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## **Psychopharmacology in a Globalizing World: The Use of Antidepressants in Japan**

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**Abstract** Despite the great popularity of selective serotonin-reuptake inhibitor (SSRI) antidepressants in North America and Europe, most of these medications have not yet been introduced in Japan. This reflects the difficulty in obtaining government approval for new drugs in Japan, as well as specific social and cultural issues. The majority of patients with depression or dysphoric mood in Japan are seen in specialty medical care, complain of physical symptoms, and are treated with anxiolytic medications. Sadness and depression may be given positive social meanings as yielding enhanced awareness of the transient nature of the world. This article explores the relevance for bioethics of cultural variations in the use of antidepressants at three different levels of analysis: (i) the varieties of depressive experience as they unfold in specific cultural worlds and value systems; (ii) the narrative construction of the self; and (iii) the political economic context of the pharmacological treatment of depression. The strong interconnections of values framed at one level with those at other levels means that there are likely to be unavoidable tradeoffs between different values or desirable short- and long-term outcomes such as energy, efficiency, happiness, maturation, depth of personality, and responsiveness to social and moral predicaments. These tradeoffs challenge the assumption of universalism in biomedicine and raise questions about the consequences of our willingness to use medications to treat the myriad forms of distress that may signal fundamental problems with our way of life.

**Key words** affective disorder • culture • depression • bioethics • Japan • mood • psychopharmacology • Zen Buddhism

Newer antidepressant medications offer the prospect of regulating dysphoric mood among many people who were formerly viewed as having temperamental or character traits that rendered them shy, inhibited or melancholic. Some of these people state they 'feel like a new person' or, more paradoxically, that they have finally found their real or true self. How are we to judge transformations of the self that are caused by drugs? Is a more functional self or happier self somehow more real? Does our 'true' self have any meaning other than being the self we prefer and endorse or that others agree to hold us to?

Critics have raised the prospect of a 'cosmetic psychopharmacology' (Kramer, 1993), applied like make-up to make us look *and* feel good, while our existential predicaments go unanswered. What if it is true that we now have the chemical technology to reconfigure our brains, to 'sculpt our personalities' (Healy, 1997, p. 160), to make ourselves more outgoing, gregarious, bold and optimistic? Shouldn't we all embrace a technology that will make us larger selves? If we feel some trepidation, how does the use of pharmaceuticals differ practically or ethically from the many disciplines of the self – ancient and modern – aimed at refining our character (Nussbaum, 1994)?

This whole debate takes place against a backdrop of cultural assumptions about the nature of depression, emotion, personality and the good life. In this article I try to lay bare and challenge some of these assumptions through considering the relative lack of use of antidepressants in Japan until very recently. This cultural difference may be a temporary anomaly related to the history of psychiatry and the local development of widely available mental health services. Within Japan, as in every country, there is wide variation in belief and practice among clinicians and laypeople. Cultural change is also occurring at an extraordinarily rapid pace through the forces of globalization, so that any characterization of a cultural world is likely to be out-dated by the time it is committed to print. Nevertheless, national and cultural differences in psychiatric practice – however quickly they fade in response to market forces and the transfer of knowledge and technology – raise some basic questions about what it is that we treat when we prescribe antidepressant medication.

### **Listening to Prozac in Japan**

Hakuin Zenji used to say to his disciples: 'Listen to the sound of the Single Hand' (Miura & Sasaki, 1965, p. 44)

Antidepressants represent one of the great successes of psychopharmacology in the last 50 years. The introduction of new classes of antidepressants, particularly selective serotonin-reuptake inhibitors (SSRIs) in the 1980s – of which Prozac is the most famous – is generally recognized to be a significant advance, not because of any greater efficacy, but because they are much easier for patients to take as they have fewer side effects. These new medications are widely prescribed and reap enormous profits for the drug companies. In 2000, the sales of the antidepressants market in leading regions grew by 18 percent totaling \$13.4 billion per year (IMS Health, 2001).

Japan is an important market for pharmaceuticals. In 2001 Japanese bought more than \$50 billion U.S. worth of retail medications and this figure does not include the use of various medicines based on traditional Japanese medicine (*kanpō*; Lock, 1981). Japan also has one of the highest levels of psychiatric services in Asia with over 7 psychiatrists per 100,000 population (Tajima, 2001). Japanese psychiatry descends from German neuropsychiatry at the turn of the century and tends to be 'biologically' oriented so there is no conceptual problem with employing medications to treat what are understood as biological disorders (Kitanaka, 2000).

It comes as some surprise, therefore, to learn that until 2001 antidepressants were not widely prescribed in Japan. Indeed, SSRI medications were not even available in Japan until very recently. The first SSRI in Japan, fluvoxamine (*Luvox*, Solvay) was introduced in May 1999, and paroxetine (*Paxil*, SmithKline Beecham) was released in November 2000. Although some Japanese psychiatrists obtained SSRI medications themselves in other countries and made them available to their patients, the initial adoption of newer antidepressant agents was very slow. As psychopharmacologist and historian David Healy (2000) remarked, 'the antidepressant market here [in Japan] seems very small – it seems amazing that Prozac isn't even on the market here.' (p. 287). As of the autumn of 2001, however, the situation was rapidly changing and the combined sales of the SSRI antidepressants paroxetine and fluvoxamine had reached more than 2.6 billion Yen (about \$25 million U.S.) per month (Tajima Osamu,<sup>1</sup> personal communication, November 4, 2001). This rapid change speaks to the malleability of both popular culture and professional practice but the long lag time to the introduction of new antidepressants and widespread diffidence about their use still demands an explanation.

There are many reasons for the initial reluctance of Japanese psychiatrists and patients to use antidepressants in general and to adopt the newer SSRI medications in particular. Certainly, depression is a significant problem in Japan as elsewhere and it is likely that there are many cases in the community among people who do not seek help (Ono et al., in press; Tajima, 2001). However, there are wide variations across countries in the

prevalence of depression (Kirmayer & Groleau, 2001) and the actual community prevalence of depression in Japan is not known.

Until recently, psychiatry in Japan has been focused almost exclusively on inpatient treatment of major psychoses in private psychiatric hospitals (Munakata, 1986a, 1986b). The emphasis on severe disorders reinforces the stigma associated with psychiatric diagnosis and treatment. As a result, patients with milder neurotic or depressive conditions prefer to be seen as outpatients in general internal medicine or 'psychosomatic' clinics. Visits to outpatient psychiatry came under the coverage of national health insurance in the mid-1980s and since then the use of outpatient services has increased. Nevertheless, 'depressed individuals in Japan often do not visit their family physicians, and if they do they are often told that they just need to relax more' (Berger & Fukunishi, 1996, p. 318). Instead, they often go to internists who deal with 'psychosomatic medicine' and estimates are that about 20 percent of patients seen in that setting have depression. There they are likely to receive a diagnosis of a stress-related condition or constitutional sensitivity and be given anti-anxiety medications, primarily benzodiazepines.

Again, until very recently, Japanese psychiatrists have tended to prefer anti-anxiety drugs to antidepressants (Tajima, 2001). This reflects the salience of anxiety in Japanese psychology and psychiatry (Kirmayer, 1991).<sup>2</sup> There is also a tendency to prescribe small doses of anti-psychotic medications to patients who have borderline or schizotypal personality traits. This fits with a view, inherited from German psychiatry, of many problems as being related to specific temperaments or character types which are constitutional and which can sometimes be modified by pharmacological interventions (Kitanaka, 2000).

There are also regulatory and economic reasons for the lack of use of SSRI antidepressants in Japan. It takes a very long time for new medications to be approved by the Ministry of Health and Welfare.<sup>3</sup> This follows on past episodes in which new drugs were withdrawn when it was discovered that they had terrible side effects. At present, government regulations require independent demonstrations that the medication is safe and effective in the Japanese population. Thus, drugs must undergo a new randomized clinical trial (RCT) in Japan. However, it is difficult to conduct RCTs in Japan. Patients and their families have been reluctant to take part in any drug trial and this is compounded in the case of antidepressants because of the stigma of psychiatric disorders. Western medicines are perceived as 'strong,' harsh or unnatural, which is a problem particularly when the condition they are supposed to treat is not viewed as severe or life-threatening.

The high cost of carrying out drug trials in Japan blocks development, especially if the potential market seems small (Berger & Fukunishi, 1996).

Rumor has it that Prozac initially was not introduced in Japan because Eli Lilly considered that they could not recoup the costs of the trials and evaluation procedure. More recently, a clinical trial of nefazadone (*Serzone*, Britsol-Myers Squibb) was abandoned because of the company's pessimistic view of its potential market (Tajima Osamu, personal communication, October 24, 2001).

Of course, there is no guarantee that a clinical trial will demonstrate the drug's effectiveness. A clinical trial of sertraline (*Zoloft*, Pfizer) was unable to show a therapeutic benefit.<sup>4</sup> Similarly, buspirone (*Buspar*) was not approved because of a lack of benefit greater than placebo in two multicenter double-blind trials in Japan. There are also institutional complexities in how drug trials are carried out in Japan, so that small beneficial effects may not be detected. Collegial relationships and the small size of many hospitals mean that trials often involve many centers, each contributing only a few patients; this leads to too much intersite variation, which can swamp clinical effects (Berger & Fukunishi, 1996). As well, in some studies mildly anxious patients, for whom less benefit from antidepressants might be expected, were included in the trial along with more severely ill patients. Indeed, similar studies in Japan have failed to show effectiveness of diazepam (*Valium*) – although evidence from elsewhere is overwhelming that it is more effective than placebo for anxiety.

The use of antidepressant medication reflects physicians' judgments about which types of problems are appropriately treated by that specific class of medication. This judgment is both an empirical decision about what works and a consequence of how disorders are grouped together or related in psychiatric nosology.

Although biomedicine is based on scientific evidence about the efficacy of different treatments, in actual practice, clinical decisions involve going beyond the available pool of scientific information. Clinical practice involves a process of translating information about groups or populations into a course of action for a given individual. Empirically, drugs do not have single effects both because they usually affect several different receptor sites and because specific neurotransmitters in the brain are involved in many different functional systems, which need not correspond to any single coherent category in our folk psychology or notions of human faculties. The brain has spatial structure and connectivity that involve higher levels of organization than those captured by analysis in terms of neurotransmitter systems or receptor sites.<sup>5</sup> As a result, every medication has many different, sometimes competing or contradictory, effects and the balance of these may differ in different patients. Clinicians' impressions as to what works, therefore, are biased by their experiences with particular groups of patients and by the weight they give to the different effects of medication.

In addition to these neurophysiological facts, we need to recognize that systems of psychiatric classification are not simply accounts of natural categories in the world but reflect cultural conventions for how to group problems together in ways that make sense (Kirmayer & Young, 1999). Depression, as 'melancholia,' has a long tradition in the West as a socially meaningful category of distress – although its social and moral significance has changed radically over the years (Jadhav, 2000; Radden, 2000). Accordingly, depression occupies a central place in psychiatric nosology and the discovery of effective drug treatments reinforced that category. The recognition that many other conditions are also helped by 'antidepressants' (including panic disorder, generalized anxiety, obsessive-compulsive disorder, body dysmorphic disorder, hypochondriasis, chronic pain and many other conditions), far from challenging the definition of depression as the prototype for a core category, has led to efforts to widen the definition to cover a broad spectrum of disorders.<sup>6</sup> Of course, the mere fact that a treatment is effective for many conditions does not prove they are all related.

For Japanese psychiatrists, problems with anxiety and social-relatedness form salient prototypes for constructing families of disorders (Kirmayer, 1991). In the 1920s Morita Shoma (1928/1998) described a range of anxiety-related problems, including neurasthenia, hypochondriasis and social phobia that he felt reflected common underlying problems of excessive self-awareness (*toraware*) and effortful striving to fit in to social situations. Morita developed a specific form of treatment, modeled on the meditative practices and philosophical orientation of Zen Buddhism, aimed at leading patients to 'let go' and accept things as they are (*arugamama*; Reynolds, 1976). He found the treatment effective for a wide range of conditions (Ishiyama, 1988). Although Morita therapy has never been more than a marginal practice in Japan, available at a few centers, its underlying assumptions and perspective fit well with cultural and professional notions of personality as rooted in constitution but as modifiable through disciplined practice (Kitanishi & Kondo, 1994; Ono & Berger, 1995).

American psychiatric nosology and practice has had increasing influence on Japanese psychiatric theory and practice in recent years (Honda, 1983). Some younger Japanese psychiatrists have had training in the USA and are promoting models of practice similar to those standard in North America. Nevertheless, there are many distinctive features to Japanese psychiatric practice.

From a Japanese point of view, the popularity of Prozac as a medication that 'changes personality' is related to the importance of competition in American society. Dr Sakai Kazuo, Director of Stress Care Hibiya Clinic, was quoted in the *Tokyo Shimbun* newspaper (8/18/99):

[Prozac] is a drug that can transform minus thinking to plus thinking. It became known as a drug that gives confidence to the unconfident, and was used by a TV-caster. This drug swept away negative images associated with psychiatry. In the background of this popularity, there seems to be a need to live 'tough' in the competitive American society.

This enthusiasm for SSRIs is found among some younger psychiatrists but it has not penetrated the general practice of psychosomatic medicine, where 'if it comes to a choice between anxiolytics and antidepressants, the anxiolytics still win out' (Kobayakawa, quoted in Healy, 2000, p. 287).

In an interview with David Healy, Kobayakawa Toshi-Hiro, a leading Japanese psychopharmacologist, invoked differences in the Japanese genetic constitution and value system to account for the slow adoption of SSRIs:

... genetically the Japanese seem to have less mental disease than in the west. In the west, people are always preoccupied with themselves, whereas the Japanese system is much more modest and co-operative – people work together much more. Against this background, amphetamines are much more of a problem than are the benzodiazepines; we are much more sensitive to the changes, the exaggerations of behaviour, produced by the amphetamines. The behaviour of people in the west is already more exaggerated, so amphetamine-induced problems are less obvious, but here amphetamine abuse is a big social problem and it interacts with criminal activities. Sedative agents are seen as much less of a problem in Japan . . . there is something of a preference for an agent that will be sedative rather than arousing, like, perhaps, Prozac. (Healy, 2000, pp. 286–287)

In his remarks, Kobayakawa slides easily between notions of a distinctive Japanese biology or physical constitution and of a unique culture or value system. There may well be important differences in drug metabolism and response to psychopharmacological agents due to genetic polymorphisms and diet or other environmental factors, but in most cases these remain to be established (Lin, 2001). However, the confident assumption that Japanese are fundamentally different from non-Japanese is not based on research studies but reflects a form of cultural essentialism that became common in Japan during the Meiji era in a genre of literature termed *Nihonjinron* that celebrated the uniqueness of the Japanese people (Dale, 1986). Many Japanese are comfortable with the notion that they are somehow distinct from other peoples, not only because of their culture but in the very substance of their brains and bodies (for an extreme example see Tsunoda, 1985). Although there may well be local biologies (Lock, 2001), this popular literature on the distinctiveness of the Japanese is ideologically driven.

Notwithstanding this caveat, the striking differences in the practice of

psychiatry in Japan raise interesting questions about the universal applicability of psychiatric nosology and treatment. Do these differences merely reflect the persistence of old-fashioned methods of diagnosis and treatment in Japan, due a reluctance to introduce new medications? Or is there something deeper going on that challenges some of our assumptions about emotional health and illness?

A substantial literature in cultural psychiatry challenges the universality of the categories of disorder enshrined in official psychiatric nosologies like DSM-IV and ICD-10 (Mezzich et al., 1999). While there is some evidence that the cardinal symptoms of depression co-occur as a cluster or syndrome in many disparate cultures, it is equally clear that there are culturally distinctive symptoms related to idioms of distress and ethno-physiological ideas. To the extent that depression is a psychological processes involving specific cognitions and interpretations of one's self-efficacy and self-esteem, culturally shaped notions of the person and core values related to success and failure, attachment and loss, will influence both the clinical syndrome of depression and its course over time.

### **How Culture Makes a Difference**

The roots of the term 'culture' lie in cultivation, in working the natural world to make it yield what is of sustenance and value to human beings (Eagleton, 2000). Notions of what is natural and what is cultivated, 'man-made' or artificial are central to how cultures define themselves. Of course, the binary opposition of nature and culture allows different value systems. Those who embrace scientific progress herald the potency and purity of the newest drug. Those who long for simpler times put their faith in what is 'natural.' It is common in North America, for example, to hear people endorse herbal remedies as natural – implying that the natural is good, gentle, and harmonious, whereas chemically engineered medications or designer drugs, are harsh, dangerous and insulting to our bodies. The metaphors of nature and culture, natural and engineered, stand in for whole systems of values (Kalland & Asquith, 1997; Tellenbach & Kimura, 1989).

Ironically, cultures naturalize their most central values and commitments; what seems to be simply natural is, in fact, culturally constituted. This tendency to view as natural what is simply normative and familiar is particularly powerful in the domain of psychology. Ethnopsychologies – cultural models of how people work, of the functioning of thoughts, feelings, motives for action – are commonly presented as 'human nature.' This appeal to nature tends to elide the cultural and historical origins of our concepts. Cross-cultural comparison unmask this naturalizing tendency, and allows us to critically examine our assumptions in the

construction of human nature. Accordingly, in this section I consider some ways in which the regulation of affect in interpersonal relationships, and concepts of self and personhood differ between Japan and the USA.

### *The Regulation of Affect*

Individuals differ in temperament or personality. Placed in similar situations, some people are more cheerful, others more dour and pessimistic; some are outgoing and self-confident, others shy and retiring. These differences reflect both hereditary factors and early developmental experiences. Many symptoms of anxiety, depression, and milder dysphoria may reflect exaggerations of these temperamental traits. If so, SSRI medications may act to change these traits or propensities and hence, in a sense, modify the individual's personality. This might account for the report by some patients given SSRI medications, that they feel better than they ever have, indeed, 'better than well' (Healy, 1997; Kramer, 1993). The possibility that medication might alter personality raises interesting ethical issues. But these issues depend crucially on the social context that defines desirable and undesirable personality traits.

Cross-cultural research suggests that ideal personality traits may differ across cultures, along with the threshold of intensity at which traits are viewed as problematic (Paris, 1997). As a result, one society's enhancement of personality can be an others' pathology or provocation. Something like this may occur with *Prozac* where the extraversion, gregariousness and pushiness that typify the life of a salesman in the USA may be associated with inappropriately brash and insensitive social behavior in Japan (which is frequently lampooned on TV). Instead, Japanese value calmness and containment, and sensitivity to the social hierarchy, which are associated with fitting in and helping social interactions unfold smoothly.

As Healy (1997) has pointed out, the more common response to the 'better than well' claim is not to invoke a dimensional view of personality but a categorical view that assumes that people who do not have conventional symptoms of depression but who do respond to SSRIs with greater well-being did in fact have undiagnosed variants of depressive disorder (like chronic low-grade depression or dysthymic disorder, or pathological shyness and inhibition). The widespread use of the resultant categories across cultures assumes that depressed mood or social anxiety and inhibition always have the same meaning and implications for the health and functioning of the person. There is reason to believe that this is not the case.

Culture has effects across the lifespan on the neural systems, psychological representations and interactional patterns that constitute affect. Cultural ideologies, institutions and practices provide the context and rules

for interactional processes that underlie complex emotions. Cultural variations in the composition of the family, maternal–infant interaction, and childrearing practices all prime and shape affect systems. Emotion ‘display rules’ and body practices regulate socially acceptable and deviant patterns of emotional expression. Culture provides categories and a lexicon for emotional experience, making some feelings salient and others more difficult to articulate. Culture sets limits of tolerance for specific emotions and strong affect; it also provides lay theories and strategies for managing dysphoric mood, anxiety or depression. Each of these ways in which culture may influence the regulation of emotion has potential implications for the expression of dysphoric affect in clinical settings.

In many cultures, disturbances of mood, including depression and anxiety are not viewed as mental health problems but as social or moral problems. Painful feelings provide socially and morally important information about intolerable or disvalued circumstances, altering a moral landscape and providing a moral compass. Pathological moods are recognized not simply by their painfulness, negativity, intensity or duration but by their socially inappropriateness and lack of responsiveness to context.

In her ethnographic study of menopause in the late 1980s, Lock (1993) found that Japanese women frequently reported irritability as a problem but they rarely mentioned depression. This was in marked contrast to interviews in Canada where depression was a common symptom and, indeed, a reason for doctors to prescribe hormone replacement therapy as well as antidepressants. Part of the difference has to do with the cultural meaning of menopause but there are also differences related to the understanding of depressed mood in general.

In North America, ‘depression’ is both the name of a psychiatric affliction and an everyday problem in mood or morale that constitutes a cultural idiom of distress. To say ‘I’m depressed’ may mean that one is simply discouraged by life circumstances, or that one is tired and ‘worn out.’ In Japan, the notion of depression has gained wide recognition but there is no translation of the English word that covers precisely the same territory (Tanaka-Matsumi & Marsella, 1976). Japanese terms usually glossed in English as ‘melancholy’ or ‘depression’ include *yuutsu* (related to grief, but also gloominess of spirits and weather), *ki ga fusagu* (one’s *ki* or vital energy is blocked or clogged); *ki ga meiru* (*ki* is leaky); *shizumu* (low in spirits); *inki* (*ki* is yin rather than yang – that is, *in* rather than *yō*). These general notions of loss or blockage of energy lead to bodily as well as mental manifestations: ‘the subjective experience of melancholy or depression in Japan is not associated primarily with the head . . . or simply with affective states but is a much more diffuse concept that manifests itself as numerous physical changes including headaches, chest pain, a “languid” body, or a “heavy” head.’ (Lock, 1993, p. 222). This notion of energy fits

with a Japanese concept of the body not as a machine (which can be functioning efficiently or broken down) but as an organic process in constant exchange with the environment (Lock, 1981; Ohnuki-Tierney, 1985).

In Japanese culture, sadness and grief may be positively valued experiences – indeed, there is a whole esthetic surrounding the acknowledgement of impermanence and loss.

Feeling sad and reacting sensitively to losses, particularly of loved ones, is an idea that has a singular appeal in Japan. The theater, a range of literature and indigenous popular songs, traditional and modern, positively wallow in nostalgia, sensations of grief and loss, and a sense of the impermanence of things. People cry freely (by North American and northern European standards) about separation and lost loved ones, but at the same time they seem to draw strength from these experiences, to tighten their bonds with those who remain among the living, and to reaffirm group solidarity. . . . Unlike anger and irritability, which both disrupt harmony and threaten the social order, sadness, grief, and melancholy are accepted as an inevitable part of human life and even welcomed at times for their symbolic value, as a reminder of the ephemeral nature of this world. An association between melancholy and the weather reinforces sad feelings as natural and unavoidable and hence as states not induced solely through human exchange. (Lock, 1993, pp. 222–223)

In recent years the notion of depression as disorder or disease, termed *utsubyō* (depressive illness) has gained currency in Japan. But milder forms of depression are not generally recognized as an affliction. Mild depression, manifesting as somatic symptoms of pain or energy depletion, may be viewed as a personal affliction, *jibyō*, which is something to manage on one's own, and which may have a positive value, both because its mastery strengthens one's character and because it draws people together through acts of care giving or indulgence (Doi, 1985). In an effort to make the diagnosis of depression more acceptable, it has been compared with the common cold: an acute and transient ailment, but one that affects the *kokoro*, the heart–mind (Ono Yutaka, personal communication, October 26, 1999).

Given the positive value of sadness derived from acknowledging impermanence, loss, and imperfection, any medication that mutes the individual's capacity to experience ordinary sadness and grief would be damaging to their moral personhood, their esthetic sensibility, and their spiritual development.

### *Concepts of Self and Personhood*

In the 1920s, Mauss (1979) pointed out that all societies have implicit notions of what it is to be a person. Personhood is not necessarily conferred

in equal measure on all individuals or in quite the same way at different developmental stages (infancy, childhood, adulthood, old age). Outside legal or juridical settings, the cultural concept of the person is implicit and encoded in moral notions of what makes a person good or bad, in ethnopsychological concepts of mental health and illness, and in social norms for gender roles and developmental tasks.

European and American notions of the person have strongly influenced psychiatric theory (Gaines, 1992). The American concept of personhood centers on an ideology of individualism (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985). A person is the locus of private experience, of rational choice and preference, of unique agency and action. Our notions of health and illness, implicit in psychiatric nosology and in everyday clinical judgments about patients, are based on this notion of the person and corresponding ways of narrating and experiencing the self.

The Euro-American self is described as egoistic, individualistic or independent, and values the exercise of idiosyncratic choice and agency, extraversion, and instrumental efficacy. In contrast, Japanese (or more widely Asian) concepts of personhood, emphasize the interconnectedness of self and others, focus on social context, and encourage the person to engage in self-criticism, to improve the self through sympathy for others in relationship (Lebra, 1976; Rosenberger, 1992; Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000). The development of these culturally divergent forms of the self may be mediated by the ways in which everyday mundane situations are collectively defined and negotiated, that is, by the tacit rules and practices of everyday social life. These are encoded as prototypical scenes, situations, and scripts or narratives.

Traditionally, Japanese notions of the person are relational, and stress interdependence rather than independence (DeVos, 1985; Doi, 1985; Lebra, 1976; Kitayama & Markus, 2000; Rosenberger, 1992). This has implications both for how health is measured and for hierarchies of values. Japanese cultural practices and lay theories of the person affect basic ways of construing or constructing the self and managing adversity. Specifically, there are differences in processes of critical self-appraisal, attachments or investment in the self, and long-term commitments to relational self-improvement.

Thus, Japanese tend to avoid attributing positive outcomes to themselves and emphasize interdependence in achieving goals (Kitayama & Markus, 2000). Success tends to be attributed to the group, failure to one's own limitations. Failure leads to re-orienting oneself to the group rather than protecting one's self by attributing failure to the actions of others.<sup>7</sup> American health psychology would deem this a recipe for demoralization and depression. The conventional wisdom has it that to avoid depression one should attribute success to one's own efforts and failure to external

exigencies. But there is no evidence that this contrary strategy has negative effects for the Japanese. Instead, conformity to cultural values supports the person's adaptation and well-being.

Health psychology has other versions of this optimal person that also reveal cultural biases. Consider the construct of 'Hardiness,' a concept introduced by Maddi (1988) and applied to health psychology research by Kobasa, Hilker, and Maddi (1979). Hardy individuals are optimistic and resilient; they are active copers, and adjust well to adversity or obstacles and are able to continue to pursue their own goals and to modify them appropriately, without getting unduly anxious or depressed when aspects of a situation are insurmountable. They exhibit a deep sense of commitment and purpose in life, flexibility in adaptation to changes and a sense of personal control over events. In short, they are rugged individuals. Throughout Maddi's account of hardiness, American middle-class values of expressive individualism hold sway (Bellah et al., 1985). The hardy person takes on the world as something to be mastered, bested, and transformed to his liking.

It is revealing to compare Maddi's account of psychological health to other notions of personhood and the good life. Whereas Maddi emphasizes the healthy individual's ability to control the environment to make it conform to his agenda, control in Japan tends to be diffused throughout the work or family group while responsibility is held by each individual vis-à-vis the group (Azuma, 1984; Weisz, Rothbaum, & Blackburn, 1984). For Maddi (1988), 'to do something new is developmentally more valuable than persisting in the old.' (p. 184). Few masters of traditional arts in Japan would agree. Doing things more slowly, traditionally, the 'hard' way, has its own merits (Kondo, 1992).

Based on research conducted around 1990, Mathews (1996) discusses the importance in everyday Japanese moral discourse of the concept of *ikigai* – a term that can be glossed as 'that which makes one's life seem worth living' (p. 5). Japanese men tend to find *ikigai* in work or family, whereas women locate it in their relationships with family and children. The focus on *ikigai* in public discourse was surely a reflection of the relative wealth of Japanese society and increasing longevity. Although surveys indicate that most men find *ikigai* in their work, this may be insufficient and some articles warned that reporting work as *ikigai* may be associated with depression (p. 16). Japanese recognize the danger of being a workaholic (*wākahorikku*) and over extension at work can lead to death (*karoshi*). The economic downturn after the burst of the bubble economy has been associated with an increase in suicide, particularly among middle-aged men facing reversals at work (Tajima, 2001; Takahashi et al., 1998).

Contemporary Japanese concepts of the person have their roots in older traditions but underwent profound transformations in the transition to an

urban industrial and bureaucratic society from the late 1800s onward (Kinmouth, 1981). Classic Anglo-American books on self-development, notably, *Self-Help* by Samuel Smiles were bestsellers in Japan and extremely popular among the samurai in the 1870s. The Meiji reformation (1868) attempted to bring Japan into a modern economic exchange with the west by dismantling the feudal structure and allowing people to pursue different vocations. No longer were social status, wealth and honor decided by birth and divine order. In this context, the translation of *Self-Help* with its famous first line: 'Heaven helps those who help themselves' supported the attack on hereditary status (Kinmouth, 1981).

The Japanese translator of *Self-Help*, Nakamura Keiu was a Confucian scholar in the employ of the Tokugawa house. He visited Victorian England and was deeply impressed by its wealth and power, successes he attributed to a national character based on values of hard work, prudence and self-restraint (Kinmouth, 1981).

Of course, the text rooted in British individualism was given a Japanese Confucian reading in translation. 'For the translator, Nakamura Keiu, the chief attraction of *Self-Help* was this assertion by Smiles: "National progress is the sum of individual industry, energy, and uprightness, as national decay is of individual idleness, selfishness, and vice." (p. 20) Thus, Nakamura kept the collective identity of the nation in the foreground of his translation, producing a text that reinforced socio-centric values even as it spoke of individual advancement. 'Individualism and individuality were two important concepts appearing in *Self-Help* that were not well articulated in either Confucian or samurai traditions' (p. 27).

Both Confucianism and Buddhism had a concept of the self and gave much attention to the subject but they did so in the context of suppressing or negating the self. Confucianism was used most often to link the individual to social or political entities and to encourage contentment with the status quo. It denied the intrinsic worth of all individuals, an essential element for individualism, and called instead for recognition of differential worth according to age, sex, rank, or relationship . . . it generally did not recognize a sphere of privacy in which the individual was free to pursue his own way. (Kinmouth, 1981, p. 332)

While the concept of the person in Japan has continued to change, the emphasis has remained on a relational view in which the person is understood to develop and mature in and through relationships with others (Haga, 1995; Plath, 1980).

Japanese personhood is thus located not so much in a private inner theater as in the space between individuals where a web of obligations, respect and mutual nurturance can be developed. Japanese forms of self-discipline can be understood as responses to the 'endless need to reconcile

the claims of different circles of human attachment' (Plath, 1980, p. 219). What happens when we take a drug that alters our sensitivity to these circles of attachment; that changes the valences or values assigned to particular options, that alters our sensitivity to subtle social cues? Although it may be helpful in the USA to assert oneself whatever the wishes or discomfort of others, in Japan to barrel along without attending to others would be a path to social suicide.

### Buddhist Transformations of the Self

*Hifu datsuraku shitsukushite*

*Tada ichi shinjitsu nomi ari*

Now that I've shed my skin completely

One true reality alone exists

(Miura & Sasaki, 1965)

In an influential article, Obeyesekere (1985) argued that depression was a culture-bound construct. He claimed that he had friends and acquaintances in Sri Lanka who met many of the criteria for a major depressive episode, in terms of bleak and negative thoughts, but who were not disabled. Instead, as practitioners of Buddhism, their 'symptoms' of depression were cultivated as indications of the unfolding of wisdom. Obeyesekere's argument was somewhat rhetorical or tongue-in-cheek and certainly overstated in that the Buddhist practitioners he described were not suffering from the sort of anguished and derailing depression that brings people to a psychiatrist. Such severe depression is recognized in Sri Lanka and would surely interfere with meditation as well as the social role performance demanded of Buddhist monks. But Obeyesekere's argument is worth considering seriously in relation to the milder forms of everyday unhappiness for which SSRIs may sometimes be prescribed.

The human condition is inevitably marked by illness, aging, loss and death. Buddhism teaches that suffering comes, not directly from these realities, but from our incessant efforts to deny or ignore them and to hold on to what we desire while shutting out what we dislike. This ignorance and grasping is the real cause of suffering. Liberation begins with acknowledging this reality and meditating on impermanence or emptiness to achieve wisdom and compassion through non-attachment. Buddhism offers many techniques to achieve this transformation of the self, not simply as a philosophical principle, but as an experiential reality. The most basic of these techniques are the various forms of meditation developed in different Buddhist traditions. The aim of meditation is not greater effectiveness in the everyday world – although, tellingly, this is how Buddhism is often packaged, especially in the West. The ultimate goal is enlightenment

– transcending ordinary confusion and suffering through understanding that the self is an illusion.

Although the insights of Buddhism are usually hard-won achievements after long meditative practice and study, there is, within many traditions, a notion of sudden enlightenment or transformation. Zen Buddhism, one of several families of approaches to Buddhist practice developed in Japan, has many stories of practitioners suddenly achieving enlightenment (Suzuki, 1959). Often these were associated with situations that revealed the ordinary working of mind even as they completely undermined usual modes of constructing experience. These dramatic moments of transformation were captured in brief stories or sayings called ‘koans’ and used by others later as objects of meditation or philosophical study to advance their own practice.

Koans form part of a several systems of meditative practice. The story, poem or fragment of dialog works as a focus of meditation not simply because of its density and opacity but because the koan is interpreted in terms of a larger religious system. Whereas in Rinzai Zen, the use of koans aimed to induce an enlightenment experience through intensification of doubt, confusion and blockage and confutation leading to breakthrough, in medieval Soto Zen, koans were studied as ‘models of truth or idealized statements of truth’ (Bodiford, 1993, p. 213). Koan study ‘encapsulated Zen transcendence in tangible forms, expressed it in concrete performances, and allowed it to be communicated easily to monks, nuns, and laypersons’ (Bodiford, 1993, p. 143).

Koans were used in Rinzai Zen to attain sudden enlightenment (*kensho*) (Miura & Sasaki, 1965). It is instructive, therefore, to compare the process of Koan meditation with drug-induced changes of mind. Both drugs and meditation offer the possibility of sudden transformations of experience. But the path through koans involves hard work and mental application. Only when the student’s mind is exhausted by paradox and the Zen master’s rejection of facile answers, does the koan accomplish its work of confuting or short-circuiting rationality. This then leads to a sudden reorganization of consciousness and experience.

The sudden transformations celebrated in Zen seem to promise an end to suffering no less abrupt than what is achieved by medication. If the goal of self-development is simply to feel better, to not over-react to adversity, or to be less attached to one’s own pleasure and pain, then a pharmacological path toward enlightenment would seem close at hand. If not, what precisely is the difference between the fruits of meditation and the quick fix of medication? What sort of transformative practice is a drug? Can it have more far-reaching effects than a change in mood?

To begin to answer these questions, we must see both meditation and the taking of medication as what Wittgenstein (1958) called ‘forms of life.’ In a

course of spiritual practice, years are devoted to training with consequences for many aspects of the self and the person's understanding of the world. Zen practice is culturally and historically situated.<sup>8</sup> The religious experience of practitioners and the wisdom they achieve depend on the cultivation of specific cultural knowledge. 'The koan genre, far from serving as a means to obviate reason, is a highly sophisticated form of scriptural exegesis: the manipulation or "solution" of a particular koan traditionally demanded an extensive knowledge of canonical Buddhist doctrine and classical Zen literature' (Sharf, 1995, p. 108). Each meditative experience has meaning within a larger moral system, which it confirms and extends. The insights achieved through practice transform the self and at the same time reaffirm the larger spiritual community with whom the practitioner remains in dialog. So, even where there is an apparent rupture or radical transformation of identity and experience, the experience fits a narrative template that is familiar and consolidates the individual's understanding.

Similarly, the act of taking a drug has meanings that are embedded in larger cultural systems of value and practice. The difference between drug and meditation, thus, lies not only in their physical effects on the nervous system but also at higher orders of organization involving longer temporal spans, that involve accessing memories, alterations of awareness, and new modes of self-construal – in short, the workings not just of a few families of molecules in the brain but a whole head full of cultural particulars. The resultant structures of experience are expressed through and embodied in narratives of the self.

### **Psychopharmacology and the Narrative Construction of the Self**

Not thinking of good, not thinking of evil, just this moment, what is your original face before your mother and father were born? (Zen master Eno, quoted in Kasulis, 1981, p. 52)

Many strands of contemporary philosophy, cognitive science and literary studies have converged on the notion that the self is a narrative construction (Bruner, 1990; Freeman, 1993; Kirby, 1991). This means that our sense of being a person, of having a point of view, an idiosyncratic history, a social position and a trajectory along which we move toward an unknown but variously imagined horizon of the future are all brought into being and maintained by stories we tell ourselves and others. This powerful idea has reshaped our understanding of memory and identity and, more recently, has begun to shift approaches to moral and ethical reasoning (Nelson, 1997).

Taking an antidepressant alters the narrative self in at least three different ways: (i) it changes the bodily feeling and stance that subserve our

metaphorical constructions of self, for example, by making us feel more upright and energized; (ii) it provides a new inner agent to which to attribute our feelings and actions and a new actor ('the drug') in the social world, with significance to others; and (iii) it may reshape our empathic response to others and so alter the fabric of social life itself.

A drug that alters mood exerts a bias on our self-narrative by changing the topography and dynamics of our emotional response to events. Emotions govern our access to specific memories, the stance or position we take vis-à-vis others, and our sense of what is important. Narratives of self are anchored in a cultural logic of emotion. A shift in mood or a change in emotional reactivity to other persons and events, therefore, can radically reshape the form and content of our self-narratives.

A second way that drugs alter the narrative self is through the attributions we make for our actions. We may understand our behavior as chemically biased or determined and so claim we could not act otherwise. Alternatively, finding that a drug helps us, we may evaluate other people's predicaments in these terms, wondering why they don't simply take the drug to feel better.

Finally, drugs may change the sensitivity of neural systems that subservise various aspects of social behavior in ways that can alter the nature of social life itself. The enhancement of serotonergic systems, for example, may make an individual more likely to exhibit dominant behavior in social interactions (Moskowitz, Pinard, Zuroff, Annable, & Young, 2001). This in turn, will be reflected in self-narratives. For example, if medication makes us feel the pain of others less acutely, we may view them as over-reacting to their predicaments and as being fundamentally different from ourselves.

Our ability to feel empathy with others and to respond to their plight depends on the capacity to feel vicarious emotion, understand their predicament, and respond with emotionally appropriate action. Vicarious emotion (e.g. feeling sad when encountering someone who is sad) depends on the power of another's facial expressions, gestures, speech and contextual cues to evoke a parallel emotional response. Complex emotions, however, also involve the ability to appreciate the causes and consequences of our feelings, and this aspect on empathy depends on imaginative reconstruction of another's life world and predicament. Emotion and imagination form a cycle in which each contributes to a more complete re-creation of the experience of another person. Finally, our ability to distinguish between our own experience and that of others, to achieve a level of detachment, allows us to understand the other's predicament as distinct from our own and hence respond to them in terms of what they need rather than what we ourselves would find comforting.

We need a full range of affective responses to empathize with others and so to understand and respond to their predicaments. Too little

emotional responsiveness also may prevent accurate empathy. Too much responsiveness may lead us to over-react to others and lose sight of their feelings in the drama of our own reactions. Persistent moods of depression or euphoria (as seen in bipolar disorder, for example) make it hard to track another person's feelings. Clearly, drugs that alter our mood and emotional responsiveness to others may influence our capacity for empathy. They may render us insensitive to the feelings of others so that we are unable to know what they feel. Alternatively, drugs may make us too sensitive to other's feelings and so unable to think clearly about another (or even to differentiate their pain from our own) and this too might impair our moral sense.

The socio-moral consequences of medication (or for that matter of psychotherapy) may be difficult to see because we focus on the individual and not on interactions in characterizing depression and good functioning (Joiner & Coyne, 1999). We tend to view our social world as a given and not malleable or evolving as the outcome of micro-interactions. As well, we are constantly engaged in rationalizing or justifying our actions in terms of socially acceptable ideologies. So any impact that drugs may have on our weighing of social situations is likely to be hidden or discounted by this process of narrative smoothing and rationalization. To see this impact requires that others close to us hold up a mirror – one into which we may not wish to look.

A view of the self as a narrative construction leads naturally to the importance of community (however loosely it is defined). Narratives are, in the first instance, stories told to someone in social context. The others from whom we learn and to whom we tell and retell the stories that define and locate us include our intimate relations, family and friends but extend through the nested circles of community to wider social institutions and global networks. Part of characterizing a narrative and understanding its meaning involves identifying its multiple sources or influences as well as its intended and actual audiences. To a large extent, it is the response of the community in which we live that determines whether our story makes sense or nonsense, whether our values lead us to health and happiness or to rejection and ruin. As a result, the form of narratives depends on cultural notions of the person. Even such basic qualities of self-narratives as coherence, continuity, and intelligibility differ according to cultural templates for the self.

This dependence on culture and community means that there is a logical circularity between narratively constructed selves and the moral systems that sustain them. This circularity, in turn, raises the problem of moral relativity: If any story we choose to live becomes our moral compass, we have no way of choosing between stories except from within the one that already defines the moral options. One way to escape the arbitrariness this implies is to make claims for the authenticity or integrity of the self.

This usually invokes some form of essentialism in which there is a real or true self that stands above or behind the multiplicity of possible selves invented by the stories we tell others and ourselves. This real self was there at the beginning.<sup>9</sup> Unlike the selfless 'original self' invoked in Zen koans like the epigraph for this section, the 'true self' of American folk psychology is closely tied to a version of personal history that provides a counter-story to redress all the ways we feel we have been wronged by others. At the same time, the 'true self' usually closely conforms to one of a few cultural templates for the person and the good life. Far from an original self, this 'true self' is a culturally shaped moral aspiration.

Against the fiction of the true self we can array the many possible selves we would like to be, the person we are supposed to be, the person we 'really' are in some higher or larger or ultimate frame. These may all be opposed to the person we are judged to be by others based on our personal history and trajectory. But the traces of our personal acts cannot and should never be erased in the process of re-creation. Owning up to our past is the basis on which moral action is built. Here then is one of the most worrisome implications of the chemical reconfiguring of our selves: that it might reinforce our tendency for selective memory of our past deeds and their impact and so, undermine the possibility of moral accountability, reparation and integration.

Western literature also attests to the ethical and esthetic value of depressed mood (Burton, 1932/2001; Radden, 2000). Melancholy is the royal road to recollection and the effort to avoid painful affect may lead to serious lacunae in personal and collective history. The moral danger of forgetting, and the creative power of grief and sadness are strikingly illustrated in the novels of W. G. Sebald (1996, 1998, 2001). A German expatriate who lived and worked as a professor of literature in England, Sebald invented a narrative form that is a sort of modern memory theater in which faded photographs serve both to trigger memories and hint at the untold stories of others' lives. In *The Rings of Saturn*, for example, the narrator begins with a brief account of his hospitalization for profound depression and then recounts his meandering walks through the English countryside which thread together a series of allusive vignettes from the lives of friends, acquaintances, and historical figures with whom he feels kinship. The episodes are linked by a process of 'free association' located not in the individual psyche but in the landscape itself. The reader's uncertainty about what is fact and what is fiction is amplified by the ambiguous photographs that accompany the text. All of Sebald's stories wander about an unspoken absence at their center, tracing the contours of a more profound loss, both personal and collective, in the Holocaust. The act of recollection brings a gradual lightening of mood and freeing of consciousness, though never a complete escape from Saturn's gravity. Sebald's novels are

anti-antidepressants that produce their own strange exaltation while calling us to the hard moral work of remembering.

### **Envoi: Globalization and the Monoculture of Happiness**

Despite the great popularity of SSRI antidepressants in North America and Europe, most of these medications have not yet been introduced in Japan. To a large extent this reflects the general difficulty in obtaining government approval for new drugs. However, there are also specific reasons why the newer antidepressants have been slow to reach the Japanese market. Clinical trials of some SSRI antidepressants in Japan have found limited efficacy or excessive side effects. There may be much depression in the general population that is not recognized or treated as such owing to a different tradition of nosology and organization of the health care system. Most patients with dysphoric mood in Japan are seen in specialty medical care, complain of physical symptoms, and are treated with anxiolytic medications. As well, some of the effects of medications like fluoxetine (*Prozac*) that are viewed as beneficial in the USA, like increased extraversion and ebullience, may be less valued in everyday life in Japan since they contravene social norms for calmness and deference in interpersonal interactions. Dysphoria itself may be given positive social meanings as yielding enhanced awareness of the transient nature of the world.

This example from Japan illustrates how the personal and social value of the effects of medication depends on prevailing cultural ideologies of the person. These ideologies are implicit in narratives of the self in illness and health. The effects of a drug are not just on the level of mood but on the narrative fabric of the self. This narrative is evaluated by both lay people and clinicians in terms of a moral calculus based on social norms and cultural values. However, any characterization of cultural differences in terms of local norms of conduct and ideologies of the person must be set against the forces of globalization in which multinational pharmaceutical corporations are working to redefine normal mood and mental health on a global scale.

The pharmaceutical industry exerts strong influences on physicians prescribing practices, the direction of research, and even the debate on ethical issues in treatment. Millions of dollars are spent on advertising, gifts and salespeople who convince physicians to prescribe newer more costly medications in favor of generic compounds often on specious grounds (Wazana, 2000). More insidiously, the pharmaceutical industry has become the major source of funds of clinical trials of new treatments for psychiatric disorders: 'as government after government fails to provide their nonprofit independent granting agencies with sufficient resources to meet society's growing demand for high-quality evidence, the drug

industry, with its inescapable competition between health and profit, pays and calls the tune for more and more RCTs' (Sackett & Hoey, 2000). Consequently, the generation of new evidence on which to base rational medical care is controlled by economic interests: 'knowledge in psychopharmacology doesn't become knowledge unless it has a certain commercial value. The survival of concepts depends on the interests with which they coincide.' (Healy, 1997, p. 176). The selective generation of knowledge frames the field of 'evidence-based medicine.' The range of alternatives available in clinical decision-making is constrained by these larger economic forces. As a result, we are left with an illusion of free choice among a highly limited set of 'reasonable' options. Critical analysis of this situation may be compromised by the fact that drug companies also sponsor and support programs in biomedical ethics (Elliott, 2001).

Pharmaceutical corporations and the psychiatric profession are working hand in hand to popularize the notion of depression as a medically treatable disease. There has been an aggressive medicalization of the problem of depression in developed countries like Japan in recent years. This vision has been extended to developing countries through programs like the WHO Nations for Mental Health – a program largely supported by Eli Lilly and other pharmaceutical companies (Anonymous, 1998). In the shantytown of Independencia on the outskirts of Lima Peru, in 1999, colorful posters described the symptoms of depression and urged readers to see their doctor and ask for the latest SSRI by brand name. Professional autonomy thus rides the tail of marketing.

There is a global monoculture of happiness in which we are all enjoined to work to achieve the good life, which is understood to reside in being pain free, completely comfortable, and ready and able to acquire and consume the greatest quantity and variety of the newest goods and fashions.<sup>10</sup> The rapidity with which the notion of depression and the use of antidepressants are taking hold in Japan may reflect the belated recognition and treatment of a long-standing problem from which many have suffered. It may also reflect a profound transformation of cultural modes of understanding and responding to personal and social problems with far reaching effects on the concept of the person and the conduct of everyday life.

Few would argue against the notion that crippling depression should be recognized and treated effectively. The concern is about the wider and more prevalent forms of dissatisfaction and distress that may be sensitive indicators that something is wrong not with the individual's psyche but with the social world. The riches of modernity bring their own problems and pathologies rooted in excesses of choice and change, overwork, overstimulation, time pressure and dislocation (Bauman, 1998; Schwartz, 2000). In place of the familiar suffering of privation, people in wealthy nations suffer from misery in the midst of plenty due to a sense of relative

deprivation, and a loss of connectedness to family and community. Our feelings of dysphoria and depression may point to problems not in brain chemistry but in the way we live. The study of cultural difference and diversity provides alternative vantage points from which to consider the moral choices implicit in the mundane practice of taking a pill to feel better.

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### Notes

1. As is customary, Japanese names are written family name first.
2. A culture-specific form of social phobia, *taijin kyofushō*, continues to be a focus of attention in the Japanese medical literature with over 200 abstracts on the diagnosis published in 1999, compared with fewer than 100 on depression (Tajima, 2001).
3. This cautiousness does not extend to all drugs. The sexual potency-enhancing drug sildenafil (*Viagra*) was introduced in Japan in 1999, within a year of its release in the USA and just 6 months after Pfizer applied for approval.
4. Among other psychiatric medications: clozapine (*Clozaril*) was not accepted because of agranulocytosis although a new clinical trial is in progress at a limited number of facilities; bupropion (*Wellbutrin*, Glaxo Wellcome), received U.S. approval in 1989, but is not in development in Japan); venlafaxine (*Effexor*, Wyeth-Ayerst) had U.S. approval 1994, and is currently in development in Japan).
5. Indeed, the tendency to talk about specific chemical systems in the brain (e.g. 'serotonergic systems,' which use the neurotransmitter serotonin and which are preferentially affected by SSRI medications) is a sort of neo-humoral theory that, in its tendency toward sweeping generalization, harkens back to ancient Greek notions of the bodily humors; the link between black bile and dysphoria is attested in the etymology of the term 'melancholia' (Radden, 2000).
6. In fact, there is evidence that depression and anxiety are closely related (Kendler, Heath, Martin, & Eaves, 1987) and that bipolar disorder and schizophrenia may share a common diathesis (Blacker & Tsuang, 1992). Even the broad structure of existing psychiatric nosology, therefore, is still contentious.
7. Situations of overt competition, however, evoke self-enhancement in social psychological experiments with Japanese students (Kitayama & Markus, 2000).

8. Sharf (1995) discusses how Zen was repackaged in the Meiji era as a tradition that encapsulated the essential uniqueness of Japanese character, esthetics and spirituality. This occurred through a dialog with Western religions and psychology that gave rise to a rich literature on Zen in English. This literature claimed that Zen practice provided a direct, unmediated, experience of truth. This version of Zen Buddhism was substantially different from the religion described in traditional literature and, indeed, differs from contemporary Zen in Japan.
9. Sharf (1995) argues that the popularity of Zen in the West had much to do with a similar problem of relativism that emerged from the encounter with the diversity of religious practices:

Philosophers and scholars of religion were attracted to Zen for the same reason that they were attracted to the mysticism of Otto, James and Underhill: it offered a solution to the seemingly intractable problem of relativism engendered in the confrontation with cultural difference. The discovery of cultural diversity coupled with the repudiation of imperialist and racist strategies for managing cultural difference, threatened to result in the 'principle of arbitrariness,' the notion that there is no necessary reason for us to conceive of the world one way rather than another. In mysticism intellectuals found a refuge from the distressing verities of historical contingency and cultural pluralism; by invoking a *sui generis* nondiscursive, unmediated experience they could gracefully elide problems of ontological reference. (p. 139)

10. Applbaum (2000) describes how this global monoculture is constructed and deployed through the marketing practices of transnational corporations in many domains including the pharmaceutical industry.

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