CRAZY LIKE US

THE GLOBALIZATION OF THE AMERICAN PSYCHE

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For my mother, Mary Pulliam Watters

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CRAZY LIKE US

Introduction

To travel internationally is to become increasingly unnerved by the way American culture pervades the world. We cringe at the new indoor Mlimani shopping mall in Dar es Salaam, Tanzania. We shake our heads at the sight of a McDonald's on Tiananmen Square or a Nike factory in Malaysia. The visual landscape of the world has become depressingly familiar. For Americans the old joke has become bizarrely true: wherever we go, there we are.

We have the uneasy feeling that our influence over the rest of the world is coming at a great cost: loss of the world's diversity and complexity. For all our self-incrimination, however, we have yet to face our most disturbing effect on the rest of the world. Our golden arches do not represent our most troubling impact on other cultures; rather, it is how we are flattening the landscape of the human psyche itself. We are engaged in the grand project of Americanizing the world's understanding of the human mind.

This might seem like an impossible claim to back up, as such a change would be happening inside the conscious and unconscious thoughts of more than six billion people. But there are telltale signs that have recently become unmistakable. Particularly telling are the changing manifestations of mental illnesses around the world. In the past two decades, for instance, eating disorders have risen in Hong Kong and are now spreading to inland China. Post-traumatic stress disorder (PTSD) has become the common diagnosis, the lingua franca of human suffering, following wars and natural disasters. In addition, a particularly Americanized version of depression is on the rise in countries across the world.

What is the pathogen that has led to these outbreaks and epidemics? On what currents do these illnesses travel?

The premise of this book is that the virus is us.

Over the past thirty years, we Americans have been industriously exporting our ideas about mental illness. Our definitions and treatments have become the international standards. Although this has often been done with the best of intentions, we've failed to foresee the full impact of these efforts. It turns out

that how a people in a culture think about mental illnesses—how they categorize and prioritize the symptoms, attempt to heal them, and set expectations for their course and outcome—influences the diseases themselves. In teaching the rest of the world to think like us, we have been, for better and worse, homogenizing the way the world goes mad.

There is now a remarkable body of research that suggests that mental illnesses are not, as sometimes assumed, spread evenly around the globe. They have appeared in different cultures in endlessly complex and unique forms. Indonesian men have been known to experience *amok*, in which a minor social insult launches an extended period of brooding punctuated by an episode of murderous rage. Southeastern Asian males sometimes suffer from *koro,* the debilitating certainty that their genitals are retracting into their body. Across the Fertile Crescent of the Middle East there is *zar,* a mental illness related to spirit possession that brings forth dissociative episodes of crying, laughing, shouting, and singing.

The diversity that can be found across cultures can be seen across time as well. Because the troubled mind has been perceived in terms of diverse religious, scientific, and social beliefs of discrete cultures, the forms of madness from one place and time in history often look remarkably different from the forms of madness in another. These differing forms of mental illness can sometimes appear and disappear within a generation. In his book *Mad Travelers,* Ian Hacking documents the fleeting appearance in Victorian Europe of a fugue state in which young men would walk in a trance for hundreds of miles. Symptoms of mental illnesses are the lightning in the zeitgeist, the product of culture and belief in specific times and specific places. That thousands of upper-class women in the mid-nineteenth century couldn’t get out of bed due to the onset of hysterical leg paralysis gives us a visceral understanding of the restrictions set on women’s social roles at the time.

But with the increasing speed of globalization, something has changed. The remarkable diversity once seen among different cultures’ conceptions of madness is rapidly disappearing. A few mental illnesses identified and popularized in the United States—depression, post-traumatic stress disorder, and anorexia among them—now appear to be spreading across cultural boundaries and around the world with the speed of contagious diseases. Indigenous forms of mental illness and healing are being bulldozed by disease categories and treatments made in the USA.

There is no doubt that the Western mental health profession has had a remarkable global influence over the meaning and treatment of mental illness.

Mental health professionals trained in the West, and in the United States in particular, create the official categories of mental diseases. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, the *DSM* (the "bible" of the profession, as it is sometimes called), has become the worldwide standard. In addition American researchers and organizations run the premier scholarly journals and host top conferences in the fields of psychology and psychiatry. Western universities train the world's most influential clinicians and academics. Western drug companies dole out the funds for research and spend billions marketing medications for mental illnesses. Western-trained traumatologists rush in wherever war or natural disasters strike to deliver "psychological first aid," bringing with them their assumptions about how the mind becomes broken and how it is best healed.

These ideas and practices represent much more than the symptom lists that describe these conditions. Behind the promotion of Western ideas of mental health and healing lies a variety of cultural assumptions about human nature itself. Westerners share, for instance, beliefs about what type of life event is likely to make one psychologically traumatized, and we agree that venting emotions by talking is more healthy than stoic silence. We are certain that humans are innately fragile and should consider many emotional experiences as illnesses that require professional intervention. We're confident that our biomedical approach to mental illness will reduce stigma for the sufferer and that our drugs are the best that science has to offer. We promise people in other cultures that mental health (and a modern style of self-awareness) can be found by throwing off traditional social roles and engaging in individualistic quests of introspection. These Western ideas of the mind are proving as seductive to the rest of the world as fast food and rap music, and we are spreading them with speed and vigor.

What motivates us in this global effort to convince the world to think like us? There are several answers to this question, but one of them is quite simple: drug company profits. These multibillion-dollar conglomerates have an incentive to promote universal disease categories because they can make fortunes selling the drugs that purport to cure those illnesses.

Other reasons are more complex. Many modern mental health practitioners and researchers believe that the science behind our drugs, our illness categories, and our theories of the mind have put the field beyond the influence of constantly shifting cultural trends and beliefs. After all, we now have machines that can literally watch the mind at work. We can change the chemistry of the brain in a variety of ways and examine DNA sequences for abnormalities. For a

generation now we have proudly promoted the biomedical notion of mental illness: the idea that these diseases should be understood clinically and scientifically, like physical illnesses. The assumption is that these remarkable scientific advances have allowed modern-day practitioners to avoid the biases and mistakes of their predecessors.

Indeed modern-day mental health practitioners often look back at previous generations of psychiatrists with a mixture of scorn and pity, wondering how they could have been so swept away by the cultural beliefs of their time. Theories surrounding the epidemic of hysterical women in the Victorian era are now dismissed as cultural artifacts. Even recent iatrogenic contagions, such as the sudden rise of multiple personality disorder just fifteen years ago, are considered ancient history, harmful detours but safely in the past. Similarly, illnesses found only in other cultures are often treated like carnival sideshows. *Koro* and *amok* and the like can be found far back in the American diagnostic manual (*DSM-IV*, pages 845–849) under the heading "Culture-Bound Syndromes." They might as well be labeled "Psychiatric Exotica: Two Bits a Gander."

Western mental health practitioners are prone to believe that, unlike those culturally contrived manifestations of mental illness, the 844 pages of the *DSM-IV* prior to the inclusion of culture-bound syndromes describe *real* disorders of the mind, illnesses with symptomatology and outcomes relatively unaffected by shifting cultural beliefs. And, the logic goes, if they are unaffected by culture, then these disorders are surely universal to humans everywhere. Their application around the world therefore represents simply the brave march of scientific knowledge.

But the cross-cultural researchers and anthropologists profiled in this book have a different story to tell. They have shown that the experience of mental illness cannot be separated from culture. We can become psychologically unhinged for many reasons, such as personal trauma, social upheaval, or a chemical imbalance in our brain. Whatever the cause, we invariably rely on cultural beliefs and stories to understand what is happening. Those stories, whether they tell of spirit possession or serotonin depletion, shape the experience of the illness in surprisingly dramatic and often counterintuitive ways. In the end, all mental illnesses, including such seemingly obvious categories such as depression, PTSD, and even schizophrenia, are every bit as shaped and influenced by cultural beliefs and expectations as hysterical leg paralysis, or the vapors, or *zar*, or any other mental illness ever experienced in the history of human madness.

The cultural influence on the mind of a mentally ill person is always a local and intimate phenomenon. So although this book describes a global trend, it is not told from a global perspective. In the hopes of keeping the human-scale impact in sight, I have chosen to tell the stories of four diseases in four different countries. I picked these tales because each illustrates how the globalization of Western beliefs about mental health travel on different currents. From the island of Zanzibar, where beliefs in spirit possession are increasingly giving way to biomedical notions of mental illness, I tell the story of two families struggling with schizophrenia. To document the rise of anorexia in Hong Kong, I retrace the last steps of 14-year-old Charlene Hsu Chi-Ying and show how the publicity surrounding her death introduced the province to a particularly Western form of the disease. I deconstruct the mega-marketing of the antidepressant Paxil in Japan to illustrate how drug companies often sell the very disease for which their drug purports to be a cure. The aftermath of the 2004 tsunami in Sri Lanka provides the opportunity to examine the impact of trauma counselors who rush into disaster zones armed with the diagnosis of posttraumatic stress and Western certainties about the impact of trauma on the human psyche.

At the end of each of these chapters I turn the focus back to the West, and to the United States in particular. When viewed from a far shore, the cultural assumptions and certainties that shape our own beliefs about mental illness and the human mind often become breathtakingly clear. From this perspective, it is often our own assumptions about madness and the self that begin to appear truly strange.

The cross-cultural psychiatrists and anthropologists featured in this book have convinced me that we are living at a remarkable moment in human history. At the same time they've been working hard to document the different cultural understandings of mental illness and health, those differences have been disappearing before their eyes. I've come to think of them as psychology's version of botanists in the rain forest, desperate to document the diversity while staying only a few steps ahead of the bulldozers.

We should worry about this loss of diversity in the world's differing conceptions and treatments of mental illness in exactly the same way we worry about the loss of biological diversity in nature. Modes of healing and culturally specific beliefs about how to achieve mental health can be lost to humanity with the grim finality of an animal or plant lapsing into extinction. And like those plants and animals, the diversity in the human understanding of the mind can disappear before we've truly comprehended its value. Biologists suggest that within the dense and vital biodiversity of the rain forest are chemical compounds

that may someday cure modern plagues. Similarly, within the diversity of different cultural understandings of mental health and illness may exist knowledge that we cannot afford to lose. We erase this diversity at our own peril.

4

The Mega-Marketing of Depression in Japan

> One of the chilling things about these events, whether a puzzle or a scandal, is how a very few people in key positions can determine the course of events and shape the consciousness of a generation.
>
> DAVID HEALY

I went to visit Dr. Laurence Kirmayer in his book-lined office at McGill University in Montreal because he had a particularly good story to tell. I'd heard that a few years ago, Kirmayer had a personal brush with the pharmaceutical giant GlaxoSmithKline and the remarkable resources that the company employed to create a market for their antidepressant pill Paxil in Japan.

In person Kirmayer is the picture of a tweedy academic. He speaks in complete paragraphs in a deep authoritative voice. He has a large head and a broad face that is covered nearly to the cheekbones in a thick light-gray beard. His slightly wandering left eye suits his demeanor. If you look at the left side of his face his expression is attentive and focused on the conversation. If you look at the right side of his face he appears to be looking past you into the middle distance, as if searching for a word or pondering a thought.

In telling his story of being feted by GlaxoSmithKline, Kirmayer likes to point out that he is unaccustomed to the trappings of great wealth. Not that he's doing badly. As the director of the Division of Social and Transcultural Psychiatry at McGill, he makes a respectable living and adds to his income with a private psychiatric practice. As editor in chief of the journal *Transcultural Psychiatry*,

he is well known in certain circles and can draw a crowd of admiring grad students and colleagues at an anthropology or mental health conference. But to get to those conferences he flies coach.

It was in the fall of 2000, as he tells it, that he came to understand just how *un* spectacularly rich he was. That was when he accepted an invitation from something called the International Consensus Group on Depression and Anxiety to attend two all-expenses-paid conferences, the first in Kyoto and the second a few months later on the shores of Bali.

Accepting the invitation didn't at first seem like a difficult decision. Although he knew that the conference was sponsored by an educational grant from the drug maker GlaxoSmithKline,* such industry funding wasn't unusual for academic conferences in the field of psychiatry. When he checked out the list of other invitees, he recognized all the names. It was an extremely exclusive group of highly influential clinicians and researchers from France, the United States, and Japan, among other countries. The topic, "Transcultural Issues in Depression and Anxiety," was right up his alley. Even better, he had an eager young graduate student named Junko Kitanaka who was in Japan finishing her dissertation on the history of depression in the country; such a gathering of luminaries would be a boon to her research. In addition to those incentives, attendees would be given the chance to publish their presentations in a supplement of the prestigious *Journal of Clinical Psychiatry*. "I wouldn't say it was a no-brainer, but it wasn't very hard for me to say yes," Kirmayer remembers. "How much trouble could I get in?"

His first inkling that this wasn't a run-of-the-mill academic conference came when the airline ticket arrived in the mail. This ticket was for a seat in the front of the plane and cost nearly $10,000. The next hint came when one of the conference organizers told him in no uncertain terms that these would be closed-door meetings. His grad student, Kitanaka, would not be allowed to attend. There would be no uninvited colleagues and no press.

On arrival in Kyoto in early October 2000 he found the luxury of the accommodations to be beyond anything he had personally experienced. He was ushered into an exclusive part of the hotel, where he was given a drink while an attractive woman filled out the hotel forms. His room was a palatial suite. The bath was drawn and strewn with rose petals and dosed with frangipani oil. There was a platter on the credenza filled with fruits so exotic that he could identify only the mangosteens.

"This was Gordon Gekko treatment—the most deluxe circumstances I have

ever experienced in my life," Kirmayer says, smiling at the memory. This was how the other half lived, he realized—or, rather, how the other .01 percent lived. "The luxury was so far beyond anything that I could personally afford, it was a little scary. It didn't take me long to think that something strange was going on here. I wondered: What did I do to deserve this?"

Kirmayer was well aware that drug companies routinely sponsor professional conferences and educational seminars and that these events do double duty as marketing seminars. It was also common knowledge that drug makers use enticements to encourage both researchers and practitioners to attend. A prescribing doctor might be treated to a round of golf or a fancy dinner in exchange for attending an hour-long seminar about the effectiveness of some new drug. These practices are the medical equivalent of what real estate agents do to sell vacation timeshares.

But it was clear from the start that the gatherings of the International Consensus Group on Depression and Anxiety were different from the normal drug company dog and pony show, and not simply because the enticements being offered were so dear. Once the group of academics actually gathered in a plush conference room and began their discussions, Kirmayer realized quickly that the GlaxoSmithKline representatives in attendance had no interest in touting their products to the group. Indeed there was little mention of the company's antidepressant drug Paxil, which was just a few months away from hitting the market in Japan. Instead they seemed much more interested in hearing from the assembled group. They were there to learn. "The focus was not on medications," Kirmayer remembers. "They were not trying to sell their drugs to us. They were interested in what we knew about how cultures shape the illness experience."

As Kirmayer got to know them during the conference, he realized that the drug company representatives weren't from the ranks of the advertising or marketing departments or the peppy salespeople. As best he could tell, these were highly paid private scholars who could hold their own in the most sophisticated discussion of postcolonial theory or the impact of globalization on the human mind. "These guys all had PhDs and were versed in the literature," Kirmayer said. "They were clearly soaking up what we had to say to each other on these topics."

The intense interest the GlaxoSmithKline brain trust showed in the topic of how culture shapes the illness experience made sense given the timing of the meeting. The class of antidepressant drugs known as selective serotonin reuptake inhibitors (SSRIs) had become the wonder drug of the 1990s, at least in terms of the profits they'd garnered for the drug companies. That year alone, in the

leading regions for SSRIs, sales grew by 18 percent and totaled over thirteen billion dollars. Most of those sales were still in the United States, but there was wide agreement that lucrative international markets had yet to be tapped.

Indeed it was somewhat remarkable that none of the best-selling SSRIs had been launched in Japan. This was more than twelve years after Prozac became available for prescription in the United States. What caused this uncharacteristic timidity on the part of these pharmaceutical giants? It certainly wasn't that the Japanese eschewed Western drugs. To the contrary, U.S.-based companies at the time were exporting upwards of fifty billion dollars in medications to the country each year. It was said that Japanese patients felt underserved if they didn't come away from a doctor's visit with at least a couple of prescriptions.

But Eli Lilly, then the out-front world leader in the SSRI horse race with Prozac, had decided in the early 1990s not to pursue the Japanese market because executives in the company believed that the Japanese people wouldn't accept the drug. More precisely, they wouldn't want to accept the disease. "The people's attitude toward depression was very negative," explained a spokeswoman for Eli Lilly to the *Wall Street Journal.* She was referring to the fact that the Japanese had a fundamentally different conception of depression than in the West, one that made it unlikely that a significant number of people in Japan would want to take a drug associated with the disease.

Most other SSRI manufacturers followed Eli Lilly's lead and held off as well. Getting drugs approved in Japan was a costly gamble. The rules at the time required that drugs already on the market in Western countries had to be retested in large-scale human trials using an exclusively Japanese population. That meant years of effort and millions of dollars spent, with the distinct possibility that the drug might fail the trial. No company wanted to make such an investment if no market existed for the drug.

The Japanese pharmaceutical company Meiji Seika was the first to break from the pack, working through the decade to run Japanese trials on the SSRI Luvox, which it had licensed from the Swedish company Solvay. After reading Peter Kramer's 1993 book *Listening to Prozac*, Meiji's president, Ichiro Kitasato, sensed an unexplored opportunity in the Japanese marketplace. "People in the company said there are too few patients in Japan," he told a reporter in 1996. "But I looked at the U.S. and Europe and thought this is sure to be a big market."

GlaxoSmithKline was the next to get in the race. In the years prior to the 2000 conference in Kyoto, the company had spent an immense amount of money and resources jumping through the regulatory and bureaucratic hoops to get the green light to put Paxil on the market in the country. Having watched Prozac

dominate the American market in the late 1980s, drug company executives knew the advantages of early market share, and GlaxoSmithKline didn't want Luvox to be the only SSRI in Japan.

But both companies faced the same problem: there was no guarantee that Japanese doctors would prescribe the drug or that the population would be interested in taking it. The problem was that the profession of psychiatry in Japan, unlike in the West, seldom ministered to the walking worried; rather they focused almost exclusively on the severely mentally ill. Consequently, talk therapy was all but nonexistent in the country. For the small percentage of the population diagnosed with a debilitating mental illness, long hospital stays were the norm. The average stay in a mental hospital in Japan was over a year, versus just ten days in the United States. So although there was a psychiatric term for depression in Japan, *utsubyô,* what it described was a mental illness that was as chronic and devastating as schizophrenia. *Utsubyô* was the sort of illness that would make it impossible to hold down a job or have a semblance of a normal life. Worse yet, at least for the sales prospects of Paxil in Japan, *utsubyô* was considered a rare disorder.

At the Kyoto meeting Kirmayer began to understand the company's intense interest in the question of how cultures shape the illness experience. To make Paxil a hit in Japan, it would not be enough to corner the small market of those diagnosed with *utsubyô.* The objective was to influence, at the most fundamental level, the Japanese understanding of sadness and depression. In short, they were learning how to market a disease.

To have the best chance of shifting the Japanese public's perception about the meaning of depression, GlaxoSmithKline needed a deep and sophisticated understanding of how those beliefs had taken shape. This was why, Kirmayer came to realize, the company had invited him and his colleagues and treated them like royalty. GlaxoSmithKline needed help solving a cultural puzzle that might be worth billions of dollars.

Judging from the records of the conference, it's clear that the company got its money's worth. During the meetings eminent scholars and researchers gave insightful presentations on subjects ranging from the history of psychiatry in Japan to the Japanese public's changing attitudes about mental illness. The prominent Japanese psychiatrists in attendance were particularly helpful in framing the state of the public's current beliefs about depression and anxiety disorders.

Osamu Tajima, a professor at the Department of Mental Health at Kyorin University and a leading Tokyo psychiatrist, told the assembled group of a rising

public concern about the high suicide rates in Japan. He described how dozens of middle-aged men each year hike deep into the so-called suicide forests in the foothills of Mt. Fuji with lengths of rope to hang themselves. He described how service along the Central Line Railway in Tokyo was routinely disrupted by office workers leaping in front of commuter trains.

Tajima also gave a detailed description of how psychiatric services were structured within the overall health care apparatus of Japan. Services were in the midst of a critical change, he reported. There was a burgeoning concern in the population about mood disorders and the need for social attention to suicide rates and depression. He also documented how the Western definition and symptom checklist for depression—thanks to the influence of the *DSM* in the profession—was steadily gaining ground among younger psychiatrists and doctors in Japan. "Japanese psychiatry is undergoing a period of important change," he concluded, which was certainly good news for GlaxoSmithKline. He was upbeat about the changes heralded by the standardization of psychiatry around the world. "Adoption of internationally standardized diagnostic criteria and terminology in psychiatry will provide additional advances in assessing prevalence and facilitating accurate diagnosis." He was also clearly impressed with the scientific advances in drug treatments that were soon to come to his country. "New and effective treatment options," he said, "most notably the SSRIs, will contribute to reducing the burden of depression and anxiety disorders in Japanese society."

After lunch on the second day of the conference, it was Kirmayer's turn to speak. He had written many papers in his career documenting the differing expressions of depression around the world and the meaning hidden in those differences. He had found that every culture has a type of experience that is in some ways parallel to the Western conception of depression: a mental state and set of behaviors that relate to a loss of connectedness to others or a decline in social status or personal motivation. But he had also found that cultures have unique expressions, descriptions, and understandings for these states of being.

He told the assembled scholars and drug company representatives of how a Nigerian man might experience a culturally distinct form of depression by describing a peppery feeling in his head. A rural Chinese farmer might speak only of shoulder or stomachaches. A man in India might talk of semen loss or a sinking heart or feeling hot. A Korean might tell you of "fire illness," which is experienced as a burning in the gut. Someone from Iran might talk of tightness in the chest, and an American Indian might describe the experience of depression as something akin to loneliness.

Kirmayer had observed that cultures often differ in what he called

"explanatory models" for depression-like states. These cultural beliefs and stories have the effect of directing the attention of individuals to certain feelings and symptoms and away from others. In one culture someone feeling an inchoate distress might be prompted to search for feelings of unease in his gut or in muscle pain; in another place or time, a different type of symptom would be accepted as legitimate. This interplay between the expectations of the culture and the experience of the individual leads to a cycle of symptom amplification. In short, beliefs about the cause, symptomatology, and course of an illness such as depression tended to be self-fulfilling. Explanatory models created the culturally expected experience of the disease in the mind of the sufferer. Such differences, Kirmayer warned the group, tended to be overlooked when clinicians or researchers employed the symptom checklists relating to the *DSM* diagnosis of depression.

Understanding these differences is critical, however, because culturally distinct symptoms often hold precious clues about the causes of the distress. The American Indian symptom of feeling lonely, for instance, likely reflects a sense of social marginalization. A Korean who feels the epigastric pain of fire illness is expressing distress over an interpersonal conflict or a collective experience of injustice.

The wide variety of symptoms wasn't the only difference. Critically, not everyone in the world agreed that thinking of such experiences as an illness made sense. Kirmayer documented how feelings and symptoms that an American doctor might categorize as depression are often viewed in other cultures as something of a "moral compass," prompting both the individual and the group to search for the source of the social, spiritual, or moral discord. By applying a one-size-fits-all notion of depression around the world, Kirmayer argued, we run the risk of obscuring the social meaning and response the experience might be indicating.

Indeed, around the world, it is the Western conception of depression, in particular the American version of the disease, that is the most culturally distinctive. Kirmayer told the group that Americans are unique both in being willing to openly express distressful emotions and feelings to strangers and in our penchant for viewing psychological suffering as a health care issue. Because people in other cultures find social and moral meaning in such internal distress, they often seek relief exclusively from family members or community elders or local spiritual leaders. The idea of seeking help from a doctor or mental health professional outside one's social circle has traditionally made little sense.

The drug company representatives listened closely to Kirmayer's presentation

and thanked him heartily afterward. To this day, he's not entirely sure what they took away from his presentation. In the end Kirmayer's comments could have been taken in two ways. On the one hand, they could be seen as a warning to respect and protect the cultural diversity of human suffering. In this way, he was like a botanist presenting a lecture to a lumber company on the complex ecology of the forest. On the other hand, he might have told the GlaxoSmithKline representatives exactly what they wanted to hear: that cultural conceptions surrounding illnesses such as depression could be influenced and shifted over time. He made that point clearly in the conclusion of the paper he wrote based on his presentation:

> The clinical presentation of depression and anxiety is a function not only of patients' ethnocultural backgrounds, but of the structure of the health care system they find themselves in and the diagnostic categories and concepts they encounter in mass media and in dialogue with family, friends and clinicians.

In the globalizing world, he reported, these conceptions are

> in constant transaction and transformation across boundaries of race, culture, class, and nation. In this context, it is important to recognize that psychiatry itself is part of an international subculture that imposes certain categories on the world that may not fit equally well everywhere and that never completely captures the illness experience and concerns of patients.

In other words, cultural beliefs about depression and the self are malleable and responsive to messages that can be exported from one culture to another. One culture can reshape how a population in another culture categorizes a given set of symptoms, replace their explanatory model, and redraw the line demarcating normal behaviors and internal states from those considered pathological.

Kirmayer's appreciation of the irony of his brief encounter with GlaxoSmithKline has only grown over the years since he gave that presentation. "People like me got into cultural psychiatry because we were interested in differences between cultures—even treasured those differences in the same way a biologist treasures ecological diversity," Kirmayer told me. "So it's certainly ironic that cultural psychiatrists sometimes end up being handmaidens to these global marketing machines that are intent on manipulating cultural differences . . . in order to capitalize on those changes."

I asked Kirmayer how clear it was to him that GlaxoSmithKline was interested in changing notions of depression in Japan. "It was very explicit. What I was witnessing was a multinational pharmaceutical corporation working hard

to redefine narratives about mental health," he said. "These changes have far-reaching effects, informing the cultural conceptions of personhood and how people conduct their everyday lives. And this is happening on a global scale. These companies are upending long-held cultural beliefs about the meaning of illness and healing."

The consensus paper produced to summarize the Kyoto conference provided both an action plan and a marketing piece for GlaxoSmithKline. In that paper the International Consensus Group on Depression and Anxiety warned that depression was vastly underestimated in Japan but that Western scientific advances would soon be on hand to help. "Clinical evidence supports the use of SSRIs as first-line therapy for depression and anxiety disorders," the paper concludes.

Looking back, Kirmayer can now see how the company used the conference as the beginning of its broader marketing strategy; its representatives identified the cultural challenges and fleshed out the resonant cultural notes the company would attempt to play in the critical coming months and years. Among those themes were that suicide in Japan was an indicator of undertreated depression; that Western SSRIs represented proven scientific advances in treatment; that primary care physicians should use simple three-minute surveys to help diagnose mental illness; that patients not meeting the criteria for depression should still be considered sick; and that the Japanese should be helped to reconceive social stress related to work and industrialization as signs of depression that should be treated with SSRIs. These confident conclusions would prove the foundation on which GlaxoSmithKline would begin to change the culture of Japan.

Psychiatry in the Time of Cholera

The rapid rise of the depression narrative in Japan, which took place over the next few years, is remarkable in many respects. The marketing campaign of GlaxoSmithKline and other SSRI makers set off a seismic shift in the culture, the aftershocks of which are still being felt. And just as earthquakes are the expression of tectonic pressures that build slowly over decades, there were unseen forces in the cultural history of Japan that laid the groundwork for Glaxo-SmithKline's remarkable success.

To understand how GlaxoSmithKline was so successful in selling depression in Japan at the beginning of this millennium, it's important to spend some time

with a guide who knows the historical lay of the land. Ironically the person who best understands the cultural history of depression in Japan turns out to be none other than Junko Kitanaka, the grad student who was barred from the conference in 2000. In the years since, she finished her award-winning dissertation, “Society in Distress: The Psychiatric Prod-uction of Depression in Contemporary Japan,” and has taken up an associate professorship at Keio University, often called “the Harvard of Japan.”

A visitor to the university will quickly notice that Keio’s architects were intent on giving the place an Oxford–Ivy League flavor. At the Mita campus where Kitanaka works, campus gates are set in arches in red brick buildings and paths run into open courtyards filled with huge ginkgo trees that turn a luminescent yellow in the fall. As the style of the architecture suggests, Western influence on Japanese academia, particularly science and medicine, is hardly new.

When I asked Kitanaka how far back in time it was necessary to go to begin tracking the Western influence on mental health trends in Japan, she suggested that a good starting point was the mid-nineteenth century. This was when ideas of German neuropsychiatry and notions of neurasthenia—the disease of frayed nerves—first began to filter into Japanese professional and popular culture.

Cultures are most susceptible to outside ideas about the nature of the human mind at times of social change and upheaval, and the second half of the nineteenth century was just such a time in Japan. The Edo era—the rule of the shogun warlords—was at an end. For the previous 250 years Japan had stayed relatively isolated from many cultural trends and forces in the West, including those in science and medicine. During the long Edo era the population of Japan had thought of health mostly in terms of *yojo*, a set of concepts imported from China sometime between the seventh and tenth centuries. *Yojo* connected health with diet, mental control, exercise, and sexual restraint. It focused less on the control of disease or longevity and more on issues of social health, including morality, culture, and education.

During this time the concept that most closely tracked modern notions of depression would have been *utsushô*, which described the stagnation of vital energy, or *qi*. This stagnation or blockage could come from a combination of emotions, social conflict, loss, or the changing physiology of the body. Critically, however, *utsushô* was not thought of as an illness. As portrayed in plays and popular books of the time, *utsushô* described a nonpathological—indeed, a respected—way of being. The person affected by *utsushô* was not considered sick and did not necessarily seek a cure for his symptoms; rather it was expected that those affected would have to look for the social or moral

meaning in their distress.

As the rule of the shoguns was replaced with that of the emperor, Japan began to open up to ideas from Europe and the United States. The Japanese public's acceptance of psychiatry as a legitimate field of science and mental health largely paralleled the growing influence of Western medicine.

It was the cholera epidemics, which began in 1859 and plagued the nation for the rest of the century, that were critical in breaking the hold of the *yojo* beliefs regarding health. These deadly epidemics terrified the population. Thousands died. The sick and those thought to be infected were hauled away to hospitals under police guard. Whole neighborhoods were sealed off and quarantined. According to Kitanaka, the state used the outbreaks to justify the creation of an imposing network of local government controls that claimed authority from Western advances in medicine. Improvements in sanitary conditions and public hygiene did appear to limit the cholera epidemics, and the success was taken as proof that European and Western knowledge about health and illness had validity. Traditional beliefs surrounding *yojo* were increasingly replaced by newer ideas of *eisei*, which encouraged the population to think of health as something that must be actively and carefully cultivated by following scientifically approved hygienic practices.

In choosing which Western public health models to follow, health ministers in the Japanese government were particularly taken with the German model, which promoted the idea that the individual and the society were best thought of as a single organism, each dependent on the health of the other. As more and more Japanese doctors and public health officials studied advances in German medical practices, the burgeoning science of neuropsychiatry was bound to follow. It wasn't long before many of Japan's most promising psychiatrists were making pilgrimages to Germany to find mentors among the ranks of the famous neuropsychiatrists of the day.

Those German doctors were focusing their attention on the severely mentally ill, especially patients with psychotic symptoms related to schizophrenia or manic depression. For the most part they believed that such dramatic mental illnesses were caused by malfunctions somewhere in the brain or nervous system and were likely the result of inherited predispositions. Following these interests, the first psychiatrists in Japan also focused their ministrations on those with severe psychotic symptoms.

As the cholera epidemic introduced the Japanese public to Western notions of medicine, Western psychiatry was carried into public consciousness through crisis. That crisis was the combination of rapid social changes at the end of the

nineteenth century that included urbanization, the Industrial Revolution, and three wars within thirty years. Government officials and social commentators expressed increasing concern during this time over rising social problems such as increased juvenile delinquency and the disappearance of traditional practices and values. The government produced reports on rising suicide rates and the discontent of the working class. And just as Western-oriented medical doctors consulted with government officials to control the outbreaks of cholera, psychiatrists gave advice on the social discontent of the time. Newly minted psychiatrists in Japan, trained in German neuropsychiatry, suddenly found that they had a voice in these public debates.

In popular lectures and newspaper and magazine articles, these psychiatrists began to introduce new ideas into the popular culture. The people learned about hysteria in women, mental hygiene, and antisocial personalities. Given the uneasiness about the new realities of industrialization and urban living, there was intense interest and debate on these topics. One prominent intellectual wrote in the early part of the twentieth century that the new medical knowledge had brought to light many ailments that the people had never heard of and that had previously gone unnoticed. The people, he said, were now “constantly worried over the slightest changes in their health” and had consequently become “more vulnerable to illness.”

Japan’s First Mental Health Epidemic

Of the many ideas being imported from those Western advances in psychiatric thinking, one in particular struck a chord with the Japanese population. Riding on its recent popularity in the United States and Europe, neurasthenia was introduced to the Japanese public as an illness of modernity.

Writing in professional and popular forums, Japanese psychiatrists and others knowledgeable about Western illness categories carefully explained to the public that neurasthenia (translated as *shinkeisuijaku*) was a disease of the nerves. The idea that the body had nerve pathways, often described as tiny electrical cables, was a new one for the Japanese, but the notion quickly became conventional wisdom. The metaphor often employed to describe this new condition was that of electric streetcars. Just as a trolley would fail to function if its electric cables became worn or broken, so too could human wiring fray and malfunction from overuse.

What made neurasthenia different from other psychiatric illnesses studied by Japanese psychiatrists at the time was that it was not a disorder of the severely mentally ill but of the common man. “The rise of neurasthenia,” Kitanaka says, “was the first instance of the broad-scale medicalization of everyday distress in Japan.” She found remarkable parallels between the rise of neurasthenia at the beginning of the twentieth century and the introduction of the Western conception of depression at the beginning of the twenty-first.

Neurasthenia, she believes, became a compelling social narrative in Japan because it distilled and gave a name to the inchoate anxiety of the times. Commentators connected the disease with all manner of troubling trends, including increased marketplace competition, excessive studying, smoking, drug abuse, labor inequities, rising crime rates, and juvenile delinquency.

The excitement surrounding the diagnosis of neurasthenia came not only from the mental health professionals of the time but from popular culture as well. Articles, pamphlets, and books provided guides to self-diagnosis, symptom lists, and suggestions for which specific groups should be considered particularly vulnerable. People were told to be on the lookout for symptoms: insomnia, ringing in the ears, lack of concentration, stomach pains, eye fatigue, and the feeling that a heavy pot covered one’s head. A brisk market in pills and potions to cure the illnesses soon sprang up.

Unlike other mental illnesses being discussed in popular culture at the time, this one carried little social stigma. Indeed, because neurasthenia was at first considered an illness of the elites, the diagnosis became somewhat trendy. An article in an intellectual magazine circa 1902 was headlined “Neurasthenia: Operators, Writers, Government Officials, and Students, Read This.” The assumption was that those employed in positions requiring strenuous intellectual labor were dangerously taxing their nerves. “The media initially depicted it as an inevitable outcome for people on the forefront of the process of modernization, for whom exhausted nerves even became a mark of distinction,” Kitanaka explains. “An unprecedented number of cases of neurasthenia among elites, including government officials, company executives, university professors and artists began to be reported.”

The belief that neurasthenia was a disease of the elites and intellectuals no doubt helped with the wide acceptance of the illness in Japan. By the early years of the twentieth century, however, it was not only the elites on the front lines of cultural change who were claiming this disease of modernity. In 1902 an article reported that fully one-third of patients visiting hospitals for consultations were suffering from this new disease. Large and diverse segments of the population

were also reporting or being diagnosed as having frayed nerves. Neurasthenia was suddenly being referred to as Japan's "national disease."

But although the Japanese people seemed willing to accept, even idolize, this disease when it was only in an elite population, they were less sanguine when large numbers of regular citizens also invoked the diagnosis. With tens of thousands claiming the illness, the country was poised for a backlash.

An early sign of that change could be heard in the debate surrounding a single suicide that caught the public's attention. In 1903 a young student named Misao Fujimura carved a poem in a tree near Nikko, a popular scenic area north of Tokyo. The message in the brief verse was that life was "incomprehensible." When he finished, he walked to a local waterfall renowned for its beauty and leaped to his death.

Those who wrote about his suicide in the years afterward fell into two broad categories. There were many artists and intellectuals who saw such suicides as having great social and philosophical meaning. Fueling the rise of the neurasthenia diagnosis was a popular idea that some Japanese were too pure of heart to live with the conflicts, compromises, and demands of modern life. Misao's suicide was a brave act, some prominent thinkers suggested, committed by a young man freeing himself from the mental torture of modernity. This understanding of his actions was in line with a long Japanese tradition of viewing suicide as an act of personal resolve. Just as neurasthenia was considered a mark of distinction among certain elite groups, suicides among similar groups were often excused or even admired as expressions of the purity of the Japanese character.

But as the diagnosis of neurasthenia began to rise exponentially, some prominent doctors and officials stepped forward to challenge the social status given individuals like poor Misao. In a speech to psychiatrists reprinted in a 1906 issue of the *Journal of Neurology*, the statesman Shigenobu Okuma took a harder line:

> 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].

Prominent psychiatrists also began to question the diagnosis. In a book on mental illness published in 1912 a professor at Kyushu University wrote that

those who suffered from neurasthenia were “born with an inherent weakness in the brain” and had only “half the mental capacity of a normal person.” Not everyone who had a mentally taxing job, other psychiatrists pointed out, developed the disease; thus there must be something fundamentally wrong with the affected individuals to make them vulnerable.

Psychiatrists began to offer up new categories and formulations. They began to talk of the difference between the few who had “true neurasthenia” and a larger number of people who were burdened with a type of nervous disposition. This sort of disposition was not caused by the overwork and mental stress that came with high-profile elite jobs but came from an inherited abnormal personality that made the sufferer incapable of withstanding the everyday challenges of a normal life.

Looking back on the debate, it seems as if acceptance of neurasthenia had been so successful that psychiatrists felt obligated to *restigmatize* this mental disorder in hopes of limiting its adoption. By the end of World War II the diagnosis had almost completely gone out of style among both psychiatrists and the population at large. A new generation of psychiatrists wrote papers and gave presentations dismissing neurasthenia by suggesting that the thousands of patients who had claimed to suffer from the illness had either been misdiagnosed by uninformed doctors or were malingerers trying to get time off work.

The Culture of Sadness

During the early part of the twentieth century the concept of depression remained attached to the diagnosis of severe manic depression imported from those German neuropsychiatrists. It wasn’t until after World War II that depression became a disease category of its own. There was nothing mild about this conception of depression. This so-called endogenous depression was a crippling type of psychosis believed to be caused by a genetic abnormality. Professors of psychiatry at the time often explained endogenous depression using the metaphor of an internal alarm clock. “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,” Kitanaka explains. Endogenous depression expressed itself only in individuals with that ticking alarm clock and wasn’t connected to external causes.

At the same time another idea was gaining ground in Japan's mental health community. The personality *typus melancholicus* was introduced in the early 1960s by a professor of clinical psychopathology from Heidelberg named Hubert Tellenbach. This idea never caught on in the United States and rather quickly became dated in Germany, but it influenced psychiatric thinking in Japan. As Tellenbach first described it, someone with a melancholic personality possessed a highly developed sense of orderliness as well as "exceptionally high demands regarding one's own achievements." *Typus melancholicus* mirrored a particularly respected personality style in Japan: those who were serious, diligent, and thoughtful and expressed great concern for the welfare of other individuals and the society as a whole. Such people, the theory went, were prone to feeling overwhelming sadness when cultural upheaval disordered their lives and threatened the welfare of others.

Neither endogenous depression nor the melancholic personality type were of great concern to the general public at the time. Because endogenous depression was thought of as a psychotic state, akin to schizophrenia in severity, it carried a severe stigma and was considered rare. As for the melancholic personality type, its association with such prized Japanese traits as orderliness and high achievement meant that having such a sadness-prone personality was something not to be feared but aspired to.

This absence of a category parallel with the modern Western-style depression persisted for many years. When the *DSM-III* was first translated into Japanese in 1982, the diagnosis of depression, with its two-week threshold for low mood, was widely criticized among Japanese psychiatrists as far too expansive and vague to be of any use. Prominent psychiatrists believed, in short, that the description did not amount to a meaningful mental illness.

Indeed, as Kirmayer has pointed out, in the late twentieth century no word in Japanese had the same connotations as the word "depression" in English. Consider the various words and phrases that have often been translated into English as "depression." *Utsubyô* describes a severe, rare, and debilitating condition that usually required inpatient care and thus was not much of a match for the common English word "depression." *Yuutsu*, which describes grief as well as a general gloominess of the body and spirit, was in common use. There was also *ki ga fusagu*, which refers to blockages in vital energy. Similarly, *ki ga meiru* is the leakage or loss of such energy. Although each of these words and phrases had overlaps with the English word "depression," there were also critical differences. The experiences these words describe do not exist only in the thoughts and emotions but encompass full-body sadness. As such, the Japanese

person who felt *yuutsu* or *ki ga fusagu* was likely to describe it in terms of bodily sensations, such as having headaches or chest pains or feeling heavy in the head.

Not only did Japanese ideas of sadness include both the body and the mind but, metaphorically at least, they sometimes existed beyond the self. The experience of *yuutsu* in particular contained connotations of the physical world and the weather. A young Japanese researcher named Junko Tanaka-Matsumi, studying at the University of Hawaii in the mid-1970s, conducted a simple word-association test on a group of Japanese college students and compared the results to Caucasian American college students. The American students were asked to respond with three words that they connected with "depression." The Japanese students were asked to do the same with *yuutsu*.

The top ten word associations for the native Japanese were

1. Rain
2. Dark
3. Worries
4. Gray
5. Suicide
6. Solitude
7. Exams
8. Depressing
9. Disease
10. Tiredness

For the Caucasian Americans, the top ten word associations were

1. Sad or sadness
2. Lonely or loneliness
3. Down
4. Unhappy
5. Moody
6. Low
7. Gloom
8. Failure
9. Upset
10. Anxious

Comparing these answers, Tanaka-Matsumi saw a notable difference. In the responses given by the Japanese natives, only a few of the words (such as

"worries" and "solitude") were related to internal emotional states. On the other hand, the majority of the word associations supplied by the American students related to internal moods. The Japanese, in short, were looking outward to describe *yuutsu*, and the Americans were looking inward to describe depression. Tanaka-Matsumi believed that these were not simply linguistic differences but cultural "variations in the subjective meanings and *experience* of depression."

The Japanese and Americans weren't just talking about depression and sadness differently, she believed; they were *feeling* these states differently as well. What she saw reflected in the language was a difference between how Japanese and Americans conceived of the nature of the self. The word associations suggested that Americans experience the self as isolated within the individual mind. The Japanese, on the other hand, conceive of a self that is less individuated and more interconnected and dependent on social and environmental contexts. Feelings that Americans associate with depression have, in Japan, been wrapped up in a variety of cultural narratives that altered their meaning and the subjective experience for the individual.

Even as the *DSM* diagnosis of depression became more widely employed around the world during the 1980s, the experience of deep sadness and distress in Japan retained the characteristics of the premodern conception of both *utsushô* and the mid-twentieth-century idealization *typus melancholicus,* the idea that overwhelming sadness was natural, quintessentially Japanese, and, in some ways, an enlightened state.

As Kirmayer has documented, this was a culture that often idealized and prized states of melancholy. Feelings of overwhelming sadness were often venerated in television shows, movies, and popular songs. Kirmayer noted that *yuutsu* and other states of melancholy and sadness have been thought of as *jibyo,* that is, personal hardships that build character. Feelings that we might pathologize as depressive were often thought of in Japan as a source of moral meaning and self-understanding. He and others have connected this reverence to the Buddhist belief that suffering is more enduring and more definitive of the human experience than transient happiness.

Other cross-cultural scholars have also noticed this Japanese affinity for states of sadness. Studying menopause in Japan, McGill Social Studies of Medicine professor Margaret Lock wrote:

> Feeling sad and reacting sensitively to losses, particularly of loved ones, is an idea that has a singular appeal in Japanese. The theater, a range of literature and indigenous popular songs, traditional and modern, positively wallow in nostalgia, sensation 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.

This cultural embrace of sadness, Lock believes, might have been motivated by society's discouragement of other emotional states.

> 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.

Given these cultural currents, it makes sense that the first popular psychopharmacological medications adopted in the 1960s and 1970s were sedatives, whereas amphetamines and early mood enhancers were viewed with suspicion. As Lock implies, culturally designated pathological states are often the flipside of states a culture values. Along with the sedating drugs, Japanese quickly adopted disease categories describing social anxiety or aggression but resisted viewing deep and extended periods of sadness as a mental illness.

When the first SSRIs came online in the West, consequently, Japanese considered them harsh medications that exaggerated types of personality valued in the United States. A leading Japanese psychopharmacologist described how classes of drugs matched or ran afoul of different cultural narratives: "The Japanese system is much more modest and co-operative—people work together more. Against this background, amphetamines are much more of a problem than are the benzodiazepines; we are much more sensitive to the changes, the exaggeration of behavior, produced by the amphetamines. 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."

"One society's enhancement of personality can be another's pathology or provocation," remarks Kirmayer. "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."

Given all these cultural forces, it is not surprising that major drug companies at first saw no market for SSRIs in Japan at the beginning of the 1990s. The psychiatric category of depression was not a widespread public concern, and the capacity to experience great sadness was considered not a burden but a mark of

strength and distinction. That belief, combined with a suspicion of drugs that heightened moods or extraverted personality traits, made the market for SSRIs unpromising. Those public perceptions, however, were soon to change.

In the Lost Decade a Young Man Joins an Ad Firm

In the spring of 1990, 24-year-old Oshima Ichiro joined the Dentsu advertising agency, the largest company of its kind in the world. When he first showed up at Dentsu, Oshima was healthy and athletic. His fellow employees described him as honest, happy, and committed. Like many unmarried men, he lived with his mother, father, and brother. He had a girlfriend but no immediate plans to get married; establishing his career would come first. At Dentsu he was assigned the daunting task of handling public relations for more than forty corporate clients.

Because Oshima would come to symbolize a new understanding of depression among corporate workers in Japan, it is worth pausing to note the timing of his hiring in relation to the trajectory of the economy of Japan.

It was on the last trading day of 1989, just three months before Oshima started his new job, that the Japanese Nikkei index hit an all-time high. That index had nearly quadrupled in value over the previous five years. At the end of those go-go days, choice apartments in the Ginza district of Tokyo were going for nearly $100,000 per square foot. The Japanese economy was the envy of the world. It was a time when it seemed that any business could secure a loan and everyone with the willingness to work hard could ride the wave of prosperity.

But when stock traders got back to their posts at the beginning of January 1990, something had shifted. In the next days and weeks stocks began to slide, and then free-fall. By the time Oshima started his job in April there was something approaching panic in the financial markets.

As was true of many new hires, the sudden economic downturn steeled Oshima’s resolve to prove his worth. He showed right away that he was willing to roll up his sleeves and dig into his considerable workload. He often spent the first eight hours of his workday just trying to juggle meetings and field phone calls. Staying at work after hours was the only way he could write the press releases and proposals his clients required. Just a few months into his job, he was coming home past midnight on most nights. On some mornings, when his colleagues showed up for work, it was clear that the hard-driving Oshima had been at his desk the entire night. He took no days off.

In November 1990 his mother and father began to worry about his health. Oshima's eyes looked unfocused and he sometimes fell asleep while sitting with them at the kitchen table. In his contract, Oshima was promised ten days of vacation each year, and his parents suggested that he schedule some days to rest. But he refused. He felt that any days off would only increase the burden he would face when he got back to work. Anyway, he told them, he didn't think his boss would allow him the time off. Not knowing what else to do, his mother made him nutritious breakfasts in the morning and drove him to the train station to ease the burden of his hour-long commute.

After months at this sprinter's pace, cracks began to show in his behavior. At work small setbacks and mistakes brought on waves of self-loathing. "I'm no good as a human being," coworkers sometimes heard him saying out loud to himself. "I'm of no use."

The New Year brought no relief from the economic bad news or from Oshima's burdens. From its high in 1989, the Nikkei had lost nearly half of its value. Home prices were plummeting just as precipitously. The normally hardworking life in corporate Japan became even more intense. The frustration of Dentsu executives at their declining profits rolled down the chain of command, putting ever more pressure on the rank and file. At one late-night drinking binge at the office, Oshima's boss poured beer into his own shoe and demanded that Oshima drink it down. When he momentarily refused the request, his boss beat him.

By the summer of that year Oshima's workload had only gotten worse. On top of his regular duties, he was put in charge of a four-day conference for a client to be held in August. If he got home at all that summer, his parents remember, it was often simply to clean himself up before getting back on the train to the office. On the night before the beginning of the conference he managed to get home at 6 a.m. He was back at work less than four hours later to drive his boss to the site of the conference.

As they drove, his boss couldn't help but notice that Oshima seemed troubled. He drifted and swerved erratically from lane to lane. He mumbled incoherently, something about being possessed by spirits.

After a grueling four days at the conference, Oshima finally made his way back home at 6 a.m. on August 26. He looked so drawn and haggard that he promised his brother that he would go to the hospital that day. He called the office at 9 a.m. to tell them that he was sick and would not be in that day. Less than an hour later, his family found him dead. He had hanged himself in the bathroom.

When Oshima's parents' lawsuit against Dentsu came to court a few years after his death, newspaper editors and television producers featured the story prominently. It was an easy pick, given that the story had a clear antecedent. In the boom years of the 1980s hardworking Japanese businessmen sometimes collapsed and died at their desks after putting in weeks or months of overtime. In the press this was called *karoshi*, death from overwork, and reports on the trend had become popular. In the early 1990s suicides topped thirty thousand a year. This was between three and four times the number of Japanese killed in car accidents. The suicide trend became a concern to the general public and there was much debate over who or what was responsible. When Oshima's suicide came to light, journalists and editors immediately saw the story's potential. Headlines announced the new trend: *karojisatsu*, suicide from overwork. Because the Oshima family's lawsuit sought to assign blame for his death, it was tailor-made to become the focus of this public debate.

The lawyers for Oshima's parents argued that the stress of his job and his long hours brought on a depression that caused his death. This form of depression was different from the endogenous depression in the Japanese psychological literature because it hadn't resulted from an inherited defect in Oshima's brain; rather it was brought on by the circumstances of his life. This was a type of depression that could strike anyone.

The newspapers followed each revelation of the case. There was, for instance, the mystery of just how many overtime hours young Oshima worked during his time at Dentsu. According to the time sheets he submitted to the company, his overtime ranged between twelve and twenty hours each week. Lawyers for the company pointed out that that level of commitment was hardly unusual in hardworking Japan, and it was certainly not the sort of workload that you'd expect would drive a healthy and ambitious young man to hang himself in the bathroom. To prove that he had worked much longer than he claimed, the lawyers for his parents relied on the records of the office night guards, who were required to make frequent checks of each floor of the building, noting the names of the employees at their desks. Based on that evidence, it was clear that Oshima was clocking a much more problematic *average* of forty-seven overtime hours per week.

Oshima's parents won their case. As the Dentsu lawyers appealed the verdict through the courts they continued to argue that the company should not be held liable because Oshima's depression was a result of a preexisting mental weakness. They were, in effect, arguing for a pre–*DSM-III* version of endogenous depression: Oshima wouldn't have become sick had he not had that

alarm clock ticking inside his brain.

The different rulings of the higher courts rather neatly reflect a culture in the process of changing its collective mind. The Tokyo High Court first reduced the amount of the compensation, concluding that Oshima's inborn mental stamina was at least part of the cause in his death. "Not everyone becomes depressed from being overworked or being in a stressful situation," the verdict read. "It cannot be denied that his . . . premorbid personality resulted in increasing the amount of his own work." Here the court held onto earlier notions prominent in Japanese psychiatry: that inborn pathological characteristics were the psychiatric equivalent of fate. The Supreme Court, however, rejected that lower court's ruling and argued that individual character—as long as it is within a normal spectrum—should not be considered in such a case. The ruling suggested that anyone, put under enough stress, could succumb to depression.

Thanks partly to the debate over Oshima's suicide, the shift in public opinion during this period couldn't have been more dramatic. "When people first heard about the litigation, they would ask if it was the company, not the family, that was suing for the damage caused by the employee's suicide," said Kitanaka, who studied the case closely. "When Japanese heard in the media of the plaintiff's victory, many came to hear, probably for the first time, that suicide could be caused by a mental illness called depression."

That Oshima's lawsuit might be the first time many Japanese connected suicide with depression is hard for a Westerner to comprehend. Most Americans would certainly assume that suicidal acts are nearly always caused by mental illness, most commonly depression. Indeed the Western SSRI manufacturers who were eyeing the Japanese market in the 1990s routinely invoked the high suicide rate as proof positive of an epidemic of depression in Japan.

Yet the Japanese public remained split as to whether suicide was an intentional act with moral or philosophical meaning or a desperate act of a mentally ill person. In many ways the public debate regarding why Oshima hanged himself picked up the public dialogue that took place almost a hundred years before, when Misao Fujimura jumped off the waterfall. Although many Japanese agreed that the high rate of suicide was a legitimate public health concern, there was not yet a consensus that the epidemic, or the act of suicide itself, was the result of mental illness. In Japanese history, literature, and movies there were many stories of the noble suicide, such as when Samurai warriors committed *seppuku* and World War II soldiers killed themselves to avoid capture. Psychiatrist Masao Miyamoto was not alone when he remarked in 1998 that he didn't see much of a connection between the rise of suicide and

depression. Most of the reasons Japanese people kill themselves have nothing to do with depression, he argued. “A peculiarity of the Japanese is that they often die for the sake of the group,” he said. “They die for shame.” Wataru Tsurumi’s *Complete Manual of Suicide*, published in 1993, was the modern embodiment of the Japanese public’s intense interest in suicide. The book, written in flat, unemotional tones, is a guide to the ten most popular methods of suicide, including hanging, drowning, electrocution, and jumping from heights. The author awards a number of skulls to rate each method in categories such as painfulness, how much a nuisance you’ll cause others, how much effort is required, and the likelihood of success.* The remarkable sales of the book speak to a uniquely Japanese fascination. During the 1990s the book sold more than 1.2 million copies. If we can believe the author, the book was written not for shock value but from a deeply philosophical belief that suicide is a legitimate—and perfectly sane—act of personal will.

The story of young Oshima and several other prominent suicides from overwork put faces and personal stories on the growing public concern that Japan had ignored the mental health consequences of overwork. As was true at the turn of the nineteenth century, the end of the twentieth century was a disconcerting time for the people of Japan. Shameful bankruptcies were common and divorce and unemployment were on the rise. Just as at the end of the Edo era a hundred years before, the public was on the hunt to explain the distress being felt during these uncertain times.

The Japanese public’s impression that the country was behind the times in addressing mental health got a boost after the devastating earthquake in the city of Kobe in January 1995.* The government response to the disaster was criticized by Western mental health experts for being lackluster on many fronts. Researchers from the United States were soon on the scene and garnered much press attention by suggesting that the population needed not just food and shelter but more attention paid to their emotional and mental health.

Several prominent Japanese psychiatrists and mental health advocates used the authority of the visiting mental health experts to make a broad argument that Japanese culture discouraged talking about emotionally loaded issues. “The comparison, quite unfavorable to Japan, was often made to the United States, where the emphasis on psychological issues is generally believed to be culturally strong and given proper priority,” the anthropologist Joshua Breslau reported. “One well-known newspaper critic noted that his friend told him how nearly everyone in U.S. cities has a psychological counselor.”

A critical turning point came just three months after the Kobe quake. A TV producer named Kenichiro Takiguchi was browsing through the English-language section of a Tokyo bookstore and started to flip through a paperback copy of Peter Kramer's American best seller *Listening to Prozac*. Always on the lookout for good ideas for programs, he took the book to his bosses at Japan's largest television network and persuaded them to let him produce a fifty-minute special. The message of the special was similar to the beliefs made popular after the Kobe earthquake, namely, that Americans were far advanced in their recognition and treatment of emotional disorders such as depression and anxiety. The show hit a nerve. Millions watched and more than two thousand viewers called in afterward to praise the network for running the program.

Japanese psychiatrists were largely taken by surprise at this turn in public interest. Up to that point the public had eschewed the intrusion of psychiatry into daily life. As the small population of psychiatrists had mostly limited their practice to the severely mentally ill, the call to address common unhappiness and anxiety that came with bad economic times caught them off-guard. Like many people in the country up to that point, they had not considered unhappiness (or divorce or suicide) a mental health issue. They were in need of a new and compelling explanation for what was going on. Fortunately for them, GlaxoSmithKline and several other major psychopharmaceutical companies were just then preparing to throw them a lifeline.

Junk Science and First World Medicine

Kalman Applbaum, a professor at the University of Wisconsin in Milwaukee, is an anthropologist, but he doesn't study little-known tribes in far-off lands. His interest is closer at hand: the rituals and practices of international corporations. His specialty, the anthropology of the boardroom, has led to teaching posts both in anthropology departments and at business schools, including Harvard and Kellogg. He is also fluent in Japanese and often consults with companies interested in the Asian markets. When he heard in the late 1990s that major players in the pharmaceutical industry were attempting to introduce SSRIs to Japan, he knew he had the topic for his next set of research papers.

At the beginning of the new millennium, Applbaum went out of his way to visit the headquarters of GlaxoSmithKline, Lilly, and Pfizer, the major international players who were at various stages of trying to get their drugs into

Japan. At the time both Pfizer and Lilly were playing catch-up to GlaxoSmithKline, which was just then launching Paxil in the country. Although he had to sign nondisclosure agreements promising that he wouldn't identify the executives by name or company affiliation, Applbaum managed to get remarkable access to the inner workings of these companies. Several of his former MBA students who were then working in these firms helped make key introductions, but in the end these executives proved more than willing to talk. When I asked Applbaum why they were so forthcoming, he told me it was simple: because of his business school credentials and his extensive experience in the Japanese market, they thought he might be able to give them some free advice.

Applbaum discovered that the companies intent on entering the SSRI market in Japan were not battling each other like Coke and Pepsi for market share—or at least not at the beginning. Instead he found wide acknowledgment within the ranks of drug company executives that the best way for companies to create a market was for competing companies to join forces.

A critical player in this joint effort was the trade organization Pharmaceutical Manufacturers of America, or PhRMA, which functions as the national and international lobby and public relations organization for a coalition of major drug companies. In the late 1990s Applbaum found PhRMA working on a number of levels in Japan to influence what they considered to be a backward and bureaucratic drug approval process. As one PhRMA executive based in Chiyoda-Ku, Tokyo, told Applbaum, their job was to create "a market based upon competitive, customer choice and a transparent pricing structure that supports innovation." The lobby wanted drugs such as Paxil to be able to enter new markets based on "global, objective, scientific standards."

The more Applbaum talked to drug company insiders, the more righteous frustration he found. When he visited the offices of a leading SSRI manufacturer in November 2001, he discovered a wellspring of anger directed at what they perceived as Japanese resistance to pharmaceutical progress. These executives criticized scientific standards for clinical testing in Japan as "quite poor" and asserted that there was no "good clinical practice" in the country. Why, they asked Applbaum rhetorically, should their company be forced to retest these drugs in exclusively Japanese populations? The assumption was that the science behind the American human trials was unassailable—certainly better than anything the Japanese would attempt.

No doubt that annoyance at having to retest drugs was so intense because a couple of recent large-scale human trials of SSRIs in Japan had *failed* to show

any positive effects. Drugs such as Pfizer's Zoloft, which were widely prescribed in the United States, had at least one large-scale human trial failure in Japan in the 1990s. Instead of considering the meaning of such results, the drug company executives railed at Japanese testing practices, calling them second rate. "There is no sense of urgency about patient need in Japan," one executive complained to Applbaum.

The Mega-Marketing of Depression

Although drug company executives clearly would have preferred to avoid the expensive and time-consuming process of retesting their SSRIs in Japan, they ultimately found a way to put those trials to good use as the first step in their marketing campaign. The drug makers often bought full-page ads in newspapers in the guise of recruiting test subjects. Applbaum believes that this was one of several savvy methods the drug companies employed to sidestep the prohibitions in Japan on marketing prescription drugs directly to the consumer. These advertisements, supposedly designed only to recruit people for the trials, were well worth the cost, as they both featured the brand name of the drug and promoted the idea of depression as a common ailment. One company scored even more public attention when it recruited a well-known actress to take part in the trials.

But getting the drug approved for market was only the first step. Talking with these executives, it became clear to Applbaum that they were intent on implementing a complex and multifaceted plan to, as he put it, "alter the total environment in which these drugs are or may be used." Applbaum took to calling this a "mega-marketing" campaign—an effort to shape the very consciousness of the Japanese consumer.

The major problem GlaxoSmithKline faced was that Japanese psychiatrists and mental health professionals still translated the diagnosis of "depression" as *utsubyô*, and in the mind of many Japanese that word retained its association with an incurable and inborn depression of psychotic proportions. In hopes of softening the connotations of the word, the marketers hit upon a metaphor that proved remarkably effective. Depression, they repeated in advertising and promotional material, was *kokoro no kaze*, like "a cold of the soul." It is not clear who first came up with the phrase. It is possible that it originated from Kenichiro Takiguchi's prime-time special on depression. In that show, it was

said that Americans took anti-depressants the way other cultures took cold medicine.

Whatever its origin, the line *kokoro no kaze* appealed to the drug marketers, as it effectively shouldered three messages at the same time. First, it implied that *utsubyô* was not the severe condition it was once thought to be and therefore should carry no social stigma. Who would think less of someone for having a cold? Second, it suggested that the choice of taking a medication for depression should be as simple and worry-free as buying a cough syrup or an antihistamine. Third, the phrase communicated that, like common colds, depression was ubiquitous. Everyone, after all, from time to time suffers from a cold.

Although advertising couldn't mention particular drugs, companies could run spots in the guise of public service announcements encouraging people to seek professional help for depression. In these ads SSRI makers attempted to distance depression further from the endogenous depression as it was understood by Japanese psychiatrists for most of the century. One GlaxoSmithKline television advertisement showed an attractive young woman standing in a green field, asking, "How long has it been? How long has it been since you began to worry that it might be depression?" The scene then shows a woman on an escalator and then a middle-aged office worker staring out a bus window. The voiceover then recommends that if you've been feeling down for a month, "do not endure it. Go see a doctor."

The subtext of the ad is clear to Kitanaka. It presents depression as "intentionally ambiguous and ill-defined, applicable to the widest possible population and to the widest possible range of discomforts. . . . 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.'"

Depression was so broadly defined by the marketers that it clearly encompassed classic emotions and behaviors formerly attributed to the melancholic personality type. The label of depression then took on some laudable characteristics, such as being highly sensitive to the welfare of others and to discord within the family or group. Being depressed in this way became a testament to one's deeply empathic nature.

To get these messages out to the Japanese public, the SSRI makers employed a variety of techniques and avenues. Company marketers quickly reproduced and widely disseminated articles in newspapers and magazines mentioning the rise of depression, particularly if those pieces touted the benefits of SSRIs. The companies also sponsored the translation of several best-selling books first

published in the United States on depression and the use of antidepressants.

Given all the ways that GlaxoSmithKline and the other SSRI makers managed to make the average Japanese aware of their drugs, the official ban on direct-to-consumer marketing became almost meaningless. If there was any doubt about this, one only had to look at how these companies used the Internet. “The best way to reach patients today is not via advertising but the Web,” one Tokyo-based marketing manager told Applbaum. “The Web basically circumvents [direct-to-consumer advertising] rules, so there is no need to be concerned over these. People go to the company website and take a quiz to see whether they might have depression. If yes, then they go to the doctor and ask for medication.”

The mega-marketing campaign often came in disguised forms, such as patient advocacy groups that were actually created by the drug companies themselves. The website utu-net.com, which appeared to be a coalition of depressed patients and their advocates, was funded by GlaxoSmithKline, although visitors to the site would have had no clue of the connection. What they would have found was a series of articles on depression driving home the key points of the campaign, including the idea that it was a common illness and that antidepressants bring the brain’s natural chemistry back into balance.

The public interest in the new diagnosis brought a remarkable amount of media attention. Often in back-to-back months, the major magazines *Toyo Keizai* and *DaCapo* ran pieces on depression and the new drugs. In 2002 a leading Japanese business magazine ran a twenty-six-page cover story encouraging businesspeople to seek professional help for depression. The article rather perfectly mirrored the key points of the SSRI makers’ mega-marketing campaign and in many ways reflected the early conceptions of neurasthenia a century before. The article suggested that it was the more talented and hard-charging workers who were the most susceptible to depression. Estimates of how many Japanese secretly suffered from depression, which ranged from 3 to 17 percent of the population, seemed to increase every month.

The distress caused by the long-ailing economy also proved to be a useful selling point. GlaxoSmithKline promoted the idea that there was an enormous economic cost for untreated depression, which could be counted in lost man-hours and decreased productivity. In this way, the lure of the drug, especially to the younger generation, was tied to ideas about competition in the global marketplace. One Japanese psychiatrist was quoted in a local newspaper describing SSRIs as “drugs that can transform minus thinking into plus thinking” and that “can help a person live tough,” like financially successful Americans.

The SSRI makers made much of one public relations windfall in particular. It was rumored for years (and finally confirmed by the Imperial Household Agency) that Crown Princess Masako suffered from depression. Soon it was revealed that she was taking antidepressants as part of her treatment. This was a huge boost for the profile of depression and SSRIs in the country. Princess Masako's personal psychiatrist was none other than Yutaka Ono, one of the field's leaders that GlaxoSmithKline had feted at the Kyoto conference in 2001.

As a marketing line, there was one problem with the phrase *kokoro no kaze:* the metaphor lacked a sense of urgency about the condition. After all, one rarely rushes to the doctor with a cold. Worse yet, medicating a cold was always optional, as the illness goes away rather quickly on its own.

To counter this aspect of the metaphor, the drug companies leveraged the population's growing concern over the high suicide rates. The medical anthropologist Emiko Namihira reported that SSRI makers were funding studies to prove the link between depression and suicide. Those studies that showed a connection were reprinted in pamphlet form and reported to national media outlets as breaking news. Studies that failed to show a connection could simply be ignored. The founder of the Mood Disorders Association of Japan claimed in the *Japan Times* that "90 percent of those who commit suicide are considered to suffer from one kind of mental illness or another, and 70 percent of suicides are attributable to depression." Without medical attention, the message went, this "cold of the soul" could kill you.

When taken together, the messages advanced by GlaxoSmith-Kline during their rollout of Paxil don't always make sense. Previous notions of endogenous depression were employed only sparingly in order to evoke the seriousness of the disorder. On the other hand, they were happy to associate this new conception of depression with the Japanese veneration of the melancholic personality, even though that didn't particularly jibe with the parallel message that this was an illness caused by an imbalance of serotonin. Neither did the message that overwork could spark depression mesh with the idea that individuals should counter such social distress by taking a medication that changed their brain chemistry. If it was unrealistic social demands that were the cause of distress in the population, why should the individual be taking the pills? In the end, however, the coherence of these various messages took second place to their effectiveness.

Speeding the Evolution

After the Kobe earthquake in Japan there was growing consensus in the country that the West, and the United States in particular, had a deeper scientific understanding of pathological emotional states such as PTSD and depression. Responding to this insecurity, the advertisements, websites, waiting room brochures, and other materials produced by the drug companies played up the idea that SSRIs represented the cutting edge of medical science. These drugs, which were said to rebalance the natural chemicals in the brain, would bring Japan up to date.

GlaxoSmithKline worked very hard to win over the most prominent medical researchers and psychiatrists in the country and keep them on message. Their inclusion at lavish conferences such as the one Kirmayer attended was just a taste of the incentives offered. Drug companies offered grants to sponsor research on their drugs; those researchers who produced results favorable to the drugs found themselves with new offers of research funding. Research that showed the drug in question to be both safe and effective was trumpeted by the company and the researchers often paid as consultants. In addition, researchers were given honoraria for speaking about their findings at drug company–sponsored professional conferences. Influence over the prominent scientists and researchers in Japan was so pervasive that Applbaum concluded that these scientists and doctors had been basically "commandeered into a kind of market research by pharmaceutical companies. The research simultaneously serves as publicity for the essentially predetermined consumer need."

It is important to note that the drug company executives whom Applbaum interviewed didn't present themselves as people driven only by profits. Rather these men and women saw themselves as acting with the best of intentions, motivated by the belief that their drugs represented the proud march of scientific progress across the world. They styled themselves as people fighting depression, anxiety, and social phobia—diseases that remained cruelly untreated in Japan and elsewhere. Applbaum could see that this mixture of moral certainty and the lure of billions of dollars in potential profits was a potent force.

"These executives seemed to believe that they are straightforwardly trying to heal the world," said Applbaum. When he was meeting them in 2000 and 2001 he had no reason to doubt these self-assessments. "They seemed to believe their products were effective and they were baffled that anyone should question their value. The pharmaceutical industry, more than other industries, can link its marketing activities to ethical objectives. The result is a marriage of the profit-

seeking scheme in which disease is regarded as ‘an opportunity’ to the ethical view that mankind’s health hangs in the balance. This helps even the most aggressive marketers trust that they are performing a public service.”

Bolstering their certainty was their faith in the science behind these drugs. The fact that these SSRIs had proven clinically effective made it morally imperative that they be introduced into other cultures. The drug companies were replacing what one executive referred to as “junk science” in Japan with “first world medicine.”

During his talks with the executives, consultants, and marketers for the drug companies, Applbaum heard a repeated theme. These men and women kept talking about different cultures as if they were at different stages of a predetermined evolution. The American market, with its the brand recognition, high rates of prescriptions (by specialists and nonspecialists alike), and free market pricing, was seen as the most modern and advanced of markets. Japan was fifteen years behind the United States, executives would say. Or China was five years behind Japan. The lucrative U.S. market, Applbaum could see, was the standard against which all others were measured. We were the most “evolved” culture and, as one executive said to Applbaum, their job was to “speed the evolution along,” that is, to move other countries along the path to be like us.

This talk of evolutionary process wasn’t idle chatter, for it was often the same executives and marketing specialists who went from country to country waiting for the right moment to make their push. “Pharmaceutical manufacturers . . . circulate internal instructional materials regarding experiences with the same product in what they consider similar markets,” Applbaum said. “Managers fly about the world to training conferences where such archetypes are hardened. And old advertisements and communications strategies from the earlier stage of more ‘advanced’ markets are imported.” With each new implementation of the mega-marketing campaign, these drug companies learned new maneuvers and strategies. They got better at helping along the evolution.

The reasons these executives were so open about this endeavor goes back to their shared belief that the evolution in question was toward higher quality science. Westerners may have lost their sense of moral authority in many areas of human endeavor, but we can still get our blood up defending our science. We lead the world in scientific discovery and medical breakthroughs, so why shouldn’t the citizens of Japan and other countries around the world have access to the newest brand-name antidepressants? These molecules were created using the latest advances in science and technology. They had been reviewed by the

leading researchers at the world's most famous universities and found effective in studies published in the most prestigious scientific journals. The latest antidepressants, in this moral logic, were akin to antiretrovirals, polio vaccine, and penicillin. Everyone in the world deserved access to the fruits of our scientific discoveries as a human right.

It is not an argument without merit, but it depends rather critically on the accuracy and validity of the science behind the medical advance being touted. If the science is overblown, skewed, or downright wrong, then the moral certainty that fuels the charge into other cultures becomes suspect.

Blinding Them with Science

Of all the luxuries provided him during that Glaxo-sponsored Kyoto conference in 2001, Kirmayer remembers one evening with particular relish. On the second night of the conference he was instructed to dress in a "smart suit" and was taken to the Tsuruya restaurant, one of the most exclusive and expensive restaurants in Japan. At the restaurant he was shown the guest book, where Henry Kissinger and other world leaders had left their compliments. During dinner a personal geisha sat at his arm smiling and pouring his tea and sake. After trying to make small talk with this young woman in his limited Japanese, he turned to James Ballenger to bring up a question that had been on his mind.

Ballenger was the head of the International Consensus Group on Depression. For three years he and a group of other academic researchers hosted seven meetings at various luxury resorts and hotels around the world. At these conferences, funded by GlaxoSmithKline, Ballenger gathered prominent scholars and researchers to consider the best treatments for PTSD, panic disorder, and generalized anxiety disorder. In the end these supposedly independent scholars, with their affiliations to some of the world's finest universities, recommended that SSRIs be prescribed for all of these conditions. Tellingly, the only SSRI mentioned by name in the Consensus Group's summation paper was paroxetine, aka Paxil.

Kirmayer was curious about the relationship between the drug companies and academics like Ballenger who published the papers recommending these drugs. Wanting to be polite, he thanked Ballenger for the remarkable accommodations and treatment he was receiving. Kirmayer was, of course, in no position to take the moral high road, as he was at that very moment enjoying the splendor and

luxury for which GlaxoSmithKline was picking up the tab. Nevertheless he felt compelled to ask Ballenger, as nicely as he could: Isn't this something of a conflict of interest?

Although he can't remember what Ballenger said word for word, he remembers the gist.* "He told me, 'Look, I've made my peace with this a long time ago. The drug companies are going to do this anyway—they are going to market drugs and produce guidelines, so they can either do it with input of good people who are knowledgeable and scientifically sophisticated and evenhanded or not,'" Kirmayer remembers.

"In their heart of hearts," Kirmayer said, "I think academics who have consulted with drug companies think that they are doing good and that they deserve the consulting fees and perks." In short, no one seemed to be losing any sleep over the ethics of such a luxurious meeting being sponsored by a drug company. No doubt the thread count in the sheets helped in this regard.

At the time Ballenger's response did not seem unreasonable to Kirmayer. This was before it was revealed that many of the most influential studies on SSRIs, supposedly written by prominent academics, were in fact ghostwritten by private firms hired by drug companies. This was before it was widely known that many academics had taken hundreds of thousands of dollars (sometimes millions) in consulting and speaking fees while at the same time helping to hide or disguise negative data on the very drugs they were supposedly evaluating.

It has been only in the past few years, in fact, that these issues have become a public scandal prompting ongoing litigation and an investigation in the U.S. Senate. Many drugs and companies have been implicated in this recent upheaval, but one company and one drug have been at the very heart of the scandal: GlaxoSmithKline and Paxil.

Under even the mildest scrutiny, the confident marketing messages proclaiming the scientific validity of SSRIs begin to break down. Take for instance the idea, often repeated in the ads and promotional material surrounding the launch of SSRIs in Japan, that a depletion of serotonin is the root cause of depression and that SSRIs reestablish the "balance" of the "natural" chemicals in the brain. Pharmaceutical companies have been repeating this idea ever since SSRIs came on the market twenty years ago. On their website the makers of the SSRI Lexapro are still telling the story: "The naturally occurring chemical serotonin is sent from one nerve cell to the next. . . . In people with depression and anxiety, there is an imbalance of serotonin—too much serotonin is reabsorbed by the first nerve cell, so the next cell does not have enough; as in a

conversation, one person might do all the talking and the other person does not get to comment, leading to a communication imbalance."

Here's how GlaxoSmithKline describes the same idea on its website advertising Paxil CR: "Normally, a chemical neurotransmitter in your brain, called serotonin, helps send messages from one brain cell to another. This is how the cells in your brain communicate. Serotonin works to keep the messages moving smoothly. However, if serotonin levels become unbalanced, communication may become disrupted and lead to depression. . . . Paxil CR helps maintain a balance of serotonin levels."

As often repeated as this story is, it turns out that there is currently no scientific consensus that depression is linked to serotonin deficiency or that SSRIs restore the brain's normal "balance" of this neurotransmitter. The idea that depression is due to deficits of serotonin was first proposed by George Ashcroft in the 1950s, when he thought he detected low levels in the brains of suicide victims and in the spinal fluid of depressed patients. Later studies, however, performed with more sensitive equipment and measures, showed no lower levels of serotonin in these populations. By 1970 Ashcroft had publicly given up on the serotonin-depression connections. To date, no lower levels of serotonin or "imbalance" of the neurotransmitter have been demonstrated in depressed patients. The American Psychiatric Press *Textbook of Clinical Psychiatry* states simply, "Additional experience has not confirmed the monoamine [of which serotonin is a subgroup] depletion hypothesis."

SSRIs don't bring a patient's brain chemistry back into balance, but rather broadly alter brain chemistry. Although that change may sometimes help a depressed patient, the idea that SSRIs restore a natural balance of serotonin is a theory without evidence. Put another way, this idea is more of a culturally shared story than a scientific fact, in the exact same way neurasthenia's invocation of "frayed nerves" was a story.

What made this story so popular was that it turned out to be an effective marketing line, first employed in the United States and Europe and then around the world. SSRIs came on the heels of the public scandal about the overprescribing of benzodiazepines. These drugs, including Valium and Librium, were initially embraced by the medical establishment until they were revealed to be highly addictive. As SSRIs came to market, the public was understandably wary of psychopharmacological agents. The story that SSRIs only helped balance natural chemicals in the brain, therefore, was just what the public needed to hear. This marketing line was useful in a similar way in Japan, where many considered Western psychiatric medicines to be harsh and

unnatural.

In the end, to judge the value of a drug, its benefits must be considered in light of its risks. Unfortunately, in judging the benefit-risk balance of SSRIs one immediately runs into an even more complicated and thorny question: To what extent can the Western scientific literature describing the risks and benefits of these drugs be trusted? What worries many researchers is that the makers of pharmaceutical drugs such as SSRIs have gained remarkable control over the creation and presentation of the scientific data that purport to show that these drugs are safe and effective.

No man has fought harder to expose the process by which pharmaceutical makers control the knowledge pipeline behind their drugs than David Healy, a psychiatrist in the North Wales Department of Psychological Medicine and a professor at the University of Cardiff. Healy's particular crusade is not against SSRIs or the use of any drug in particular, but for the full and unbiased accounting of the data.* Because GlaxoSmithKline and other drug companies have control over the creation of the science, Healy argues, "there is almost no possibility of discrepant data emerging to trigger a thought that might be unwelcome to the marketing department of a pharmaceutical company."

This skewing and shaping of the data becomes more confounding as the information gets transmitted across cultures and languages by the marketers intent on selling the medication.

According to Healy, drug companies first started ghostwriting scientific papers for university researchers in the 1950s. Back then it was seen as a marginally disreputable practice, and these papers usually appeared only in obscure journals with little prestige or influence. But by the 1970s the drug companies had taken control of funding the major randomized control studies, and by the mid-1990s, Healy estimates, over half of the studies in the most prestigious journals were being drafted not by the university researchers supposedly heading the studies but by medical writing companies paid by the drug companies.

Once this became an accepted practice, the drug companies found that they not only had control over what information made it into print but they also had remarkable power over which university researchers rose to become stars in their field. "In effect," writes Nassir Ghaemi, director of the Mood Disorders and Psychopharmacology Programs at Tufts Medical Center, "ghost authorship is the steroid problem of academia; some of our experts get their fame artificially, their achievements appearing greater than they really are." Those who take the high

ground and refuse to be part of this process run the risk of falling behind their colleagues who are, so to speak, on the juice.

In the scientific and public discussion that surrounds these drugs, it is usually only the published results that influence opinion. Unfortunately, negative results almost never see print and therefore rarely become part of the debate. A recent review of seventy-four studies of antidepressants found that nearly all (thirty-seven out of thirty-eight) of the positive studies were published in professional journals. Of the thirty-six negative studies, only three managed to make it to print. The other thirty-three negative studies either went unpublished or were reported in a form that claimed a positive outcome different from the one the study intended to examine.*

When the raw data from the published and unpublished studies are examined together, the SSRIs begin to look nothing like the miracle drug being promoted in Japan and elsewhere. An analysis of the clinical trial data submitted to the U.S. Food and Drug Administration shows that about five out of ten test subjects given an SSRI improve over a couple of weeks on the depression rating scale. This at first seems like a fantastic outcome, until one considers the placebo group, those people in the trial who were given a sugar pill. On average, four out of ten patients taking a fake pill improve. Indeed, in many of the unpublished studies, SSRIs have failed to outperform placebos.

This means that only one in ten test subjects shows a positive response that can be attributed to the effect of the SSRI. This is hardly impressive, especially when one considers the fact that “improvement” doesn’t mean that the depression goes away but often only indicates a change on a symptom rating scale. A person who is still depressed but sleeping better, for instance, might be seen as improved. Indeed with enough test subjects, even minor changes in one or two of the checklist items can appear to be significant.

This rather anemic level of effectiveness would certainly surprise many Japanese who have been subject to the mega-marketing campaign promoting SSRIs as a cure for depression. Negative data get weeded out or spun, while even small beneficial results zoom through the supposedly scientific gatekeepers (the academics “authoring” the studies and the journal editors) to the salespeople, the marketers, and the public relations firms and out of the mouths of credulous journalists. Each stage of the process by which this information is manufactured distances the doctor and the depressed patient from the actual benefits and risks of the drug. When this information pipeline crosses cultural boundaries under the auspices of a mega-marketing campaign funded by the drug maker, the relation between the consumer’s perception of the product and

the science behind the drug becomes all but illusory.

In judging just how honest drug companies are being with the data, one example stands out. In July 2001, just as GlaxoSmithKline's marketing campaign in Japan was ramping up, a paper titled "Efficacy of Paroxetine [Paxil] in the Treatment of Adolescent Major Depression: A Randomized, Controlled Trial" was published in the *Journal of the American Academy of Child and Adolescent Psychiatry*, the most influential journal in the field. Among the half dozen authors were many prominent names, including lead author Dr. Martin Keller, the chairman of psychiatry at Brown University. The study had been conducted between 1994 and 1997 and included almost three hundred depressed adolescents. It was a double-blind study—the gold standard—meaning that neither the patient nor the doctor giving the pills knew which of the subjects were getting the drug being tested rather than the placebo. In the paper the authors gave their hearty approval, writing that Paxil was "generally well tolerated and effective for major depression in adolescents."

Within a month of the publication of the study, the company sales reps were alerted to the good news. A memo dated August 2001 from Paxil Product Management to "all sales representatives selling Paxil" trumpeted "this 'cutting edge,' landmark study" as having "demonstrated remarkable Efficacy and Safety in the treatment of adolescent depression."

Internal company documents that have come to light through lawsuits and government investigations report remarkably different results. Those internal memos suggest that the study had in fact failed to show a significant difference between Paxil and the placebo on any of the eight measures the study had set out to use. A company memo reported that the results had proven "insufficiently robust" and recommended that the company "effectively manage the dissemination of these data in order to minimize any potential commercial impact." The memo went on: "It would be commercially unacceptable to include a statement that efficacy had not been demonstrated, as this would undermine the profile of paroxetine (aka Paxil)."

Needless to say, this in-house assessment by GlaxoSmithKline staff stands in remarkable contrast to the published conclusion that Paxil was "well tolerated and effective for major depression in adolescents." But more disturbing still is that the published study apparently downplayed or hid the drug's side effects. Early drafts of the study, which came to light during lawsuits, show that serious side effects (including hospitalizations and suicide attempts) were more than five times more likely in the teens taking Paxil than in those taking the placebo. In addition, severe and often incapacitating problems with the nervous system were

four times more likely for those on the drug. Nevertheless, in the first version of the study submitted for publication there was no mention of any serious adverse side effects. In a subsequent version there was a sentence suggesting that "worsening depression, emotional lability, headache, and hostility" were possible side effects. Even that acknowledgment was left out of the final published version of the paper that reports the side effects as only one "headache."

So here is an example of the knowledge pipeline created by Glaxo-SmithKline. From the company's own internal documents we see that the study data that entered the pipeline showed that the effect of the drug on depression in teens was "insufficiently robust" and that some of those teens on the drug showed dramatic increases in hospitalizations and suicide attempts over those given the placebo. At the other end of the pipeline comes the marketing claim that the study "demonstrated remarkable Efficacy and Safety."

The story of this study, and the problem that it highlights, is not isolated. After two decades of working at the esteemed *New England Journal of Medicine*, Dr. Marcia Angell became convinced that the system by which these drugs gain scientific status is broken. "It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines," she wrote in 2009 in the *New York Review of Books*. The problems of ghostwriting and payments to researchers from the drug companies have, she said, reached their most florid form in the field of psychiatry and the studies of SSRIs.* The science behind SSRIs used to justify their sale in other cultures has proven to be suspect at best.

Suicides and SSRIs

The question of whether these drugs can, in some patients, increase thoughts of suicide has become a contentious public debate. Given that GlaxoSmithKline was leveraging the suicide-depression connection to sell Paxil in Japan, this question becomes even more salient. Healy estimates that SSRI trials, when taken together, show that about one in twenty patients become extremely agitated on these drugs. For some, that agitation will be so disquieting that it will spark suicidal thoughts or behavior. The likelihood is that these drugs are ineffective in most patients, work well for a small percentage of patients, and spark suicidal thoughts or behaviors in another small segment. Two well-

designed studies conducted fifteen years apart both point to this conclusion. In 1993 three researchers from the Department of Psychiatry at Harvard concluded that antidepressants, including the SSRI Prozac, likely lessened the chances of suicide in some patients while raising it in others. “These observations suggest that antidepressants may redistribute the risk, attenuating risk in some patients who respond well, while possibly enhancing risk in others who respond more poorly.”

Fully fifteen years later another set of researchers, these from the College of Physicians and Surgeons of Columbia University, came to a similar but more refined conclusion. This study looked closely at two years’ worth of patient data and found that in adults there was no significant difference between the group that got the drug and the group that didn’t. In teenagers and children, however, those who took the drug were significantly more likely than those who didn’t to attempt suicide within four months after being started on the drug. Looking at the data further, researchers found one group in which the drug had a protective effect against suicidal behavior: adult men. The redistribution of the risk, in this case, appeared to be away from adult males and toward teenagers and children.

In the end it is possible that both the critics of SSRIs and their promoters might have legitimate points on the suicide question. The agitation and aggression sometimes noted in association with these drugs are most pronounced early in the treatment, the very period often focused on in clinical trials. In real-world use such negative reactions to the drug may lessen or disappear after this early period. In addition, attentive doctors may quickly take a patient off the drug, so that only patients who respond well (or at least don’t spiral into suicidal behavior) continue taking the drug. Thus it is possible that these drugs increase suicidality in test subjects in short-term clinical trials, as critics have contended, *and yet*, when judged over years, reduce suicide in the overall population.

Even if it proves to be true that SSRIs reduce suicidality in large populations, the drug companies and the researchers who helped them distort or underreport negative data might still be culpable. Had those early treatment risks been accurately reported in the published research on these drugs, doctors would have had a chance to change the way they monitored their patients and been better prepared to spot a patient having a bad reaction. Because suicidal behavior has been demonstrated even in healthy subjects (those taking the drug with no symptoms of depression), doctors almost certainly would have second-guessed prescribing this medication to those with only mild symptoms of depression.

The timing of who knew what and when regarding the risks associated with Paxil is a critical issue because Japan was so late in adopting the drug. Was

GlaxoSmithKline hiding or downplaying side-effect risks at the same time it was rolling out its mega-marketing campaign in Japan? Internal company documents that surfaced in a recent lawsuit appear to answer that question quite clearly. Data originally submitted to the U.S. Food and Drug Administration back in the late 1980s and early 1990s, but never published, appear to have been presented to intentionally hide results that test subjects on the drug had an eightfold increase in the risk of suicidality. “It looks like GlaxoSmithKline bamboozled the FDA,” Senator Charles Grassley said in a speech on the floor of the Senate after he examined the evidence. “We cannot live in a nation where drug companies are less than candid, hide information and attempt to mislead the FDA and the public.”

The extent to which the SSRI makers have manufactured and systematically controlled the creation, flow, and international distribution of the science is hard to overstate. Take a step back and look at the system as a whole, and you can suddenly see it in a different light, as a massive interconnected marketing system. Applbaum, the anthropologist who documented the SSRI invasion of Japan, puts it this way:

> Actors traditionally found outside the “distribution channel” of the market are now incorporated into it as active proponents of exchange. Physicians, academic opinion leaders, patient advocacy groups and other grass roots movements, nongovernmental organizations, public health bodies, and even ethics overseers, through one means or another, have one by one been enlisted as vehicles in the distribution chain. . . .
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> In our pursuit of the near-utopian promisea of perfect health, we have, without realizing it, given corporate marketers free rein to take control of the true instruments of our freedom: objectivity in science, ethics and fairness in health care, and the privilege to endow medicine with the autonomy to fulfill its oath to work for the benefit of the sick.

Even the patient, often now referred to as the “consumer,” has been enlisted in the distribution chain. In marketing directly to the consumer through the Internet and various other avenues, drug companies can claim to be treating patients as informed consumers. Such informed consumers can be enlisted to petition their doctors and drug review boards for access to the drugs. This has been heralded as a positive change: no longer is the patient a passive recipient of the doctor’s privileged knowledge. Unfortunately, the patients, particularly those living outside the United States, are often the last to know that the knowledge they are acquiring may have been manipulated to create specific beliefs and desires.

Early Adopters Have Second Thoughts

There is no doubt that the efforts of GlaxoSmithKline in Japan proved profitable. In just the first year on the market Paxil sales brought in over 100 million dollars. At the end of 2002 the company reported, “Sales of Seroxat/Paxil, GSK’s leading product for depression and anxiety disorders, was the driver of growth in the CNS (Central Nervous System) therapy area, with sales of 3.1 billion, up 15% globally and 18% in the USA. International Sales of Paxil Grew 27% to $401 million led by continued strong growth in Japan, where the product was launched only two years ago.” By 2008 sales of Paxil were over one billion dollars per year in Japan.

Kitanaka has been stunned to see how fast things have changed in Japan since SSRIs were introduced. “The whole culture surrounding psychiatry has changed drastically,” she told me. “From a stigmatizing notion that no one talked about, depression has become one of the top concerns of people. It has become a legitimate disease at so many different levels and at the same time these changes have transformed the nature of depression as an experience itself.”

Some Japanese psychiatrists, even Ono and Tajima, whom the company feted in 2000, felt they were not leading this new trend but reacting to it. Ono reports that starting in 2001 he suddenly had a rush of patients showing up at his office with either a magazine article or an advertisement in hand and wanting to talk about their depression. It was clear to him that the mild symptoms these patients described would not previously have been considered an illness. As more and more Japanese began to identify themselves as depressed and as the risks of SSRIs came to his attention, he has wondered if there were ways to reverse the trend.

“The marketing campaign has been in many ways too successful. The slogan, depression is like a ‘cold of the soul,’ has convinced far too many people to seek medical treatment for something that is often not an illness,” Ono told me. “Perhaps we could start saying that depression is like a ‘cancer of the soul.’ That would be more accurate and perhaps not so many people would be willing to adopt that belief.”

Dr. Tajima has come even further in his thinking. Tajima is the prominent psychiatrist who made such encouraging remarks in Kyoto in 2000 about the adoption of international diagnostic standards that would “facilitate accurate diagnosis.” At the time he welcomed the introduction of SSRIs, saying that they would “contribute to reducing the burden of depression and anxiety disorders in

Japanese society." For several years after the conference, Tajima was a central figure in the company's attempt to win over other psychiatrists in Japan. He was paid well by GlaxoSmithKline to give speeches and appear at conferences. The paper based on his talk at the Kyoto conference was widely used in the company's educational material.

But in the past few years he has become concerned as he's watched just how many of his countrymen have been diagnosed with depression and started on Paxil. Revelations made public by David Healy and others have caused him to become skeptical as to whether GlaxoSmithKline has accurately reported the scientific data regarding the drug's effectiveness and risks. He has taken it upon himself to translate one of Healy's books into Japanese and now jokes that he is going to become "the David Healy of Japan."

In discussing the remarkable changes that he's seen in Japan over the past ten years, Tajima does not come off as a man who is angry with GlaxoSmithKline. Indeed, in recounting his own participation in these changes, he often laughs heartily, like a man telling the story of how he was thoroughly fooled by a talented magician or card shark. His laughter communicates "I have only myself to blame."

He maintains that Paxil is helpful for some anxiety disorders and can be used in serious cases of depression so long as the patient is monitored closely through the early days of treatment. However, he has come to believe that the drug is massively overprescribed and that it can sometimes spark suicidal thoughts in patients. "After the Ministry of Health in Japan issued a warning of a suicide risk with this drug for patients under twenty-five, many doctors and patients are now aware of this risk," says Tajima. What he can't understand, however, is why the drug remains so widely prescribed for patients with depressive symptoms that are transient and relatively mild. The warning about the risk of suicide seemed not to have had much effect against the forces of the mega-marketing campaign sponsored by GlaxoSmithKline in the years since 2000.

Tajima has also come to mistrust the confident science presented by the pharmaceutical manufacturers. Although he is aware that the drug companies don't take kindly to criticism, he is committed to fighting the good fight and getting the best information to the Japanese people any way he can.

Did he have any hope, I asked him, of challenging the imported ideas that helped popularize depression in Japan? "The force of this tide is still very strong," Tajima said. He did point to some signs that might indicate a lessening of the momentum. The marginal effectiveness of the drug has not gone unnoticed. "There are so many patients in Japan who have not improved and not

recovered," he told me. "Many ordinary people now have questions about these so-called magic drugs."

As journalists often do, I saved the most uncomfortable question for the very end of my interview with Dr. Tajima. I told him that I did not want to pry too far into his personal finances, but I wanted to know how he felt about the money he had taken from GlaxoSmithKline over the years. "Yes," he said, laughing again. "This is a very important question. Some people say that this relationship between the researchers and the drug companies is a kind of prostitution. I agree. But I am not a puritan. I am a very realistic man. This is very problematic. We have to change the current situation not only in Japan but also in the United States and other countries. The strong force of the pharmaceutical industry threatens to turn medicine into a pseudoscience in the same way they have made opinion leaders in the field of Japanese psychiatry into a type of prostitute."

Then he paused, laughed again, and added, "We were very cheap prostitutes."

Conclusion

The Global Economic Crisis and the Future of Mental Illness

Cultures become particularly vulnerable to new beliefs about the mind and madness during times of social anxiety or discord. It is no surprise that the Western form of anorexia was able to worm its way into the unconscious minds of young Hong Kong women in the uneasy years between the Tiananmen Square massacre and the British handover of the province to China. As demonstrated in Sri Lanka, the Western notion of PTSD often gains a hold because it is deployed in populations that are disoriented and reeling from wars or natural disasters. It is also no coincidence that the GlaxoSmithKline version of depression caught hold in Japan during that country's lengthy and painful recession. Ongoing economic upheaval can be particularly unsettling because the unrelenting threat to one's status, security, and future seems to come from everywhere and nowhere at the same time.

In early 2009, as I was researching the chapter on depression and Japan, the world economy went into a tailspin. What happened to the Nikkei in 1990 appeared to be happening to every major stock index, from the S&P 500 to the OMX Copenhagen 20. The globalization of the world economy, which had wrought a great many disorienting changes, had now brought us something new: a truly global economic crisis. The social upheaval that made Japan vulnerable to GlaxoSmithKline's mega-marketing campaigns was now prevalent in pretty much every country in the world.

As the crisis grew I listened for the first mental health experts to step forward with warnings about the psychological consequences of the crisis. Quick on their heels, I was sure, would come the promise of new medicines and perhaps even a new category of mental illness to explain our distress.

I didn't have to wait long.

In early February articles about the downturn's effect on mental health began to appear in major publications. "Suicides: Watching for a Recession Spike" was one headline at *Time* magazine. "Suicide experts say there is a strong correlation between acute financial strains and depression," the article reported. Near the same time, *USA Today* reported, "Signs abound that the battered economy is causing serious damage to mental health. . . . Nearly half of Americans said they were more stressed than a year ago, and about one third rated their stress level as 'extreme' in surveys conducted by the American Psychological Association."

The *New York Times* soon had its own front-page story: "Recession Anxiety Seeps into Everyday Lives." Quoting experts and individuals, the article listed over two dozen mental health problems caused by economic worries. These symptoms ranged from the mundane (sleeplessness, anxiety, constant worrying) to the severe and sometimes bizarre (struggling to breathe, rapid heartbeat, chills, choking sensation, numbness and tingling in the fingers, and arthritis). Such a wide-ranging list of potential symptoms suggested that we were in the midst of creating the symptom pool for the current economic crisis. We were publicly debating, as a culture, which symptoms and pathologies we would jointly recognize as legitimate expressions of economic anxiety.

Many of these articles pointed out that our national mental health was already poor and was now certain to get worse. The National Institute of Mental Health announced that one in every four Americans age 18 and older suffers from a diagnosable mental disorder *each year*. Among young adults mental illnesses had become the leading cause of disability. There were other troubling signs: a study came out suggesting that the mental disorders sparked by Hurricane Katrina were proving strangely resistant to both treatment and the healing effect of time; fully three years after the fact, the incidence of mood disorders and PTSD linked to the disaster was still rising in Louisiana.

To counter such bad news, Senior Vice President Ken Johnson of the pharmaceutical advocacy group PhRMA announced that no fewer than 301 new medicines were in development to treat mental illnesses, including sixty-six for depression and fifty-four for anxiety disorders. It was important, given the worrisome trends, that the public knew that new medications were on the way to help people "live longer, happier, healthier lives."*

Of course, just what types of disorders those 301 new drugs will be tasked to treat depends largely on the American Psychiatric Association, which will soon publish a new edition of its influential diagnostic manual, the *DSM-V*. The research journals have been filled with suggestions for changes and additions and APA work groups are currently in the process of hashing out which

disorders will be included, changed, or cut.

As if to demonstrate the point that the creation of mental illness categories remains as much a social and cultural endeavor as a scientific process, the APA is soliciting input from the public. As of this writing there is still a "Make a Suggestion" link on the association's website describing the *DSM-V* project. Click on that link and you are presented with a number of options, including "Submit suggestions for deletion of an existing disorder" and "Submit suggestions for a new disorder to be considered for addition to *DSM-V*." All suggestions, the public is promised, will be routed to the proper *DSM-V* work group for debate.

If I had to lay a bet on which new disorder recently discussed in the psychiatric literature has the most promising future, it would be "post-traumatic embitterment disorder." PTED describes the reaction to an exceptionally negative but not life-threatening event, such as conflict in the workplace, sudden unemployment, the loss of social status, and separation from one's social group. Symptoms include embitterment, feelings of injustice, and helplessness.

If PTED can get enough allies on the right *DSM-V* work groups and a multinational drug company with a new drug targeting the condition, this disorder has the chance to be the next PTSD, for it seems well suited to describe many of the reactions to the precipitous cultural changes during this time of globalization and economic crisis. Indeed the disorder was first "discovered" among East Germans who had become unmoored, unemployed, and insecure in the social upheaval following the fall of the Berlin Wall.

Whatever new disorders end up in the *DSM-V* and whatever new drugs and treatments are declared scientifically proven to be effective for treating them, there is no doubt that the American public will show intense interest. We are a psychologically oriented people. Experts will appear on talk shows and provide quotes and commentary for journalists. Over time these new discoveries will become cultural certainties, conventional wisdom. In this process these new disorders will further shape our conscious and unconscious senses of self.

Then the Western mental health profession will take the show on the road. At international conferences in exotic locales professionals will train foreign healers in these new disease categories. Drug companies lured by potential profits will engage in ever more sophisticated mega-marketing campaigns. In cultures made vulnerable by the global financial crisis and the speed of social change, the seeds of these ideas will no doubt find fertile ground.

If the irony isn't already obvious, let me make it clear: offering the latest Western mental health theories in an attempt to ameliorate the psychological

stress caused by globalization is not a solution; *it is a part of the problem*. By undermining both local beliefs about healing and culturally created conceptions of the self, we are speeding along the disorienting changes that are at the very heart of much of the world's mental distress. It is the psychiatric equivalent of handing out blankets to sick natives without considering the pathogens that hide deep in the fabric.

While I was in Zanzibar researching how Swahili beliefs were mixing with Western biomedical notions of mental illness, my wife, who is a psychiatrist, sent me a text message from our home in San Francisco. The brief note told of a tough day. A patient in her private practice had suffered a psychotic break and had to be admitted to a psychiatric ward.

The note reminded me of a point my wife had made often: while I was traveling the world documenting how Western-born cultural currents are altering beliefs about the mind, mental health professionals in the United States and elsewhere had little choice but to do the best they could with the knowledge and technology they had at hand. She worried, you see, that this book would unfairly disparage the mental health profession, a group of people, including herself, who are doing their best to heal troubled minds.

Keeping that concern in mind, I have tried to avoid making the clichéd argument that other, more traditional cultures necessarily have it right when it comes to treating mental illness. All cultures struggle with these intractable diseases with varying degrees of compassion and cruelty, equanimity and fear. My point is not that they necessarily have it right—only that they have it different.

It is not surprising that we want to believe everyone is just like us. As with any generation in human history, we have little awareness of how our culture shapes our mental life because it so envelops us, informing both our conscious and our unconscious thinking. We are like swimmers out of sight of land: it is difficult to gauge the direction and strength of the cultural current that carries us along. Difficult, certainly, but not impossible. As this book suggests, deep explorations into the beliefs of other cultures can reveal our own cultural biases in startling ways.

So what does a cross-cultural perspective reveal about our conception of the mind?

The ideas we export to other cultures often have at their heart a particularly American brand of hyperintrospection and hyperindividualism. These beliefs remain deeply influenced by the Cartesian split between the mind and the body, the Freudian duality between the conscious and unconscious, as well as teeming

numbers of self-help philosophies and schools of therapy that have encouraged us to separate the health of the individual from the health of the group. Even the fascinating biomedical scientific research into the workings of the brain has, on a cultural level, further removed our understanding of the mind from the social and natural world it navigates. On its website advertising its antidepressant, one drug company illustrates how far this reductive thinking has gone: “Just as a cake recipe requires you to use flour, sugar, and baking powder in the right amounts, your brain needs a fine chemical balance in order to perform at its best.” The Western mind, endlessly parsed by generations of philosophers, theorists, and researchers, has now been reduced to a batter of chemicals we carry around in the mixing bowl of our skulls.

What is certain is that in other places in the world, cultural conceptions of the mind remain more intertwined with a variety of religious and cultural beliefs as well as the ecological and social world. They have not yet separated the mind from the body, nor have they disconnected individual mental health from that of the group.

With little appreciation of these differences, we continue our efforts to convince the rest of the world to think like us. Given the level of contentment and psychological health our cultural beliefs about the mind have brought us, perhaps it’s time that we rethink our generosity.