much determined by work that one may wonder why he does not quit the bank and find something else. As Thomas Rohlen once described with regard to the life of Japanese bankers, however, quitting work in a society where life employment is still the norm is an anomaly that people feel should not happen (Rohlen 1974b), even comparable to social death for some men. In fact, in the depression support group that I attended over the course of a year (whose members were exclusively male), one of the things that men often talked about was their fear (and accompanying risk of shame) of being spotted by their neighbors in broad daylight, when "decent men" are supposed to be at the office, working. The

discussions half the time centered around their worries over how to hold onto their job; to the new members who expressed their desperation to get back to work or to go to a job interview, veteran members would caution them that a rushed return would likely result in poor performance, which could further damage their employability and exacerbate their depression. To other newcomers who talked angrily about their treatment at work and fantasized about quitting in protest, veterans spoke from their own bitter experiences: "We have to drop the illusion that the [company] will be begging us to come back. Hang onto the job even if they try to make you feel like quitting." While dreaming of a full recovery by finding an alternative self elsewhere (as in post-retirement life), few men dared to leave that system and the security it provided (cf., Rohlen 1974a, 1974b). Their being bound to the workplace was, it seemed, both a blessing and a curse for these men, as they seemed unable to envision a life outside the system with which they had long been complicit, even if it was now destroying their health. Some men, however, seemed to reach what could only be described as a philosophical resignation through their experience. This seemed to be the case with Machida-san, who was introduced to me by Dr. Koyama as someone he had a lot of respect for.

Sixty-three-year-old Machida-san was a man of few words, who appeared somewhat beaten by years of hardship. He was a former managing director of a construction company, who was—at the time of my interview—cleaning toilets for a living. Until a few years before, he had been running his company with his three brothers. He reminisced about the time of hardship in building the company from scratch, and the eventual success they enjoyed as the business steadily expanded. All this changed with the bursting of the bubble economy. The number of contracts began to decrease, and the fee for each project became smaller and smaller. Soon enough, the parent company started dumping non-profitable jobs on its small subsidiaries like Machida-san's, threatening them with otherwise

discontinuing future business: "We could not afford to turn down any offers of contracts, even if we knew that it was a project no one else wanted because it was sure to produce losses, not profit." As the company struggled to survive, gradually letting go of the trucks and other construction machinery, Machida-san's elder brother died from a cerebral infarction. His younger brother, who took over the management of the company, soon sank into alcoholism, and then suddenly died from liver damage. Scrambling for funds and worrying about being able to pay the employees at the end of each month, Machida-san hardly realized the changes happening to him, but he was losing energy, concentration, and sleep. By the time he filed for bankruptcy, he was drinking heavily and severely depressed. Machida-san became uncharacteristically eloquent as he began to criticize the government, whose generous shield of protection for failing big corporations (under the prime minister's banner of "sharing the pain") barely covered little companies like his. He vividly described, with what seemed like mixed, complex emotions of anger, resentment, and shame, the final day in court. He recalled how the judge preached at him that he was obliged to pay for his company's debts, and explained to him, patronizingly, how there was such a thing as "collective responsibility."

After losing everything –his company, employees, his savings, and his house—he was, he said, "satisfied" with his simple life now. He spoke feelingly about how his family supported him throughout the hardship, and how that kept him from committing suicide. Working for the cleaning company without worrying about paying salaries or managing funds, he emphasized, was such an easy way of living. And he told me how he felt good about working with his coworkers who all had a "past" like Machida-san (one was formerly a banker, a few others former presidents), and who did not hesitate to help and cover for each other. Machida-san seemed to find, in his own way, a certain sense of contentment as he came out of his depression. Almost as if he were delivering a Buddhist sermon, he

intoned how human beings become tainted from daily living, how life is constant suffering. And since the job he had was something that no one else wanted to do, he found it meaningful, he said, to be able to engage in the work of "cleaning and removing the taint." And he added: "I'm truly thankful that I have a job I can do everyday."

His philosophical reflection partly resonated with what I heard from other depressed men I met. The men in the depression support group articulated how they came to realize, after years of battling with depression, that they could not do anything but "relinquish control."[93] Indeed, the mantra that had naturally emerged from the group was: "Focus on your depression here and now...Immerse yourself in depression (utsu ni doppuri tsukaru)." True to this spirit, one member gladly reported his recovery and added: "But I'm trying to remain modest. And I'm *trying hard not to try hard.*" The apparent contradiction in his remark made everyone laugh, as this struggle was something that they all seemed to share. The group shared the understanding that the depressed tended to be the ones who "borrowed trouble" by worrying about things over which they had no control (see Kondô 1999). Depression, they said, forced them to confront their own weakness and abandon the desire to be in command, a point I repeatedly heard from other men I interviewed.

Recognizing their own limitations made them realize, most of them also pointed out, how embedded they are in their social relationships. Watabe-san, the aforementioned entrepreneur, said that the cause of his depression was his own personality: "I used to be egoistic and would easily get upset when things got in my way.... But I've changed since then. I've come to realize that I do not live alone

[93] The support group was originally established by a Morita-oriented psychiatrist and his patients. Though they rarely discussed Morita Therapy and its ideas, some of the philosophy that emerged from the group had affinity with them.

and that I have been supported by many people all along." He was now trying to do the same by helping others in need. (Most of my interviewees cited this to be the reason for sharing their experiences with me –so that people who are suffering from depression now can learn from their hardships.) Emphasizing the importance of rebuilding their relationships, a retired science professor talked about having started an "Ikigai (Purpose in life) Club" in his neighborhood, where retired residents get together to give talks on their respective areas of expertise in an effort at reminding them of the purpose of life (cf., Plath 1980). Depression for these men was certainly a disruption in their life, but it also provided an opportunity—albeit a difficult and bitter one—to reach an inner tranquility and establish new forms of social relationships beyond work.

III. Women's depression

a. Gaining medical and social recognition

> ...in the larger context of Japanese culture, women's narrative productions of identity in work are not part of the central story. Their narratives are not the subjects of cultural celebration; indeed, their lives cannot be arranged into a teleological sequence of increasing mastery in work."
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> Dorinne Kondo, *Crafting Selves.* 1990:259.

Many psychiatrists pointed out how women's depression remained an aberration in their own model of depression. Their symptoms "lacked clarity of shape," and the form that their depression usually took defied easy classification. As if to reflect the lack of "cultural celebration" for "narrative productions of identity in work," women's own narratives often seemed to lack the uniformity of men's

narratives I heard.

Most women I interviewed began their narratives by describing their desperate search to have their pain recognized by others. This was certainly the case with Endo-san, a fifty-nine-year-old director of a nursery, whose gentle yet restrained manner seemed to accentuate the quiet agony she suffered. The nursery she directed was originally founded by her father, a social work professor who, in the aftermath of World War II, opened his own home for the children of working parents in the poverty-stricken area in which they lived. Endo-san spoke of him with apparent respect, and told me how she was initially hesitant to get involved but ended up being the one to take his place after his death. The nursery had expanded successfully under her management, and now had 90 children and 30 staff. Asked how the depression started, Endo-san recalled that she began to experience menopausal symptoms in her forties ("It's hard because menopause hits you when you are in the prime years of your work"), which also came to affect her mental state after she turned fifty. She lost interest in everything, did not want to see anyone, and felt too dull to get up in the morning to go to work. She sought out various doctors and had numerous tests for the "heavy lead in the chest," but, despite these seemingly typical symptoms of depression, none of them could help mitigate her pain. By the time she was referred to a neurologist, she had been driven to believe, like many of the women I met, that her ailment was incurable and suicide might be the only option to get away from it: "The pain was so bad that I scratched the tatami mattress in agony. ... I grabbed the sleeve of the doctor's white coat and begged him to do something about it, to please let me be hospitalized."

Women, in contrast to men, raised upfront multiple possible causes for depression, making men's narratives, where "work stress" predominated, seem almost

one-dimensional. This certainly reflected the way women's lives are segmented into different roles. At the time Endo-san began to suffer, she was being swept away by a series of hardships. In the nursery, cooking staff and nursery staff had a major conflict, in which Endo-san had to intervene and act as an intermediary. At home, her sister moved in with her after her daughter's husband's business went bankrupt. Endo-san, who was the guarantor for his business, suddenly found herself with a huge debt. She seemed to have shouldered the whole burden by herself, while her husband, who was overseeing two nurseries in different locales, was living separately from her. On top of all these troubles, her son—who had been the source of her support— married and moved out of her house, which intensified her feelings of loneliness: "I was so exhausted every day that I couldn't shake off the feeling of tiredness at the end of the day." The lack of understanding on the part of her family (except for her son), further intensified her desperation:

> Their innocent words hurt me, when they say things like why don't I go for a walk [to cheer herself up]. I guess it's no use expecting them to understand since they have never experienced it themselves.... I wish there were a barometer for the pain I feel...my husband, for one, is very healthy and thinks that I am just being lazy.

Such a persistent failure of recognition --both from families and medical professionals—was a theme that repeatedly came up in the narratives of the women I interviewed (cf., Lock 1987, 1987, 1991, 1993, Boddy 1989, Borovoy 1995, Martin 1987, Todeschini 1999a, 1999b). They described how their symptoms were dismissively treated by various doctors as either "undiagnosable," and therefore not "real," or more commonly diagnosed as a disorder of the "autonomic nervous system " (*jiritsu shinkei shicchôshô* -- a taxonomic category often used as a "catch-all" diagnosis for what is labeled as non-specific symptomatology (see

Rosenberger 1992).[94] For instance, Yatsuhashi-san, a fifty-one-year-old former part-time worker, recounted how her troubles began half a year after her mother died from cancer. While she spent her days despondent over her mother's death, she noticed that her feces were black, which made her worry that she might also have cancer. Though she was eventually treated for a duodenal ulcer, she continued to suffer from strange sensations in her body, which doctors could not diagnose. It was only the day after she nearly threw herself in front of a truck at a busy intersection that she was finally diagnosed with depression at a psychiatric hospital. The doctors' failure in these two cases to diagnose and treat (or at least give a referral to a psychiatrist) may have been partly due to the ways the women presented their symptoms. Their complaints centered on somatic symptoms, and they tended to explain their distress in terms of domestic or personal (psychological) worries (see also Lock 1993:222). However, because several psychiatrists pointed out to me that Japanese men mainly complained of physical symptoms, I knew that this style of symptom presentation was not unique to women. It often made me wonder if these women's "depression" might have been more easily spotted if they had been salarymen, who simply complained of being unable to get up for work in the morning. And if symptoms presented largely as a *private* matter may lead doctors (and others) to consider them with less urgency than with men's pain from overwork (and resulting non-productivity) which has a certain moral as well as economic significance. Apparently, what is at play here are cultural constructions of gender, and the differential value put on business (public) versus domestic (private) work.

b. Turning the psychiatric encounter into a site of power struggles

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[94] Note its similarity with the ICD-10's notion of autonomic dysfunction (a somatoform disorder not included in DSM-IV but common in many other parts of the world because it includes many common somatic symptoms related to anxiety and depression or physiological dysregulation).

Frustrated by the medical inattention, some women engaged in a long search for a psychiatrist who would understand their pain. While most women certainly had a congenial relationship with the current psychiatrist who introduced them to me, they did not hesitate to express their criticism of doctors. I remember being taken aback by the harsh tone of a seemingly docile housewife, who said: "My doctor listens to me all right but to what extent he really understands I have my doubts. I wish he could experience this pain himself so he would know how awful it is." This expression of a distrust of doctors was striking in its gender difference: whereas few men discussed having done an extensive search for a doctor, some women turned this quest into an all-consuming endeavor (cf., Whyte 1997, Janzen 1978, Garro 1994). Such was the case of Nagano-san.

Nagano-san, 49 at the time of the interview, and married with a child, is a stylishly-dressed librarian, who has been working for the city library system since graduating from university. Her depression began five years ago, she said, right before she was to be promoted to a managerial position. She was transferred to the library's administration, where the nature of her work changed drastically, and where she found her colleagues difficult to work with. Nagano-san was quick to add, however, that work was not the only problem. She said that on top of going through what she thought was an early sign of menopause, she was having marital problems ("I had an affair"). As she began to get the shakes at work, lose concentration and spend many nights sleepless, she decided to seek out an authority in psychosomatic medicine. The doctor, an old man, asked her what she thought the problem was. She told him about her problem with her husband, and how their "personalities were incompatible." Nagano-san was confounded when the doctor immediately scolded her: "You shouldn't be saying things like that," and began preaching and moralizing. Given the diagnosis of a disorder of the autonomic nervous system, she continued to suffer under his care, while people

around her assumed that her ailment was nothing serious. The second doctor she met bluntly declared: "Your problem is a marital problem," as if that was all there was to it. As her condition deteriorated, she knew that her problem was not that simple and stopped seeing this doctor after a few consultations. The third doctor she saw for a few months "fluctuated in his decisions according to [her] mood." He would prescribe whatever increased amount of medication she requested, and she ended up suffering terribly from side effects of the heavy doses, including a dry mouth, nausea, and constipation. Nagano-san had no idea how long it would take to be cured, or what goals she should be striving for. Growing desperate, she "even went to see a fortune teller," before she met Dr. Tanaka, whom she had been seeing for the last five years.

Doi Takeo, in his highly-acclaimed *The Anatomy of Dependency* (1973), demonstrated the positive values attached to dependency ("amae") in Japanese relationships and argued that the desire for mutual dependency and interrelatedness constitute the core of the Japanese self. Given this reputed importance, it is interesting how these women (who persisted until finding the right psychiatrist) emphasized their ambivalence about being dependent on medical professionals. Whereas depressed Japanese men appeared comfortable in their role of being submissive patients, these women questioned and often resented such paternalism. A number of women recounted how they were encouraged by their psychologically-minded, seemingly empathic doctors to become dependent (amaeru) on them, and how they ended up feeling betrayed in the end. For example, a thirty-year-old woman who, after graduating from an elite university, mainly stayed home because of her depressed state, described the nine doctors she had seen and how her "trust" was almost always "betrayed": "I think it's better not to tell them bad things that have happened. What you say comes back to haunt you...and you get hurt in a weird kind of way." Nagano-san spoke most eloquently about the intricate dynamics of power in psychiatric

encounters. She said she trusted Dr. Tanaka because "he never tried to create an absolute relationship, where I would become dependent on him":

> You know how psychiatrists try to control patients; patients crave it as well because they want to get better easily. But if you get a piggyback ride, then the next thing you want is to be cradled in his arms. Dr. Tanaka avoided that; he never stepped into the core of my being.

Characteristically, these women's "depression" was long in healing, in part, no doubt, because the causes –and associated meanings—remained uncertain to the women themselves. Even under Dr. Tanaka's care, Nagano-san's depression remained severe for years. She continued to lack any sense of reality, good judgment, or any desires. Though she hung on to work, she would, on the way home, blankly stare at the shelves of the supermarket unable to choose anything, and come home only to eat and sleep. She knew she had been excluded from a list of managerial candidates, and she took a year off and spent a few months in the hospital. When she was beginning to find comfort and ease in the life in the institution, Dr. Tanaka drastically reset the course of treatment by asking her what the most important thing in her life was: "Then I realized that it was work. If they had taken away my work from me, I would have lost the ground under my feet." They together planned out her return to work, which was made difficult by the lack of cooperation from her bureaucratic supervisors, who refused to work with Dr. Tanaka's rehabilitation plan (they ironically cited her "privacy" and "human rights" as the basis of their non-involvement). Even after her return to work, Nagano-san was "very low-energy at work, and sleeping most of the time at home." This lasted for years, until a year previously, when she began to feel energy welling up inside her, like an empty vase being filled with water. "The world, which was monotonous for years, came alive with vivid colors." Her

family noticed it, as she was beginning to talk and laugh again.

c. Women's recovery

Despite their different experiences up to this point, some women sounded strikingly similar to the men discussed above when they talked about their recovery as a process of coming to terms with their own limitations. Endo-san, the nursing director, said that through depression she was released from her "self-imposed pressure" (kioi) and was now able to "let things go, naturally." Nagano-san, through her long struggles for recovery, gained the "unexpected benefit" of depression. She used to be "a bit of a perfectionist," difficult to deal with, she said. Now she was much more easygoing, cheerful, with more friends than ever. She had found a way of getting along with her husband, and was much closer to her son:

> Recovering from this illness, I came to accept my own limitations. I've become free and live with the fact that I am quite helpless. I've gained the freedom by accepting my imperfections.

Though it took her years to recover, Nagano-san said that it was the length of time she needed: "My ailment had accumulated over the years. It was all the longstanding problems finally coming out at once." In a slightly different tone, Yatsuhashi-san, the aforementioned part-time worker, told me that she often wondered why she became depressed when she did. She had had an unusually difficult life history as a single mother after she left her abusive and violent husband. Enduring the stigma of a divorced woman at the time and juggling various part-time jobs day and night, Yatsuhashi-san brought up two sons on her own. Thus it was all the more puzzling for her why depression had begun only

after she met her second husband and started a stable life. When she was at the bottom, feeling suicidal, Yatsuhashi-san found solace in her brother's words that depression was an embodiment of all the suffering she had endured over the years (note how her words also resonance with the premodern notion of *qi-utsu*: see Chapter 2):

> My brother said to me, "I'm not an expert but I think what happened is not just a matter of today or yesterday. It's an accumulation of things you have gone through....So there is no way that [depression] can be cured in a year or so – it might even take five or ten years. You can't rush it if it would take twice as long as the years you had (suffered).

His acknowledgement of her depression as epitomizing her suffering—and the fact that she had persevered beyond all the hardships—apparently supported her fragile process of recovery.

d. The question of escape

If the life of salarymen is so highly structured and rigidly defined by work that they can barely envision a recovery from depression outside that system, some of the younger women, who had yet to establish their place in their careers, were tormented by the fear that their depression might be a form of escape. Nagano-san said she was able to return to work because Dr. Tanaka "cut off all the escapes." She said she might have remained, like other people she knew at work, one to "seek a psychiatrist and escape into her depression" and "become united with [her] illness." More than men (for whom work was inevitable), women discussed work as a matter of choice as well as a place of self-actualization, and thus, ironically, their ability to work effectively was all the more invested with the

meaning of their social identity. Perhaps that was partly why some women seemed torn between their desire to have their "depression" legitimized and their doubts about the nature of their ailment. This was the case with Aoki-san, who was in one of the first generations of women to get a job after the implementation of the Equal Employment Opportunity Law of 1985, which urged companies to end the quite common practice of setting restricted career tracks and implicit rules of early retirement (often for people in their twenties) for their female employees. As with many women of her generation, she entered the workforce full of aspirations and expectations for her career, when a mysterious ailment began to torment her.

I met Aoki-san, a thirty-four-year-old woman, at a psychosomatic clinic in Tokyo. Aoki-san's first job was at an extremely busy publishing company, but she enjoyed the intensity of the work and aspired to become like the experienced senior female staff in the office. Months after she started working, however, Aoki-san began to experience pain in the back of her eyes and excruciating headaches. She visited various doctors in neurosurgery and internal medicine and received various treatments, including "nerve block," none of which worked. Urged by her parents to quit work, she decided to stay home and seek out a cure. Given the diagnosis of autonomic nervous system disorder with no prospect of recovery even after a few years, Aoki-san became so despairing that she "even went to see a man who was selling chlorella therapy (a kind of a supplemental therapy with a dubious scientific basis)." She was almost driven to believe him, she said with a laugh, when he told her that she needed to go through a "purification ceremony" for the ancestral curse that was causing her pain.

> All the while, I was tormented by the feeling that I was being left behind (by others). I kept thinking, what will I do when I turn thirty? and I almost felt

like killing myself. I had a boyfriend I could have married and had a stable life with, but I did not want to.

Uncured yet desperate to get back on her career track, Aoki-san said she still "could not admit that [her] problem might be mental" because she always regarded herself as being a "mentally strong person." When she was referred to a psychotherapist, Aoki-san remained doubtful of the effect of a "talking therapy": "This doctor seemed to think that I would recover if he listened to the anguish of my heart (kokoro no nayami) and pointed to the psychological problem at the root. He wasn't concerned with the pain I was suffering at that moment." It took her nearly five years, she said, before she was able to accept others' advice and went to see a psychiatrist. She was diagnosed with "masked depression," prescribed antidepressants, and her pain "miraculously went away." Finally, with a bona fide diagnosis, she said she felt "vindicated," especially before her father and her brother, who had long insinuated that she was simply being lazy: "They didn't take my pain seriously until then, but they believed what a specialist said." She was now seeking *kanpô* (traditional herbal medicine) at the psychosomatic clinic partly because she wanted to marry and have a baby once off antidepressants, but also because she lived with the fear of being fired from the small editorial company she was currently working for after finding a clause in the work contract stating the mentally ill were not employable. (Other women I interviewed at the clinic also told me that they had sought out this clinic because they wanted to use to *kanpô* to "change [their] constitution" as a more fundamental cure for their depression.) The idea that the psychiatric medication cannot change one's self but that the traditional medicine can is something that repeatedly came up in my interviews. While there is no discourse in Japan about how antidepressants might change one's personality, some people explicitly seek out traditional medicine with the hope of strengthening their constitution, which would consequently change (or so they believe) their personality as well.

Even with the legitimacy of a diagnosis, Aoki-san found herself wondering where to draw the line between a "real illness that required medical attention" and what was "only a headache." The thirty-year-old woman who stayed home after graduating from an elite university talked about her frustration with not having made anything of her life and expressed doubt about the nature of her own illness: "I don't know if I became sick because I wanted to become sick and so created the illusion that I was sick." Similarly, a thirty-one-year-old woman, who had to abandon her dream profession (she had always wanted to become a nurse) while battling with bipolar disorder, spoke of the ambiguity of depression: "There is a core that is depression, but there are many gray areas around it, like feeling down, being socially withdrawn, not being able to get up in the morning, and being unable to go to work." Given the polymorphic symptoms and the lack of a ready diagnosis, these women keenly feel the strain of the uncertain nature of their "depression."

These women's uncertainty may also have been intensified by the doubts that psychiatrists expressed over the authenticity of their depressions. During the years I did my fieldwork, I often encountered psychiatrists being frustrated with the increasing number of people coming to see them for what they dismissively called, "self-proclaimed depression" (*jishô utsubyô*). Psychiatrists working in the 1970s have previously discussed similar types of patients increasingly seen in clinics, whose illnesses were said to differ from traditional types of endogenous depression (see Chapter 5: also see Arieti 1974 for a discussion on "the claiming type of depression"). They named such depressions: "escaping depression" (Hirose 1977) and "immature-type depression" (Miyamoto 1978). The patients they discussed at the time were often young salarymen, whose depressions seemed only to worsen when they had to work (see Chapter 5). With the introduction of SSRIs and a new wave of depression patients in the 1990s,

psychiatrists were again confronted with the question of who had a "true depression." One frustrated psychiatrist even wrote a whole book on what he termed: "mimic depression" (*gitai utsubyô*) in order to make people aware of the distinction between a true depression and a mere depressive state (Hayashi 2001). While psychiatrists often problematized the personality of the latter types of patients, such discourses were, it seems to me, dangerously moralizing. Particularly for stay-at-home, unproductive women, diagnoses lacked the moral certainty of the "true depression" of overworked salarymen. And lacking the culturally dominant terms to articulate their plight, women did not, and could not, discuss their pain as a public product of structural injustice as men did, but attributed it largely to private matters. Their ambiguous social status –poised between the private life of domesticity and public life of work—may well have been both the cause and the result of their "depression."

The struggles of the young women discussed here may be a prefiguring of what is more broadly to come for all Japanese, however, who face increasing uncertainty of their place in the work force. Lifetime employment and the seniority system, which had characterized the postwar employment system and set the basis of public life, have begun to crumble. Younger people are facing the risk of unemployment in the emerging society, even if this means they do not have to endure the suffocating sense, as the older generations did, of being bound to an organization that seeks to act as their benevolent family (Dore 1958; Rohlen 1974a). Younger women caught in this transition cannot seem to settle for a kind of quiet resignation and acceptance of their place in society. Their experience of depression remains intricately intertwined –and invested—with the question of their professional identity, and the family no longer seems to serve as the major source of psychological fulfillment. Thus, while they engage in a search for a cure in the ever-expanding network of psychiatric help available for their "depression," they often remain uncertain of what kind of "cure" this might

ultimately bring.

IV. Conclusion

This paper has illuminated how medical and social recognition of certain suffering –or lack thereof—shape gendered experiences of depression in Japan. In terms of the causes of their ailments, men, on the one hand, explicitly pointed to the contradictions and injustice in the economic and social systems, thereby linking their personal ailment with a recognizable form of collective pain. On the other hand, women, while reflecting on their sense of hopelessness, rarely seemed to link their suffering to the recognized structural causes of depression. In terms of their recovery, men recovered while submitting themselves to the familiar, protective, if paternalistic, relationships with a psychiatrist. In contrast, women often expressed skepticism, even resistance to the psychiatrists, who tried to cure them by fostering dependency. Women's sense of powerlessness is thus reinforced in the clinical encounter, and their quest for the right doctor becomes a way of gaining a sense of control. Yet such a struggle may turn out to be self-defeating when these women are labeled as suffering from a psychosomatic illness, or even worse, having a "problem in their personality." In this regard, the experience of depression –as well as the kind of reflexivity that it brings—takes on different forms according to gender—not because Japanese women suffer more than Japanese men or vice versa but because the nature of their social suffering is structured differently.

What underlies the gendering of depression in Japan is the dichotomy between the socially legitimate "overwork depression" of salarymen and the socially and morally ambiguous nature of "the depressed state" of the housewives or the young women. This seems to be a variation on the old themes commonly debated

in the history of depression: the question of whether the cause of the ailment is excessive labor or idleness. A depression expert, when referring to the popular discourse about depression in Japan, hinted darkly: "There are two sides to that story (omote to ura)." What he meant is that while depression is supposed to be an ailment of virtuous victims (diligent and hardworking), depressive patients also include people who "simply want to escape." While such desires for escape may well equally be an expression of a certain kind of pain, such pain remains, after all, impossible to objectify, and its meaning belongs more to the realm of moral discourse.

The moral meaning of depression is becoming more uncertain than ever, as more and more women and other non-traditional demographic groups (such as young people out of work) are being treated by medical professionals for their "depression." The American-derived notion of major depression is already broadening the range of patients that psychiatrists now diagnose as depressed, and as a result, many of the "depressed" women who would have gone undiagnosed before are now more likely to be seeking *and* receiving medical care. Images of depressed women are being disseminated through pharmaceutical advertisements and public lectures by psychiatrists, and lay people are also becoming much more accustomed to articulating their everyday distress as depression. Given the governmental campaign for the early detection and prevention of depression, psychiatrists are also beginning to adjust their ideas about what depression is, which people are most affected by it, and how one should recover from it. This means that most of the women's experiences discussed here may well soon be stories from the past. While such a change will likely make women more aware of their distress, whether or not this will bring social recognition of their pain, or perhaps end up silencing and fragmenting their dissent by simply urging them to take pills is a question that needs to be carefully examined in the years to come.

Chapter 9: Advancing a Social Cause Through Psychiatry: the Case of Overwork Suicide

I. Overwork suicide

In Japan in the 1980s, the term *karôshi*, or death from overwork, was coined to describe people who literally work themselves to death. In the late 1990s when Japanese began to see suicide rates skyrocket, another term emerged in the media as a national concern. This was *karô jisatsu*, or overwork suicide, and it refers to the suicide of people who are driven to take their own lives by excessive overwork (Kawahito 1998). Concern with this problem has become more pronounced since the Supreme Court ordered Dentsû, Inc., Japan's biggest advertising agency, to pay to the family of a deceased employee Ôshima Ichirô,[95] the amount of 168600000 yen (approximately US$1,500,000). The Supreme Court determined that the cause of Ichirô's suicide was clinical depression, and that his depression had been produced by long and excessive overwork (Asahi June 23, 2000). After the precedent-setting verdict, a number of similar legal victories followed (e.g., Asahi September 27, 2002; April 1, 2005; also see Daily Yomiuri October 11, 1999, Amagasa et al. 2005). In the meantime, the suicide rate continued to soar—more than 30,000 recorded victims every year between 1998 and 2004 (except for 2002, when it was just under this number). This indicates that for 7 consecutive years the number of people who have taken their own lives is 3 to 4.4 times greater than those who die in traffic accidents. Alarmed by the figures, the Ministry of Health, Welfare, and Labor has begun to implement some important policy changes, beginning with the treatment of the mentally ill in the workplace (Kôsei Rôdô Hakusho 2004, Asahi August 10, 2001). Furthermore, in 2005, the House of

[95] Hereafter referred to as "Ichirô." It is customary in such legal documents to use the first name so as to avoid confusion with other family members with the same last name.

Councilors passed a resolution for making an official request to instill a national suicide prevention system. The resolution declares that suicide "should not be reduced to an individual problem but be seen as a social problem" (Asahi July 16, 2005).

Indeed, suicide has long been a battleground for arguments for and against social causality.[96] From the early 1900s, Japanese psychiatrists such as Kure Shûzô asserted that suicide be seen as a matter of individual pathology (see Chapter 3-5). He criticized the Japanese popular idea that social predicaments drove people to suicide and claimed that the true cause lay in these people's diseased brains (Kure 1917). Though postwar psychiatrists had a reserved stance towards such genetic determinism, some even advocating social causes (Katô 1953, Ôhara 1975, Inamura 1977), psychiatrists' tendency to explain suicide in terms of mental illness had rarely had an impact on the way Japanese had thought about suicide over a century. This seems to be fundamentally changing since the 1990s, when the series of overwork suicide cases brought about a new awareness both in the government and the popular media. Psychiatrists and lawyers involved in overwork suicide cases have argued that suicide is not a matter of individual will and intentionality—as the cultural view would assume—but rather needs to be understood as an unfortunate consequence of mental pathology. Yet, where their argument clearly departs from the traditional pattern of medicalizing suicide is the fact that they are using the psychiatric argument to argue for its social cause. Some of the psychiatrists actively involved in the overwork suicide cases are directly influenced by the antipsychiatry era of the 1970s, and together with socially-oriented lawyers, they are changing the way Japanese have thought about suicide. By arguing for the pathological mechanism of suicide, they are directly

[96] Note that it was in a dispute over the psychiatric argument of Esquirol (the originator of the modern notion of depression) that Durkheim advanced his social theory of suicide.

asking how the corporations—and Japanese society itself—should take responsibility for these people's deaths (Kawahito 1997, Segawa 2001, Asahi June 21, 2000).

In order to understand how psychiatry—which has been accused of individual reductionism—had come to be employed as a tool for advancing a social cause, I observed the proceedings of several overwork death/overwork suicide court cases at the Tokyo District Court, and attended conferences and a series of study groups held by the lawyers and psychiatrists involved in such cases. I also interviewed a number of psychiatrists at various medical institutions about their views on depression and suicide and conducted archival research on both psychiatric and legal papers on overwork suicide. In the first section, I will describe the history-making Dentsû Case, which established the social etiology by drawing upon psychiatric arguments. Second, I will illustrate how the government has responded to the social argument of suicide by introducing new ideas about "stress" and about "depression and suicide." Third, I will examine the responses from psychiatrists and how they remain deeply conflicted over the conceptual transition from genetic determinism to social etiology. I ask, in the end, what may be the consequences—and problems—of advancing the social cause by way of the medicalization of suicide in Japan.

II. The Dentsû Case – How lawyers established the social cause of suicide

The Dentsû Case verdict at the Supreme Court was undoubtedly a triumphant moment for social psychiatry as well as for workers' movements (Fujimoto, T. 1996). As one of the plaintiff's attorneys, Kawahito Hiroshi says, for families to take such action against the employer for the suicide of their loved ones was almost inconceivable in the early 1990s. When people heard about their litigation,

they would ask if it was the company, not the family, that was suing for the damage caused by the employee's suicide. Things have changed since then, and the verdict has also sent a powerful message that suicide is a psychiatric problem. When Japanese heard in the media of the plaintiff's initial victory at the Tokyo District Court in 1996, many came to hear, probably for the first time, that suicide could be caused by a mental illness called depression and that such an illness could affect anyone.

In the discussion that took place during the Dentsû case (see Fujimoto T. 1996, Fujimoto S. 2002), it emerged that Ôhima Ichirô, twenty-four-year-old at the time of his death, joined the company in 1990. He showed no abnormalcy in the medical examination taken two months prior to employment. He was healthy and athletic, and his personality was cheerful, honest, and responsible as well as tenacious and thorough. He was assigned to the Radio Department and eventually was put in charge of public relations for dozens of sponsors. On his usual working days, he would leave home by eight, commute for an hour, and spend the normal working hours dealing with clients and production companies. Because the daytime was taken up with such dealings, it was only after eating dinner at seven that he could start tackling other tasks such as drafting proposals and researching new projects. Ichirô was given positive evaluations by his bosses for his high incentive and enthusiasm. His tasks and responsibility gradually increased, and by August 1990, he began to come home past midnight or even spend the whole night in the office. In March 1991, his boss, having heard of Ichirô's all-nighters, urged him to go home at night. His workload was not reduced, however, with no new hires for his section that April. By the summer of 1991, his boss noticed that Ichirô seemed despondent, lacking energy, looking pale with an unstable gaze. Ichirô himself told the boss at the time that he was feeling a lack of confidence and was unable to sleep. Preparing for a big summer PR event, Ichirô, weeks prior to his death, was working even longer hours, staying in the

office all night every four days. Around this time, he was heard making pessimistic utterances such as "I'm no use," "I'm no good as a human being." On August 23, Ichirô came home at 6:00 am, only to leave again at 10:00 am to head for Nagano, where the PR event was to take place. During the drive to Nagano, his boss noticed Ichirô's strange behavior: he was weaving while driving and talking about a "spirit" possessing him. After spending the next few days at the event and seeing it to its completion, Ichirô left Nagano on August 26, and reached home the following day around 6:00 am. He called in sick at about 9:00 am, and within an hour hanged himself in the bathroom.

In establishing that Ichirô's death had been a result of overwork, the plaintiff's attorneys had to clear three points of dispute: a) the level of stress; b) the presence and the nature of his depression, and c) the nature of his suicide. First of all, the plaintiff's attorneys had to demonstrate the severity of the stress by showing how many hours of overwork Ichirô was engaged in. This seemingly straightforward task proved to be difficult when they looked into Ichirô's self-reported hours of work. According to this report, Ichirô's overtime fluctuated between 48 and 87 hours per month, and seldom went over the limits set up by the labor union at Dentsû. This clearly contradicted the testimonies indicating that Ichirô spent many nights in the office, even coming home at 6:30 am only to leave for work again at 8:00 am. The reason for this gap was because it was customary for Dentsû workers to under-report the actual overtime they had done (this practice in Japan is commonly referred to as "service overtime"). The plaintiff's attorneys therefore resorted to the building security reports by night guards, who kept the record of the times and the names of the employees who were still within the building at the time of their routine patrols. Based upon these reports, the attorneys calculated that the actual overtime Ichirô spent at night was 147 hours per month. This meant that Ichirô was in the office for double the amount of time of his normal working hours (the total makes an astonishing 3528 work hours per year).

The defence argued that: a) Ichirô's workload was not necessarily more than that of his colleagues; b) Ichirô must have spent these hours doing other activities; and c) Ichirô must have avoided going home for personal reasons. However, the judges added in the fact that Ichirô's daytime was already filled with scheduled meetings and communications with sponsors, which left him little choice but to stay up to finish his job. Considering that Ichirô was pressured by his boss to keep deadlines, the judges concluded Ichirô's consequent overwork was done under "general and comprehensive orders" from the company.

Second, having established Ichirô's stress from excessive overwork, the plaintiff's attorneys then had to prove that, as a result of overwork, he began to suffer *depression*. According to Fujimoto Tadashi, one of the plaintiff's attorneys, this seemingly "commonsensical idea" –that too much stress may cause mental illness—turned out to be extremely difficult to prove when they resorted to psychiatric theories for explaining such a mechanism (Fujimoto, T. 1997:162).[97] Ichirô never consulted a psychiatrist while he was alive, and the defendant asserted that Ichirô never suffered depression, that fatigue does not cause depression, and that he killed himself because of the failing relationship with his girlfriend. The plaintiff's attorneys, however, sought out psychiatrists' expert opinions and proved that Ichirô was, by August 1991, exhibiting typical depressive symptoms such as despondency, low energy, and pessimism. The attorneys particularly relied on the expert opinion of Dr. Kaneko (the then-current director of Matsuzawa Hospital), who cited German psychiatrist P. Kielholz in arguing that Ichirô suffered "fatigue depression" caused by the long-term chronic fatigue, sleep deprivation, and work stress (see Chapter 5). The plaintiff also pointed out other psychological stress caused by the inhumane work culture at Dentsû. They cited, for instance, how at one drinking party, Ichirô's superior

[97] Fujimoto died before the Supreme Court verdict came out.

poured beer in his own shoe and forced Ichirô to drink out of it, hitting him when Ichirô refused to obey his orders (Fujimoto T. 1997). Illustrating how Ichirô was gradually driven to the edge physically and psychologically, the plaintiff successfully demonstrated that the work stress produced his depression.

Lastly the dispute remained over where the responsibility lay for Ichirô's *suicide* – whether or not Dentsû could have foreseen such a risk and how much the company—as opposed to the worker himself—should have been responsible in managing his health (Asahi March 29, 1996: Segawa 2001). As a legal scholar, Okamura, points out, companies had rarely been held responsible for a worker's suicide because in Japan the legal definition of suicide itself had been based upon the idea of "intentionality and free will" (Okamura 2002). Public administrators had also assumed suicide to be, in principle, an "intentional and deliberate" act of killing oneself, and thus outside such compensation coverage (Hanrei Times 1998). The rare cases in which worker's compensation was granted were when suicides happened as clear accidents on the job. These included a case of a truck driver who caused a crash and impulsively committed suicide from the (false) belief that he had killed someone. In such cases, the deceased are judged to have been in such an extreme psychological state (called "non compos mentis") that they were driven to the act without fully comprehending its consequences.[98] In the Dentsû case, however, because Ichirô had not seemed to be in such a psychotic state prior to his death, the question remained if his suicide was of a pathological nature or done out of freewill. The Supreme Court determined that Ichirô's suicide was a result of his reactionary depression by accepting the plaintiff's argument that it was caused by chronic overwork. In the verdict, the judges even venture into

[98] Such psychological states are called "non compos mentis" and include the condition of a) stupor (clouding of consciousness); b) delirium tremens (stupor accompanied by psychomotor agitation); c) psychotic/dissociative state accompanied by xenopathic experience (governed by hallucination and delusion or severe depressive state): see Kuroki 2002.

Ichirô's psychological state before his death, and point to the significance of the fact that Ichirô killed himself on the morning right after the completion of the important project. The verdict states that the project completion suddenly relieved him of the psychological burden (kata no ni ga orita), while this at the same time created in him the dreadful anticipation (and despair) for the kind of life that awaited him from that day on. The judges concluded that Ichirô thus committed suicide impulsively and accidentally, under the influence of depression that had affected his way of thinking. The Supreme Court pointed out Dentsû's negligence in having taken no concrete measures to adjust Ichirô's workload even after his superiors became aware of his deteriorating health. As legal scholars have emphasized, the Supreme Court verdict was intended as a public warning for employers to be responsible for not letting their employees' stress accumulate beyond a reasonable limit and for protecting their mental health at the workplace.

III. The emerging system for protecting workers' mental health

a. Creating the new guidelines

The rising number of such lawsuits led to the establishment of the new guidelines of mental health in workplaces (see Kuroki 2003). After the Dentsû verdict, the Ministry of Labor became increasingly concerned with the fact that juridical decisions were directly challenging and overruling the decisions made by its Labor Standard Inspection Offices. For instance, the very first application for worker's compensation for overwork suicide had been submitted in 1989 by the wife of a (metal) press operator who died from hanging himself (see Nikkei March 12, 1999; Nishimori 2002). The man was routinely working till 2:00 am or 3:00am, only to return to work after a short nap at home. In fact, his overwork

time –90 to 150 hours per month—had been so excessive that his company even arranged to have part of his salary paid to his wife's bank account so as to avoid officially violating labor regulations. Though he had talked about quitting the job, his strong sense of responsibility kept him at work, especially after he was promoted to the unit leader. (Note that people who kill themselves from overwork are often regarded by their peers and superiors to be highly responsible and dutiful. Some even leave a suicide note with minute directions for unfinished work and with apologies to their company for not having done better: Kamata 1999). Left with small children, his wife filed the application for workers' compensation for his suicide, but heard nothing from the Inspection Office for years. When she finally did in 1995, it was to be notified that her request had been turned down (as it was revealed later, despite the fact that psychiatrists consulted diagnosed his death as having been caused by overwork). The wife decided to take the Inspection Office's decision to court, finally winning the compensation in 1999 after a long battle (Nikkei March 12, 1999). As similar legal decisions followed, it was apparent that there was an undeniable gap between the governmental policies and juridical decisions, and the government was under increasing criticism about the lack of transparency in the process of granting workers' compensation. And for other families who were making such legal actions, overwork litigations have become a way of finding out how their father or husband had been driven to such extreme mental state and reaching the "truth" about their death (Fujimoto T. 1997, Kawahito 1996, 1998).

b. Standardizing stress

In response to the amounting public criticism, the Ministry of Labor in 1998 solicited legal scholars and psychiatrists input and set up a special committee in order to create a new standard for approving workers' compensation for the

mentally ill (Asahi 1998), which was issued and distributed to all the Labor Standard Inspection Offices nationwide in September 1999 (Monday Nikkei December 27, 1999). The guidelines on mental illness caused by psychological stress at work give a flowchart and tables to aid the examiners to measure workers' stress and determine the causal relationship between overwork and mental illness. For compensation to be granted in a case, it has to be demonstrated that: 1) the employee suffered mental illness; 2) there was strong (psychological) stress at work within half a year before they became ill; and 3) their mental illness was not caused by non-work-related stress or personal reasons (and that they do not have a previous history of mental illness and alcoholism). Having met these conditions, the level of the stress that workers were exposed to is measured according to the newly created Stress Evaluation Table (Okamura 2002). This table lists 31 items respectively both for work and non-work-related stressful events. Work stress includes categories such as: 1) accidents and disasters; 2) failures and excessive responsibilities on the job; 3) change in the quantity and quality of work; 3) changes in employment status; 4) changes in job roles and ranks; 5) troubles in interpersonal relationships; 6) changes in interpersonal relationships. Each item under these categories describes a specific event, which is given a predetermined number of points. For example, the events that are considered the severest stress and thus given 3 points (the highest score) include: having a major injury or a traffic accident, or making a big mistake on the job and being forced to quit work. The events given the lowest point (1 point) are: promotion; a change of boss; trouble with a client, and increase or decrease in the number of subordinates to oversee. There is also a similar table for non-work-related psychological stress, which include events such as a death in the family (3 points), divorce (3 points), pregnancy (1 point), personal illness (2 points), financial loss (3 points), child's school entrance examination (1 point), worsening environment at home (2 points), relocation (2 points), betrayal by a friend (2 points). Adding up these points to calculate the total score for stress, the consulted expert is then expected to

determine if such stress actually led to some changes in work or in interpersonal relationships at work, and if the work stress significantly outweighed that of personal stress. If it is then determined that there was a strong level of work stress and that the worker suffered a mental illness as a consequence, then such cases are approved for compensation. This Stress Evaluation Table is supposed to standardize and speed up the process of examining each case, so that judgments can be made not only by the Ministry itself (which used to examine all such applications) but also by respective Inspection Offices (see Asahi July 31, 1999, Monday Nikkei December 27, 1999; Okamura 2002). This stress table makes it clear that the government is now ready to accept the causal link between stress and mental illness.

c. Challenging the traditional psychiatric nosology

The second change implemented—and what most shocked the psychiatrists—was that the guidelines officially abolished Japanese psychiatry's conventional nosology. Previously, consulted psychiatrists would use the traditional notions of endogenous versus reactionary depressions in determining the cause of suicide (also see Watanabe 1990). If psychiatrists gave the diagnosis of endogenous depression, then there was small chance for workers' compensation because the blame was implicitly placed on the worker's predisposition. This actually became a point of contestation in the Dentsû Case particularly in the second set of proceedings at the Tokyo High Court, when the defence lawyer drew on the authority of Japanese psychiatry to argue that Ichirô's serious and overly meticulous personality was a sign of endogenous depression. Taking into consideration the argument made by the defence that the company should not be held responsible for the worker's weak constitution, the Tokyo High Court introduced a measure of comparative negligence and reduced the original

amount of compensation by 30 percent. The 1997 verdict clearly reflects this traditional psychiatric theory of depression:

> Not everyone becomes depressed from being overworked or being in a stressful situation. The individual constitution and personality are also factors involved in causing depression. Ichirô was serious, responsible, thorough, and a perfectionist; he had the tendency to voluntarily take up a task and responsibility for it beyond his capacity. It cannot be denied that his so-called melancholic premorbid personality resulted in increasing the amount of his own work, leading to delays and inappropriate methods of managing the work, and creating situations where he worried about the outcome of tasks that were beyond his control. (Tokyo High Court 1997).[99]

Though this premorbid personality theory had been routinely applied in overwork depression/suicide cases, the Supreme Court rejected this argument and stated that personality factors should not be used as a reason for comparative negligence as long as the worker's personality remains within the expected range of variance among the group of workers engaged in the same type of work. The Supreme Court added that employers have the obligation to accommodate workers' different types of personalities and assign them accordingly to appropriate tasks. This decision challenged the psychiatrists' traditional concept of "endogeneity" in Japanese psychiatry (for the history of this notion, see Nakatani 1996; Arieti 1974, Parker 2000), which, because it is etiology-based, had served to predetermine the cause of illness before the legal decisions could be made (see Kuroki 2000a).

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[99] The verdict adds, in parentheses, "Even though, in society in general, such a [melancholic premorbid] personality and behavioral tendencies are usually regarded as virtues, and thus this point should not be overemphasized," but nonetheless used this argument for comparative negligence.

In response to such verdicts, the government adopted the "stress-diathesis" model of mental illness so that each illness can be clearly conceptualized as a product of interactions between individual factors and social factors. As well, the government adopted the ICD-10 as the standard nosology for examining cases for workers' compensation and thereby significantly expanded the range of mental illness to be considered for workers' compensation (Daily Yomiuri April 11, 1999); the guideline now includes all of those mental illnesses categorized under the ICD-10's F0 to F4.[100] This is truly a radical move (particularly for traditional Japanese psychiatrists), as the international nosology has mostly abolished the notion of assumed etiology and thus opens up possibilities for almost all forms of mental illness to be legally examined for their social cause. This has the implication of seriously challenging the prevailing notion in traditional Japanese psychiatry that some illnesses—such as endogenous depression and schizophrenia—are genetically-based (Kuroki 1999, 2002).[101]

c. Redefining suicide of resolve

Another important change—which was extensively reported in the popular media—is the way suicide was now being redefined in the guidelines (Watanabe 2002). As Okamura points out, legal scholars have long held that suicide is a matter of "intentionality and free will" and thus excluded it from workers' compensation (Okamura 2002). As discussed above, the only suicides that would

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[100] These include: F0: organic, including symptomatic, mental disorders; F1: Mental and behavioral disorders due to psychoactive substance use; F2: Schizophrenia, schizotypal and delusional disorders; F3: Mood (affective) disorders; F4: Neurotic, stress-related and somatoform disorders.

[101] But also note that the stress-diathesis model certainly does not go against a genetic basis of mental diseases, and have been criticized as being used to reinfore the genetic argument.

be considered for compensation were acts committed in an acute psychotic state ("non compos mentis") when the worker failed to comprehend the consequences of their act. If a worker left a suicide note, this was seen as a proof of mental competency and was automatically assumed to lie outside of compensation coverage, regardless of individual circumstances. The new guideline's broader definition of mental illness also brought changes in this regard. Even if workers were not severely psychotic and even appeared to be acting normally, if they were suffering some form of mental illness which affected their cognition and behavior, then such suicides can be deemed pathologically-driven. The media has emphasized this change, noting that "suicide of resolve" (kakugo no jisatsu) may be a result of depression and that the presence of a suicide note does not necessarily indicate that the person had acted normally and intentionally (Asahi July 31, 1999; also see the discussion at the Labor Committee held in the Lower House in November 15, 2000). Apparently, the long held legal—as well as cultural—assumptions about suicide were being transformed.

The effects of these changes were immediate. Over the twelve years from 1983 to 1995, the Ministry of Labor approved workers' compensation for only 7 cases of mental illness (3 of which were suicide) (Nikkei May 23, 2002). Both in 1996 and 1997, the number remained a modest 2, and then went up to 4 in 1998. In 1999, however, the number notably increased to 14 cases (11 suicide). After the guidelines came out, the number of approved cases suddenly went up to 26 (19 suicide) in 2000, 70 (31 suicide), and as many as 100 (43 suicide) in 2002 (Nikkei July 5, 2003; June 18, 2005).

IV. Further points of contestation

a. Can stress be objectified?

Even with these policy changes, the juridical world was producing even more drastic decisions, further pushing the government –and the traditional psychiatrists—to accept a broader range of social causes for the mentally ill. In the meantime, the first contestation emerged with regard to the definition of "stress." Psychological stress, like pain, is notoriously difficult to measure. One worker can feel stressed out about his or her promotion while another might simply enjoy the challenge. Also, any one individual worker may take trouble with a client more seriously one day than s/he would on another day. As psychiatrists involved in overwork suicide cases have often emphasized, psychological stress is subjective and how the worker experienced the stress remains ultimately unknowable. Despite such psychiatrists' concerns, the Ministry of Labor seemed intent to define stress as objectifiable and not as a subjective experience. Probably in attempt to avoid the slippery slope such a relativist argument could take, the guidelines are explicit on this point of objectivity:

> In evaluating the stress level, examiners must base their judgment not on how the person subjectively responded to the event...but on how the same ranks of workers (engaged in the same kinds of work, position with the same kind of experience), would generally respond to it (the Ministry of Labor 1999: cited in Okamura 2002:382).

This notion of "objective stress," however, was immediately questioned by the judges presiding over the overwork suicide case of a Toyota employee (Nikkei March 12, 1999). This is a controversial case in many ways. Though the final

verdict in 2001 was often reported in the newspaper as a "victory for the weak" (e.g., Asahi June 18, 2001; Asahi July 5, 2001), the man in question was apparently an ideal "Toyota Man." According to the verdict, the assistant manager at Toyota killed himself in 1988 at age thirty-five. He was well liked by everyone and highly evaluated as a well-balanced, thorough, serious, cheerful and easy-going person. He exhibited good leadership and was able to speak his mind while maintaining good relationships with people around him. He was also a bit of a perfectionist, meticulous, sensitive, and tended to carry the work burden by himself. He was healthy and highly athletic, having competed on the rowing team at the National Athletic Meet in high school, played rugby in college, and he climbed mountains for a hobby. A good father and a dedicated worker, he had rarely complained about work and even seemed to thrive on challenges. Yet, around the time before his death, Toyota was trying to reduce the employees' overwork hours without necessarily reducing the workload, which soon began to affect this man's life. With the pressure under the "Just-in system," where a small delay in one section could profoundly affect the whole production system, the assistant manager was working with strict deadlines. While the number of subordinates he had to oversee doubled in a short time and there was a delay in his section, the man was distressed about having to draw up a plan that he knew would be hard to meet. Around this time, he also received an order for an overseas trip to be scheduled six months later (which coincided with a deadline) and another order to serve as a chairperson for the labor union, a task that would be highly time-consuming. Two months prior to his death, his wife noticed that he was beginning to complain that he could not finish his work; he would suddenly open up a design plan on the dinner table and wake up in the middle of the night to jot down ideas for work. On August 25, he came home and told his wife that he could no longer "keep up with the Toyota way," and confessed that he had gone up to the company rooftop that day to jump off, only stopping himself when his children's faces came to his mind. That night, as his wife saw him bathing with their one-month-old daughter

and weeping quietly in the tub, she made him promise to go see a doctor the following morning. He left the apartment before dawn, however, and threw himself to death from a nearby building.

What immediately surfaced as the point of dispute was the level and the sources of his stress. Under the company policy to reduce overwork at the time, the man's timesheets did not show excessively long hours of overwork (though disputes remained as to the actual hours of "service overtime" and the time he spent working at home). Not surprisingly, the defence argued that the assistant manager's workload was no more than that of his peers and that it was his own weakness (his "melancholic premorbid personality") that was the true cause of his suicide. The plaintiff, however, argued that it is *not the quantity* but rather the *quality* of the work that should be considered, and the fact that his work had grown increasingly intense over a short period of time under the new company policy. The Nagoya District Court accepted this argument that what should matter is not how each stress is "objectively" scored—as in the Stress Evaluation Table—but how the worker himself experienced the stress. The verdict went even further in arguing that the standards for work conditions should be set to accommodate not the "average" worker—as the Ministry's guidelines state —but rather those who are "most vulnerable to stress." The verdict is explicit that workplaces should not exclude those workers who might be more vulnerable to psychological stress than others, as long as their personalities remain within an acceptable range found among the workers doing the same kind of job and having a similar age and experience. The Nagoya District Court also added that the causal mechanism of depression is yet to be scientifically proven and that the government's guidelines fail to provide a clear and sufficient standard. In so doing, the Court was urging the government to reconsider its labor policies (Asahi July 9, 2003, Daily Yomiuri March 30, 2004).

b. Whose level of stress should be the standard?

In challenging the government's definition of stress, then, the Toyota verdict also raised an important question about how much corporations—and perhaps society itself—have to change to accommodate the needs of the "weak." The dissenting government (or the Toyota Labor Standard Inspection Office) appealed to the Nagoya High Court, only to lose again on the same grounds (Asahi July 9, 2003). After their defeat, the Minister of Health, Welfare, and Labor[102] Sakaguchi Chikara made a point of appearing in the media to say that they decided not to take the case to the Supreme Court because the High Court already accepted [their] argument that the Ministry's standards were appropriate (Asahi July 18, 2003). However, the verdict is strangely ambiguous on this point; it only states that the District Court's decision that the people who are "most vulnerable to stress" should be the standard for work environments, and is in essence the same thing as the High Court's idea that the standard should be for the "average" worker (the question of who is the "average" worker has since been raised). While this issue seems to have remained, in my eyes, largely unresolved, the psychiatrists I met through the study group on overwork suicide were clearly aware of the profound implication that the Toyota verdict could have, and some explicitly criticized it and said that it had "gone too far."[103] They knew that, if this decision is to be

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[102] The Ministry of Labor and the Ministry of Health and Welfare merged to create the Ministry of Health, Welfare, and Labor in 2001.

[103] Some depression experts I interviewed complain of the simplistic model of depression that lawyers and judges use. More than one occasion, I witnessed, during an overwork suicide case being deliberated in the Tokyo District Court, how the presiding judges were asking doctors to pinpoint precisely on what date the worker's depression began (as if it were an infectious disease that has a clear moment of origin). And over the Toyota case, psychiatrists also wondered what exactly constituted the cause and effect, as some of the stressful events deemed to be the cause of his depression seemed to have occurred after the man was already manifesting depressive symptoms. Thus they have asked if these events were so stressful that the man became depressed or if these events became particularly

taken seriously, then work conditions in Japan must be fundamentally changed for a wider acceptance of the mentally ill, who had long been excluded from workplaces. This also had to do with accepting on a much broader scale collective and social responsibility for the mentally ill before asking about their individual responsibility (Fujikawa 2000, Asahi February 23, 2001).

In fact, as they see their long-held assumption about the "endogeneity" of depression being abolished by the policy change, some Japanese psychiatrists seemed to be becoming uncomfortable about how far the argument for social causality should be extended. In connection with depression, the claim for social causality apparently does not trouble psychiatrists very much partly because the depressed—or at least the Japanese psychiatric representations of depressed people —provided a certain moral legitimacy for their suffering. As we have seen, Japanese psychiatrists have long asserted that it is the personality of the ideal Japanese worker (diligent, thorough, and responsible) that is most prone to depression. By arguing that the Japanese work culture itself reproduces and rewards such a personality, to the point that workers begin to take their responsibilities too much to heart, psychiatrists see some justice in demanding corporate responsibility for these workers' suicides. However, psychiatrists tend to remain much more ambivalent about other illnesses, particularly personality disorder and schizophrenia, for which blame is implicitly placed on the individual in the diagnosis itself, in the form of assumed psychological and genetic vulnerability. Because the government's guideline adopted the ICD-10 criteria, extending the workers' compensation to most mental illnesses, psychiatrists are now faced with the inevitable question –is schizophrenia socially caused as well?

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stressful because he was already depressed (Nomura et al. 2003).

This question about personal vulnerability briefly surfaced as a potential problem over one of the first cases of overwork suicide (see Nakazono 1998). In another case, whose verdict came out about a month after the initial Dentsû verdict in 1996, one psychiatrist argued that the worker had schizophrenia and clearly stated that it was a matter of predisposition and not of work stress. In this case, the worker was Kôno Jirô, who graduated from an elite university to join a steel manufacturer in Kobe in April 1983. In December of the same year, because of his good English skills, Jirô was sent to India—near Bombay—on a business trip scheduled for two months. He was to serve as an interpreter-cum-assistant for a Japanese engineer already in India and two other staff members to arrive on January 13, who were to conduct business with an Indian company and a European company. Troubles awaited Jirô upon his arrival, however, as the Indian company's guesthouse rooms, which the Japanese staff had been promised, suddenly became unavailable. Concerned about the unexpected expenses of having to stay at a hotel, Jirô tried to negotiate with the Indian company to no avail, and his attempts to seek instruction from the Japanese office also failed because of poor conditions for telecommunication. At the time when the two Japanese staff arrived on January 13, the engineer noticed that Jirô was becoming increasingly distressed and repeatedly and excessively apologizing for the accommodation inconvenience, blaming himself though that was not his fault. On January 15, Jirô was seen blankly staring at the ceiling, acting strangely, and not remembering his (odd) behavior when asked about it later. On January 16, the concerned engineer and another member of staff decided to drive Jirô to Bombay in order to establish communication with the Japanese office and to seek medical care for him. Jirô hardly spoke or responded to questions during the drive. After checking into the hotel, Jirô quarreled with the engineer, asking him why he was trying to send him back to Japan, telling the engineer to get out of their room. That night, Jirô jumped from his hotel room on the 16th floor and instantly died.

The three psychiatrists consulted in this case could not agree upon the diagnosis. The first psychiatrist gave a diagnosis of reactive psychosis caused by work stress. The second psychiatrist stated that it was a brief reactive psychosis with depressed features and that his suicide was accidental. Notably, both of these doctors also added that the (gravity of) such stress is subjective and thus ultimately lies beyond a psychiatrist's knowledge. The third doctor, however, gave the diagnosis of schizophrenia, stating that this is a "personal illness"; Jirô's schizophrenia, he said, was not caused by work stress and that it merely triggered it (the true cause being his predisposition). The Court rejected the schizophrenic diagnosis, arguing that Jirô had shown no previous signs of delusions and hallucinations. They determined that Jirô had suffered a brief reactive psychosis or reactive depression caused by the stress of working in a difficult situation in a foreign country, and that his suicide had been committed in a state of non compos mentis. This verdict was later discussed by psychiatrists, in a roundtable discussion on overwork suicide, as one of the problematic cases where diagnoses had significantly differed among psychiatrists (Nomura et al. 2003). They brought up another case of a schizophrenic worker, which ended in an out-of-court settlement, where the company recognized his illness as having been caused by work stress. Then they raised the question of to what extent social stress can be seen as a cause of mental illness and how much individual predisposition and personality should be taken into account (Nomura et al. 2003; also see Nakazono 1998).

While at the moment arguments for the social etiology of mental illness have received much attention in the media, there have been cases— even after the Dentsû verdict—where the workers' own personal vulnerability has become an issue. Some judges have rejected claims for compensation or have adopted comparative negligence and significantly reduced the amount of compensation as a way of placing certain responsibilities on the part of the workers. For instance, in

a case of a kindergarten teacher who became depressed and committed suicide after she had already quit the kindergarten, her personality and psychological factors were given much weight. In this case, the Osaka High Court introduced an argument for comparative negligence and reduced the original amount of compensation by 80 percent (Fujimoto, S. 2002:145). The fact that "no history of mental illness" in the worker's life or in the family is stated as a prerequisite for compensation coverage in the guideline also suggests ambiguity as to what extent social causality can be argued for the mentally ill (Nishimura 2001). As Kuroki points out, the tension between genetic arguments and socially deterministic arguments is becoming more pronounced now as the distinction between "private illness"—which is dealt with as a personal and family problem—and "public illness"—for which social responsibility is demanded—begins to blur (Nomura et al. 2003; Kashimi 2001, Kuroki 2000a).

c. Who is responsible for workers' suicides?

Though psychiatrists remain conflicted and divided over social causes, they are nonetheless increasingly implicated in the social management of mental illness and suicide. Up to the early 2000s, most of the overwork suicide cases for which they were asked expert opinions, were cases where the "patients" died without having consulted a psychiatrist, for which psychiatrists could only provide a posthumous diagnosis. Now, psychiatrists are faced with an increasing number of depressed patients who seek them out in hopes they can provide a cure for their illness, or by their families who expect them to avert the danger of suicide. As well, companies, concerned with the risk of employees' depression and suicides (and of potential litigations), are also urging them to take sick leaves and consult psychiatrists. The Ministry of Health, Welfare, and Labor is also considering a revision of labor safety laws, which will make it mandatory for any workers who

work more than 100 overwork hours to be examined by a medical doctor (Nikkei August 19, 2004). There is even a move to establish a suicide prevention center, where psychiatrists are expected to play the central role (Asahi July 16, 2005). This reflects the shift in Japanese attitudes towards suicide, which has long been regarded with a certain sense of romanticism and aestheticization, but for which little practical intervention has been made (e.g., Ôchi 2001). Given such rising expectations, how do psychiatrists themselves regard their role in the social management of suicide?

It may not be an exaggeration to say that, until recently, most Japanese psychiatrists have taken a "hands-off" approach to suicide. While the biologically-oriented Japanese psychiatrists have, over a century, asserted that suicide is largely a product of mental illness, they have also been sensitive to the traditional, cultural sentiment that has regarded suicide as an act of individual free will. This ambivalence was once clearly manifested in the debate over the existential, humanistic perspectives of the 1960s and 70s, when psychiatrists asked whether the existential angst that drives people to their own deaths could be understood and treated by their biological approach, and if it was acceptable that such people's subjective vulnerability should remain unknowable. This seemingly humanistic argument was also used, however, to emphasize the difficulty of preventing suicide (also see Hanrei Times 1998). In a 1985 case, parents sued a mental hospital for having failed to prevent the suicide of their depressed son, who was hospitalized there. Echoing the humanistic discourse of the era, the judge ruled in favor of the doctors by emphasizing the "individuality" of the therapeutic relationships between respective doctors and patients:

> [Depression] is, after all, not a physical disease that merely affects partial organs but is something profoundly rooted in the depth of a person. As such,

> there is no mechanical, objective measure to evaluate mental symptoms and they can only be captured through personal interaction between the doctor and the patient. .... In essence, psychiatric practice can only exist as an expression of such individuality and the personality of the therapist (cited in Nishizono 1986:190).[104]

Such reasoning would probably not work in the current context, when depression is being discussed as a "physical disease," and suicide as something treatable by antidepressants. Not surprisingly, though, most psychiatrists I interviewed at universities and mental hospitals seemed unenthusiastic about having to treat a much broader range of patients and becoming more responsible for the prevention of suicide. This is partly because of the difficulty of the tasks involved and of the uncertainty of their own "objective" knowledge of depression and suicide (Kuroki 2000b). As one suicide expert told me, writing a psychiatric expert opinion for an overwork suicide case is almost in the realm of "story-telling," where you already have a conclusion and piece together the information and build up a case to establish either the genetic story or social story. With much of their etiological theories of mental illness still open to dispute, they have little on which to go in terms of "hard science" in making either argument. But they are hesitant to get involved because they are strongly wary of the potential criticisms they face against the expanding web of psychiatric surveillance (e.g., Ishikawa et al. 1992). Aware of such criticisms because of the long lasting antipsychiatry movement of the decades past (see Chapter 3), the government also remains highly cautious when they discuss the possibility of installing a mandatory collective mental health examination for workers as a means of suicide prevention,

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[104] There was also a similar case in 1970, when the initial victory for the family of the deceased patient was reversed in the second ruling (see Takemura & Shimura 1987:62). For a review of lawsuits concerning suicides in mental hospital: see Aiba 1987.

though this was raised in the Labor committee meeting (The 150th Kokkai 1999). There is an increasing dilemma as to what extent psychiatrists should be involved in managing mental health, as the success of overwork suicide cases are shifting the focus from asking about workers' "self-responsibility" to demanding "corporate responsibility" (Nikkei, November 8, 2004; Nakajima 2001; Amagasa 1999a, 1999b, 2005), and if such a demand for collective responsibility may in the end give rise to wider—possibly sinister—forms of social surveillance.

V. The medicalization of suicide as a form of social movement

The medicalization of suicide is thus being made possible in Japan by a social movement that does not negate the cultural argument but rather actively incorporates it. That is to say, psychiatrists involved in overwork suicide have created a kind of conceptual marriage between the psychiatric view that redefines it as biologically caused and the cultural view that asserts that suicide be seen as socially produced. The current medicalization has not (so far) translated into a kind of biological individualism, where the deceased are denied any existential ponderings and intentionality. On the contrary, the ways in which psychiatrists have gained popular appeal is by drawing upon the cultural idea that reads into suicide a meaning—as silent resistance of the oppressed. By asserting the multiple layers of explanation for suicide, it may just be possible that these families, lawyers, and psychiatrists are transforming the psychiatric notion of mental illness from something beyond normalcy to something that can extend the idea of what is normal. Through relativizing both the romanticized cultural argument and psychiatry's naïve genetic determinism, they may be rewriting what suicide means for Japanese.[105]

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[105] This form of medicalization as a social movement is certainly not particular to Japan and is increasingly found in other places, where social activists have turned to psychiatry as a way of illuminating and legitimizing social distress (e.g., the

Yet such a social movement in the form of medicalization poses certain contradictions. First of all, Japanese seem to remain largely unaware of the serious implications involved in accepting the psychiatric argument for suicide. Though the questions about individual intentionality are, for the time being, left unexplored, there is clearly a contradiction in the way the deceased are said to be so ill that they were unable to tell what they were doing and the way their families see them as having performed a meaningful social action. A quick glance at the testimonies of the families who have sued the companies and held them responsible for the suicide of their loved ones attests to this implicit duality, as they often seem to accept the psychiatric argument that the deceased was clinically depressed while still expressing the idea that their loved ones were "making a protest," by taking their own lives, against the companies that had done them an injustice. These testimonies make clear that they still find a certain level of intentionality and meaning in the act of suicide, even if they regard the immediate cause of death to be depression (see Kawahito 1998, Kamata 1999, Shinbun Akahata 2003). Such contradictions are left unexamined because of the ways in which the medicalization of suicide in Japan has proceeded largely as a result of the social and juridical forces outside of psychiatry itself, as a means of getting public recognition for social injustice. But sooner or later, Japanese will have to face up to the real implications of accepting the psychiatric argument that could seriously compromise their cultural view of suicide as an intentional act. The second problem has to do with the uncertain scientific nature of the psychiatric arguments used in overwork suicide litigations, where, as we have seen, the psychiatrists' interpretations often remain in conflict with each other. For the time being, most psychiatrists seem to find the extremity of some of the conditions in Japanese workplaces (and the societal "commonsense" that have allowed overwork suicides to have happened in the first place) as reasons to

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PTSD discourse for Vietnam veterans: Young 1995).

justify the use of psychiatric arguments about cause and effects, even if some of these explanations lack scientific rigor. As workers' compensation is beginning to be distributed more widely than before to cover the mentally ill at work, psychiatrists are now increasingly confronting the century-old question of how to tell malingerers from the true patients (Nikkei January 21, 2000, Nikkei February 13, 2002).[106] When this problem surfaces on a much larger scale the uncertain scientific status of the psychiatric theories about the social etiology of mental illness will have to be challenged (cf. Duncan 2003). In conclusion, we turn to the question of in what direction this highly localized form of medicalization might proceed and what consequences this might bring.

[106] Some psychiatrists I interviewed also remained cynical that the governmental policy change was due to the fact that the vast unused budget of the Ministry of Labor for workers' compensation needed to be spent somehow.

Chapter 10: Conclusion: De-localizing Depression

I. The local versus the global

Contrary to the rising concern that the medicalization of depression may simply be a sign of biological reductionism and global standardization, this dissertation has shown that medicalization has gained impetus in Japan because of the way it has been linked to local social movements. Turning people's private narratives of pain into forms of public language, the medico-legal discourse about overwork suicide has compelled the Japanese public to consider individual depression not only in terms of biology but also in terms of its social origins. The psychiatric language of depression was not derived from a set of established scientific concepts and economic interests, but instead is both shaping and being shaped out of the space that has emerged at the intersection of medicine, politics, and public debates (Rose 1985, Clarke & Montini 1993). Furthermore, this medicalization is being made possible by the coming together of diverse actors—not only doctors and pharmaceutical companies, but also lawyers, public administrators, and the families of the depressed—each group asserting their own vision of what depression is and how it might best be managed. Amidst competing discourses, the rise of depression in Japan thus signals the potentially subversive political power that psychiatry may take in the post-antipsychiatry era, where it becomes a means of articulating dissent, voicing collective anger, and inserting social critique.

Having demonstrated these local developments, however, I want to examine in the end the possibility that these localized notions of depression may be quickly dissolving into its universalized, biological definition. This is because the Japanese psychiatric language of depression—including its insistence on the

melancholic premorbid personality that has been behind the assertion of depression's social origins—has been receiving challenges from the rising influence of American biopsychiatry (see Sakamoto 2000). Though lawyers and depression experts involved in the overwork suicide cases have often drawn upon the traditional psychopathological notions of depression, there are increasingly large gaps between popular representations of depression and how it is being treated predominantly as a biological problem in scientific literature and clinical practices. Furthermore, younger psychiatrists, who are being trained to draw on DSM-IV or ICD-10 diagnostic categories instead of traditional diagnoses, are becoming dismissive of such a localized personality theory and seem keen to re-establish the depression concept as a universally applicable notion. Thus, despite that so much of what has popularized depression in the eyes of Japanese is due to the assertion of its social origins, this may well be a transitional product in the early phase of medicalization.

Such tension between global and local knowledge in biomedicine is a topic of serious concern among anthropologists. Examining the discrepancy between (universalizing) medical science and (localizing) clinical practices, Allan Young (1995) has shown that the first retains a largely stable core of knowledge –or a "style of reasoning"—with its set of ideologies such as objectivism and universalism, while the latter work at the level of local knowledge and remain multiple, implicit, and unstable. Psychiatric practitioners themselves often see these two as different orders of knowledge, and are not troubled about their own conflicting voices or about maintaining the hierarchical order between these two (Gilbert and Mulkay 1984). The scientific style of reasoning tells them that not all scientific facts are to be invested with the same "truth" value, and thereby provides them with a sense of order and coherence (Young 1995). Medical science further moves the data away from the realm of local, clinical practices, replacing the patients' narratives (which leave the possibility for raising contradictions)

with fragments of voiceless material bodies in the laboratory. In this last phase of bio-psychiatrization, local subjectivity may no longer matter, where the dislocation of the ownership of self-knowledge becomes complete. The question remains, then, as to how local knowledge is made to remain "local," and if there is any chance that the Japanese articulation of social etiology may be retained against the evidence of global, biological standardization.

II. Biological standardization

Biological standardization is gradually being achieved by changes in the way depression is being represented in popular media. One of the signs of such standardization is a move to de-historicize the concept. Even though it was the economic recession of the 1990s and the subsequent increase in the number of suicides that attracted people's attention, the "epidemic " of depression does not seem to be showing any sign of remission, while the Japanese economy is gradually picking up year by year. On the contrary, Japanese seem to be claiming to be depressed more than ever. No longer associated explicitly with the economic recession, unemployment, or bankruptcy, depression is now increasingly talked about as occurring in the context of everyday normal experience.

Standardization is being further achieved by psychiatrists' growing reliance on the DSM (DSM-IVR). As Japanese psychiatrists are turning to the DSM's concept of major depression, they are also significantly expanding the diagnostic criteria. This conceptual shift no longer corresponds to what Japanese psychiatrists have traditionally regarded as "depression" but expands relentlessly to include the realm of experiences that Japanese psychiatrists would not have regarded as pathological until recently. The new standardization is thus also causing conceptual conflicts, creating tension between the biopsychiatrists who are keen

to adopt the global criteria and the "traditional" psychopathologists who wish to retain not only localized theories but also a firm distinction between normalcy and abnormalcy (e.g., Hayashi 2001).

Such tension is apparent in pharmaceutical advertisements. The way depression is presented here is intentionally ambiguous and ill-defined, applicable to the widest possible population and to the widest possible range of discomforts. In one 2005 TV advertisement by GlaxoSmithKline, a young actress wearing pastel-colored attire against a comforting background of blue sky and a green field asks: "How long has it been? How long has it been since you began to worry that it might be depression?" Her question is subsequently directed to a young woman on an escalator, a middle-aged salaryman on a bus gloomily looking out the window, then to a young man standing with a neutral smile in a sunny white room. Her voice says: "How long has it been that you cannot enjoy anything at all?" which is followed by a voiceover that says: "If you have been *utsu* (depressed) for a month, do not endure it. Go see a doctor." In the advertisement's defining depression in terms of depressed mood and lack of energy, the only feature that distinguishes depression as a "disease" from an ordinary depressed mood seems to be the length of time (one month) that the person has experienced these "symptoms." The accompanying pamphlet, however, is careful to include local notions such as the melancholic personality and particular social situations as important precipitators for depression. Though there is an obvious hierarchy of information about biology, social factors, and personality, the pamphlet also includes accounts by patients who describe their depression not as an isolated biological event but in terms of life changes and social stress. While it is true that overwhelming weight is given to making people understand how depression is foremost a brain disease, psychiatric explanations are characterized by diverse viewpoints rather than being a harmonious whole consisting of a totalizing, biological account.

While the popular representations of depression are rife with uncertainty, one way in which biological standardization of depression is being quickly established is through the psychiatrists' use of statistics. Ian Hacking has shown that statistics are the technology by which unfamiliar phenomena are made to appear real and concrete—establishing them as immovable "facts"—in modern societies (Hacking 1990). Margaret Lock (1993) has further shown how statistics in biomedicine take on peculiar universality, where research findings in the West are too often assumed to be the norm, with little serious investigation into possible local variations. By proposing the notion of "local biology," Lock has illuminated how the body is not a static entity that remains homogeneous across time and space, but rather is shaped by specific historical, social, and cultural forces. Depression seems to be an obvious starting point for such an investigation (Satorius & WHO 1983, Nakane et al. 1994, Lepine 1997), yet Japanese psychiatrists seem to be quickly turning away from examining possible local differences. As I have shown, Japanese psychiatrists have frequently pointed out and discussed among themselves the meanings of the unusually high rates of depression in the U.S. –as was the case, for instance, in the first conference of the Japanese Society for Depression in 2004. Yet, such puzzlement remains at the level of the clinical, or private talk and rarely goes beyond that. When Japanese psychiatrists present Western statistics as the established, scientific knowledge to the public, signs of their uncertainty completely disappear. As Japanese psychiatrists begin to strive for the new global standard, what is happening is a familiar scene in international medicine. They are articulating their views "less through any engagement with clinical reality but primarily through the oppositional dialogics of international legitimacy" (Cohen 1995:330).

One place where local statistics should receive more thorough examination is the gender ratio of depression. I have shown that Japanese psychiatrists have long

asserted that the gender difference of depression in Japan is not as striking as it is reported to be in the West and that men may be equally vulnerable to depression as women. Based upon interviews with veteran psychiatrists and analyses of psychiatric literature, I have also suggested that the model of depression in Japan has been based upon male depression, with the possible consequences of experts giving less attention to female depression than it deserves. Alternatively, as Lock (1993) has suggested, there is also a possibility that Japanese women may have had the cultural resources that have long protected them from social isolation and a sense of alienation—and perhaps from the experience of depression itself. However, in one recent epidemiological study –conducted for the first time in a long time in Japan—Kawakami et al. (2002, 2005) have shown that the depression rates may not be so different in Japan from those in the U.S. They have interviewed 1664 people and found that the prevalence rate of depression is 8.3% for women and 4.2% for men (overall prevalence rate is 6.5%), and suggested that one in fifteen Japanese become depressed sometime in their life (these numbers are now also reproduced in the government's White Paper). These statistics urge us to seriously examine whether or not the long-held Japanese psychiatrists' clinical observation about gender was indeed just a matter of social accessibility to psychiatry, of experts' selective attention, or if the number of depressed people has itself changed rapidly of late. We may further ask, as some experts did when I talked to them, if such rates are merely a result of the new "operational diagnosis," which gives the false impression of there being a real biological entity when in fact the definition of depression itself has been significantly changed to include a wide variety of subjective complaints (this has left many Japanese psychiatrists debating the validity of such a diagnosis). Instead of exploring these underlying, conflicting interpretations, some Japanese biopsychiatrists seem to be trying to establish these rates of depression as scientific facts by erasing the traces of any local differences that result from their epistemological uncertainty.

III. Questioning the moral hierarchy of the depressed

Indeed, for Japanese psychiatrists, the authenticity of local knowledge is a constant source of tension and self-doubt —perhaps for good reasons. If one goal of modern medicine has been to de-signify illnesses of their moral implications, thereby liberating people from possible blame about their behavior or personality, then Japanese psychiatrists may have failed on this point. By presenting depression as a matter of personality (albeit a socially desirable one), they have reproduced the discourse about neurasthenia from a century ago, which first postulated this to be an illness of overwork for the diligent few, if only to reverse this moralistic argument after too many people began claiming themselves to be neurasthenic. As we have seen, such a localized personality theory has helped de-stigmatize and popularize the notion of depression at the cost of creating a kind of moral hierarchy, whereby the suffering of certain people becomes much more easily recognized than others. We have also seen how this traditional notion has led to further segmentation and classification of the depressed, whereby clinicians are describing some patients as having "self-claiming depression" and "mimesis depression" to be differentiated from "true depression." What seems to be happening at the clinical level, then, is an unfortunate result of rapid medicalization, whereby these people—many of them much more informed, guarded, and demanding than patients formerly were—may well be at risk of being classified as having atypical depression, even suspected of personality disorder. In this regard, one may even argue that the new, standardized, biological knowledge of depression might put an end to the moral implications of the traditional, melancholic personality theory in Japan (cf. Sontag 1978). Alternatively, the broadening notion of major depression may serve to reproduce what happened a century earlier with regard to neurasthenia—the further segmentation of "depression" into various forms of disease (or personality-based) categories, simply re-organized with a new moral hierarchy.

As depression becomes diversified, psychiatrists cannot seem to agree upon who the vulnerable are. While clinicians still routinely resort to the traditional notion of melancholic premorbid personality as a way of mitigating patients' psychological pain, biopsychiatrists have continued to question the scientific validity of such a notion and to ask if such a personality entity is prevalent among the depressed at all (for this debate: see Takemoto 2003). While the latter try to discard such a notion altogether, the question about who the depressed are and what kind of people they are, has already surfaced in the realm of workers' mental health. As the government and industry are beginning to intervene, there have been disputes about the potential screening out of those who may be vulnerable to depression. For now, the government is refraining from screening out these people and remains highly cautious about implementing mental health examinations as part of the mandatory collective health checkups at workplaces because of their concerns about invading privacy and violating human rights (see Chapter 9: No doubt the long-lasting antipsychiatry movement is still fresh in government officials' memory). They seem to be focusing instead on establishing psychiatric care for those who have already become depressed. However, as this system is being established,[107] and once psychiatrists figure out which people are likely to become depressed, there may emerge a new system of classification, where psychiatrists might become complicit in separating out those fit for the labor system from the unfit. Already, the government seems more keen on treating individual depression on a biological basis rather than implementing any measures to scrutinize and restructure the depression-producing work environment. One recent governmental proposal was to require companies to send their workers who have exceeded 100 hours of overwork per month to a

[107] Needless to say, the government is in the position to use workers' insurance as a form of political technology for determining who are the deserving victims of overwork depression.

psychiatrist (Nikkei August 19, 2004). The implication of such prevention measures points to the possible advent of new psychiatric "factories of correction" (Scull 1979), where workers' ailments and dissatisfaction are simply quieted by the dispensing of pills. If this occurs, then depression may indeed be reduced to individualized, biological problems, devoid of any historical, social meanings or of the possibilities that the recognition of the ailment would lead people to reflect and act upon their own sense of discomfort about the environment in which they live.[108]

IV. The consequences of identifying with depression.

We are thus urged to examine the tensions evoked by today's biomedical expansion, where people use medical technologies to enhance their autonomy and realize their desires, while tinkering with troubling suspicions about the unseen consequences of compliance and potential risks for subjugation (Lock 1993, 1998, 1999; Haraway 1997, Mol & Berg 1998). The fact that more and more individuals are claiming depression in order to demand public responsibility and economic compensation is in itself suggestive of the new political environment, whereby Japanese are having to become more informed, responsible, autonomous beings. The variety of information being poured out urging people to take care of their depression reflects an era of disillusionment, where workers are increasingly having to watch out for themselves and demand public protection when corporations may no longer provide them with the security of lifetime

[108] There seems to be little discussion about the even deeper and more fundamental implication of the medicalization—that is, the fact that the medicalization is overwriting the cultural notion of freewill and agency. Particularly given the fact that psychiatry has expanded its monopoly by claiming that the self is not only unknowable to oneself but also is capable of deceiving itself (Young 1995), there may be dire consequences in heedlessly adopting the psychiatric argument to cover a wide range of problems.

employment. Thus the increasing calls for psychiatric care for the depressed should not be naively celebrated as an advancement in health care, but has to be carefully examined in light of the legal, social apparatuses that have legitimized—indeed necessitated—the move to make the depressed the agents of their own management (cf. Rose 1990).

Yet at the same time, there are signs that the language of depression—as an experience that defies such homogenization and standardization—is serving as a generative force, as people are beginning to question—beyond the technicality of "how" to treat depression—what depression means in the context of their own lives. Already people are resorting to an ever more diverse range of therapeutic treatments, which can help weaken the psychiatric monopoly of the knowledge of depression. Even within biomedicine, the increasing influence of psychosomatic medicine (whose initiative is to overcome the mind-body dichotomy) and of traditional forms of care (including herbal medicine and various forms of qi-training) provide people with multiple explanations about how depression occurs and how it can be best treated. Some of these medical practices explicitly advise people to think of their illness as the manifestation of the accumulated contradictions in their life or of a sense of discord with the environment. The rise of support groups—both in conventional and internet settings are, as I have suggested, creating new forms of solidarity among chronically depressed workers, allowing them to question the validity of psychiatric knowledge. With such diversification, the psychiatric language of depression may generate a new space that introduces "an element of suspense, comments, and distancing" (Corin 1998b:99) against the legitimacy not only of biomedical knowledge but also of the social order that demands them to return to the status quo that produced their ill health in the first place. If global medicalization tends to resolve the ambiguity of medical concepts simply by establishing stricter criteria and standardizing the diagnoses, then the local discourses raise epistemological questions about what

the nature of the experience of depression is, and what it means to recover from it.

As well, current medicalization may come to radically liberate the psychiatric meaning of the "biological" for Japanese as a whole from its century-old adherence to genetic determinism. By insisting on how the biological is simultaneously social, this medicalization process may allow people to overcome psychiatry's negative legacy that had installed a profound disconnection between the mind and body, the normal and the pathological. Instead of envisioning depression as an isolated disease entity triggered by internal brain malfunction, this language allows people to see it as intrinsically connected to the context of their social life. As discussed in Chapter 9, the testimonies of the families involved in the overwork suicide lawsuits suggest this diversification. Many of them accept the psychiatric argument that their loved ones had been depressed, while simultaneously insisting that their suicide need to be understood as a form of protest against apparent social injustice (Kawahito 1998:40, Kamata 1999). Even though their testimonies expose a certain contradiction in the way they only partially adopt psychiatric explanations, they also suggest a possibility that there might emerge much more nuanced arguments about the nature of depression that can be simultaneously biological, psychological, and social. No longer placing the depressed beyond the realm of understanding, Japanese may be finally coming to recover the language of experience, which brings together the normal and the pathological, turning "mental" distress once more into something bodily, tangible, and familiar.

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