ETHAN WATTERS

ETHAN WATTERS'S WORK IS controversial—some might even say explosive—although it has appeared in mainstream venues like the *New York Times Magazine, Discover, Men's Journal,* and *Wired.* His first two books, coauthored with University of California sociologist Richard Ofshe, are highly critical of psychiatry and psychoanalysis: *Making Monsters: False Memories, Psychotherapy, and Sexual Hysteria* (1996) and *Therapy's Delusions: The Myth of the Unconscious and the Exploitation of Today's Walking Worried* (1999). If these books still generate sharp differences of opinion, the same holds for Watters's most recent work, *Crazy Like Us: The Globalization of the American Psyche* (2010). While acknowledging the reality of mental illnesses, he wants his readers to understand that the terminology we apply to them reflects our own history and culture, and he notes that the categories other people use sometimes have strengths that our tradition lacks. One example Watters explores in *Crazy Like Us* is the aftermath of the tsunami that struck the island of Sri Lanka in 2004, killing 35,000 people and displacing half a million. Moved by genuine compassion, teams of American mental health professionals raced to the island to provide psychological services for post-traumatic stress disorder (PTSD). But Watters found that PTSD is a distinctly Western reaction. Many islanders experienced the aftermath as a loss of social connections—as loneliness rather than a disease of their private minds.

Watters fears that, because of globalization, humankind is now at risk of losing a rich legacy:

> The ideas that we export to other cultures often have at their heart a particularly American brand of hyperindividualism. These beliefs remain deeply influenced by the Cartesian split between the mind and the body ... 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 ... research into the workings of the brain has, on a cultural level, further removed our understandings of the mind from the social and natural world it navigates.

What concerns Watters even more, however, are Western drug companies engaged in a crusade to replace indigenous knowledge with Western paradigms that will

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Quotation comes from Ethan Watters, *Crazy Like Us: The Globalization of the American Psyche* (New York: Free Press, 2010), 254.

open up highly lucrative new markets. Not only does Watters nudge us to think about the ways that "scientific" notions of the mind are not universally valid, but he presses us to ask about the damage done to everyone, here in the United States and around the world, by the intermingling of mental health with the profit motive.

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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 [Diagnostic and Statistical Manual of Mental Disorders]*—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 stomach aches. 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....

The Culture of Sadness

During the early part of the twentieth century the concept of depression [in Japan] remained attached to the diagnosis of severe manic depression imported from ... 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," Junko 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 Kitanaka shows that 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....

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 antidepressants 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.... 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 GlaxoSmithKline 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....

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....

SOURCES

The scholars at McGill University are overrepresented in this book because that university is a hotbed for the study of cross-cultural psychiatry. That fact, I believe, has much to do with Laurence Kirmayer, whose work and leadership in the field informs not just this chapter but this entire book. Junko Kitanaka, Kirmayer's former graduate student, was as generous as her mentor with her time and guidance. The history of the evolution of Japanese understanding of depression relies critically on her dissertation—in particular, the recounting of the suicide of Oshima Ichiro and the public attention surrounding suicide from overwork. Her book on the history of depression in Japan will be out within a year or two, and I will be first in line at the bookstore to snap it up. David Healy was an inspiration both for his research on the science behind SSRIs and for his dogged courage.

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QUESTIONS FOR MAKING CONNECTIONS WITHIN THE READING

1. Is depression real or not? Does Watters seem to believe that the condition is imaginary? How can depression have biological roots and yet be experienced in different ways? Does Watters seem to accept the view that the West's understanding of depression is true, whereas the explanations other cultures offer are arbitrary and unscientific? Do the pharmaceutical companies feel that they possess the best understanding of depression? How do the modern Japanese regard Western psychology?
2. What can we learn from Watters's story about the relationship between academic researchers like Laurence Kirmayer and the pharmaceutical industry? Does Watters suggest that drug manufacturers are deceptive? Do they lie to Kirmayer, or is the connection between them more complex than that? Have they lied to the Japanese, or are the drug manufacturers convinced that they are truly doing good? Does Watters's narrative indicate that academic research has been compromised by commercial interests? Does he seem to think that there needs to be a stricter separation between research and commercial interests? Is such a separation possible when commercial applications drive much of academic science?
3. Based on your reading of Watters—and working without a dictionary—try to develop an accurate definition of the term *marketing*. Does marketing simply make available needed information about products that people want? Or does marketing play an active role in creating needs and shaping the way people experience the world? How does marketing differ from other forms of communication? How might we define the relationship between marketers and consumers? Which forms of marketing would qualify as ethical? Which forms would qualify as unethical? Is the marketing of antidepressants in Japan ethical or not?

QUESTIONS FOR WRITING

1. One implication of Watters's argument is that what we call *reality*, even at the level of personal experience, is shaped by culture as well as biology. But Watters never pauses, in the course of his account, to systematically explain how these three are interrelated. Write an essay in which you draw from Watters's narrative to explain the relationship between biology, culture, and experience. When the pharmaceutical companies transform the cultural attitudes of modern Japanese people, will the actual experience of the people change? If our experience is indeed always shaped by culture, do we need to be more careful about who controls it? If others can control our experience, what steps might we take to be fully in charge of our own lives?
2. The campaign to change how the Japanese think about what we call depression might be seen as an example of *cultural imperialism*—the conquest of one culture by another. Does Watters's narrative support that view? If the intention of the dominant culture is to do good instead of harm, does that behavior still qualify as *imperialism*? If we are hesitant to impose the values of one culture on another society, are we required to accept all beliefs without question? Is it possible that many Japanese people benefited from the new medicines? Is it possible for any culture to remain separate from others?

QUESTIONS FOR MAKING CONNECTIONS BETWEEN READINGS

1. Watters describes the mega-marketing of anti-depressants in Japan as a process of changing the experience and definition of mental illness. In the words of Kalman Applbaum, pharmaceutical companies planned to "alter the total environment in which these drugs are or may be used," in what Watters describes as "an effort to shape the very consciousness of the Japanese consumer." Michael Moss, in "The Extraordinary Science of Junk Food," describes the marketing of junk food in the United States as a process of changing the experience and definition of hunger in "a conscious effort [...] to get people hooked on foods that are convenient and inexpensive." In what ways is the relationship between the people of Japan and Western pharmaceutical companies the same as or different from the relationship of the US population to the food industry? Under what conditions is it permissible to attempt to alter a culture? Does either author suggest ways we might inoculate ourselves against marketing forces?
2. The mega-marketing campaign described by Watters pales in comparison to the power of social media as described by Franklin Foer in "Mark Zuckerberg's War on Free Will." Is the marketing power of the technology described by Foer simply a matter of scale or does it represent something fundamentally different in the relationship between companies and consumers? Foer says that "[w]hile it creates the impression that it offers choice, Facebook paternalistically nudges users in the direction it deems best for them." Does marketing necessarily involve paternalism? Is it possible to have marketing between equals? How do algorithms differ, if they do, from the market research, testing and advertising campaigns of GlaxoSmithKline?