Overworked or Under Recognized: Hegemonic Narratives of Depression in Japan
Joyce Chan Essay Award Submission
Overworked or Under-Recognized: Hegemonic Narratives of Depression in Japan

Depression is the leading cause of disability across all age groups in Japan and all too often has more serious, and fatal implications (Tiedt 2010: 240) therefore it is imperative to understand how it is subjectively experienced. In a country, it is argued, that over-aestheticizes suicide (Picone 2012; Ozawa-de Silva 2008; Ikenaga et al 2013), which can be seen as the embodiment of depression, it is essential to understand this illness. Psychiatrists often assert that women are twice as likely than men to suffer from depression or depressive symptoms during their lifetime; this trend has been explored in numerous cross-cultural studies and is said to be largely universal (Kitanaka 2012; Inaba et al 2005; Tiedt 2010). However, only until recently the gendered rates of depression in Japan have not been consistent with this trend; men’s rates of depression often being reported as the same, if not higher, than women’s (Kitanaka 2012: 129).

According to Arthur Kleinman and Erin Fitz-Henry, “Our subjectivities certainly have a biology, but they also, and perhaps more critically, have an equally influential history, cultural specificity, political location, and economic position” (2007: 53). In following this assertion, in order to understand depression, along with its biological pathology, one must acknowledge the sociocultural, political, and historical context through which it is mediated and subjectively experienced. Gender is one such lens through which social and cultural values, obligations, and expectations are mediated. Therefore, subjective experience, diagnosis, and treatment of depression must too be viewed through this lens (Tiedt 2010: 240).

In order to gain a greater understanding of gendered depression in Japan I will be exploring the cultural constructs of gendered roles and expectations and the cultural value placed on them, with a particular focus on the gendered division of labour in the professional and domestic sphere. The subjective experience of suffering through mental illness is undeniably mediated through gendered roles and expectations but how does this affect diagnosis and treatment of such suffering? I will argue that gender plays a key role in the ways in which depression is understood and thus explained or described by patients. However, it is not only the patients’ narratives which are...
mediated through this lens for I will show that depression as understood by medical professionals, and how it is largely represented in popular culture, is that of the overworked ‘salaryman’. This narrative is of a depression caused by the stress of long hours and social pressures that are intrinsic to the Japanese workplace. However, as shown by the rates of depression between men and women, until recently there has been a gross under-recognition of depression and depressive symptoms among women. “This narrative has created a curious void in the Japanese understanding of female suffering, bringing about real-life consequences on women’s subjective experiences” (Kitanaka 2012: 148).

**A Male Malady?**

Psychiatrists and mental health experts assert that women are twice as likely to suffer from depression than men (Kitanaka 2012; Inaba et al 2005; Tiedt 2010), however in Japan depression is largely represented not only in popular culture but also among medical professionals as a "male malady" (Kitanaka 2012: 130). This representation of depression as an illness that predominantly affects men can be seen as recently as 2006 with an NHK broadcast series proclaiming that “women also become depressed” (Kitanaka 2012: 130).

In the 1990s, the narrative of depression as caused by the stress of overwork became the recognized and widely accepted normative model of depression for doctors and psychiatrists. The rhetoric surrounding economic downturn and unemployment have often been cited for the dramatic increase in the suicide rate after 1998, which serves to reiterate this model (Inoue et al 2012a: 89). In 1996 suicide as caused by overwork was first recognized in the landmark Dentsu case, when reparations were awarded to the family of Oshima Ichiro after his suicide was deemed to be caused by depression from overwork (Kitanaka 2012: 157). This case was not only important for the recognition of suicide as a product of overwork but also allowed depression to gain significant public attention. This master narrative has made depression easily recognizable not only by medical professionals but also by family and friends. The reinforcement of recognition also helps shape the understandings and meanings of one’s illness that follows the narrative of overwork depression; there is a feedback effect and reinforcement of this hegemonic cultural narrative. Junko Kitanaka, who has conducted a significant amount of ethnographic interviews with sufferers of depression in Japanese psychiatric hospitals and other such mental health centres, suggests that “patients’ narratives are co-products of their own reflection and psychiatric persuasion” (Kitanaka...
Despite the ease of recognition for salary men in understanding and articulating their illness, I argue that this master narrative has led to a large void in the Japanese understanding of women’s subjective experience of depression which has in turn played a large part in the under-recognition of their suffering.

**Gendered Divisions of Labour**

The feminization of labour in Japan has progressed since its beginnings in the 1960’s; not only did has number of women in the workforce increased but so too has the number of women attending universities and along with this many women began to internalize the cultural notion of “careerism” (Pike and Borovoy 2004: 499). However, either through cultural and social imperatives or state incentives there remains a vastly polarized gendered division of labour. In 1962 only 44.7% of employed women were married; 18 years later in 1980 the percentage had risen to 67% (Pike and Borovoy 2004: 499). Although these trends and structural changes seem to parallel the model of “Westernization”, the meanings and responses to changes, such as that of gender roles, diverge from this model distinctly (Pike and Borovoy 2004: 499). One such distinction is that the dual-wage earner model has not been fully accepted as it largely has in the “West”. There remain significant barriers to promotion and upward mobility within the professional sphere; women still occupy less than 10% of managerial roles and on average command little more than 50% of the earning power of men (Pike and Borovoy 2004: 500). These barriers are due, to a large extent, to the entrenched cultural valence of women’s primary roles of nurturance and domesticity. Women’s career paths will often follow an “m-curve” (Pike and Borovoy 2004: 500), with an interruption to allow for maternity, and in a work culture where upward mobility is largely based on seniority many women confront this barrier to the “upper echelons of power” (Pike and Borovoy 2004: 501). The cultural and social importance of this division of labour has also been ratified by national agendas through state incentives for women to stay at home (Pike and Borovoy 2004: 500). It is clear from this state reluctance of creating gender equality in the workforce that “although the structure of Japanese society is changing gender roles continue to be based on the gendered division of labour” (Tiedt 2010: 241). Due to this entrenched gendered division and an illness that is resoundingly understood as having the social pressure and stress of overwork as its cause, women are lacking the moral certainty of the “true depression” of overworked salary men, and this ambiguity of the meaning of their illness can contribute to a difficulty in describing and explaining their suffering in terms of depression.
Although the changing structure of Japanese society resembles that of a "Westernized" model, responses and meanings of this change are dramatically different. One such example is the feminization of labour, which has led to an increase in the number of women in the workforce. However, less than half of all married women are in employment (Pike and Borovoy 2004: 499), reflecting cultural and social expectations regarding women's employment, motherhood and domesticity. These cultural and social structures that result in a gendered division of labour, both domestically and in the workplace, have translated into an under-recognition of depression in women with a hegemonic master narrative of normative, or "true depression" as caused by overwork. There are two ways, central to my argument, that this master narrative has a hegemonic effect on women's experience of the illness. Firstly, the ambiguity of what their suffering means due to the lack of "culturally fitting terms to articulate their plight" (Kitanaka 2012: 147); and secondly, the misdiagnosis or non-diagnosis due in large part to the medicalization of depression and subsequent dismissiveness toward psychological pathologies. The psychiatric encounter has thus become a site of contestation for women suffering from depression (Kitanaka 2008: 155).

Psychiatrists in Japan acknowledge within their profession that there is a traditional distinction between biological depression and psychologically caused depression (Kitanaka 2012: 142). The former often acknowledged as the 'real depression'. However, a dichotomy of biological and psychological depression can be dangerously moralizing (Kitanaka 2012: 147) and lead to further ambiguity for those who do not accept or understand their depression in these terms. Psychiatrists focus on the biological abnormality while avoiding any psychological pathology, often to the extent that they treat psychological explanations dismissively (Kitanaka 2012: 142). Many psychiatrists have suggested that the under-recognition of female depression stems from this dismissiveness of the psychological realm (Kitanaka 2012: 142). As suicide can be seen as the embodiment of depression it is to note that according to Chikako Ozawa-de Silva (2008; 2010) and others (Ikunaga et al 2013) the majority of those that interact on online suicide forums, a medium for those with suicidal intentions to interact, explain their suffering in existential or psychological terms. This points to the limits of a biological model and one that leaves a dangerous void as it has been argued that women's complaints often focus on emotional or domestic problems and often posit their suffering with "complex and heterogenous somatic complaints" (Kitanaka 2012: 142).
This further points to the “master narrative producing an uneven effect on men and women” (Kitanaka 2012: 147), which has undoubtedly lead to the under-recognition or even the de-legitimization of female depression. According to research conducted by Kitanaka (2008, 2012), there are many cases in which women have sought medical help for their suffering only to be either misdiagnosed or even undiagnosed.

One such case was that of Aoki-san (Kitanaka 2012: 145) who began her career at a busy publishing company where she worked under many experienced female staff of whom she aspired. Not long after she began high intensity job she began to suffer from pain in the back of her eyes and frequent headaches, for which she sought medical intervention, but to no avail. She decided to quit work at the advice of her parents to seek out care. She was diagnosed numerous times with Automatic Nervous System Disorder with little prospect of recovery. After being disheartened with the psychotherapeutic treatment she was receiving, she tried “alternative” therapies and said that she “almost felt like killing [her]self” (Kitanaka 2012: 146). However, she was finally diagnosed with “masked depression” and prescribed anti-depressants; her pain “miraculously went away” (Kitanaka 2012: 146). She felt “vindicated” (Kitanaka 2012: 146), particularly because her family had often insinuated that she was simply lazy. Aoki-san is not alone in her long and often despairing plight for recognition of her suffering, and as one can see from this case it was not only medical recognition that was lacking but also recognition from her family. What is clear from this case, and the many others that parallel it, is that through the hegemonic cultural narrative of overwork depression, both within the medical profession and also in popular representation, many women lack the conformity and uniformity of such an easily recognized narrative. It has been noted that such cases of misdiagnosis or non-diagnosis have led to the mistrust of mental health professionals, and even the labeling of such patients that switch between doctors in search for an ease of their suffering as “problem patients”, or even as “personality disorder patients” (Kitanaka 2012: 144). This mistrust, along with a stigmatization of mental illness has played a large part in the low numbers of those seeking medical intervention; it being reported that approximately only one in five that show at least moderate depressive symptoms seek medical help (Borovoy 2008: 556).

Amy Borovoy has argued, “the sphere of mental health care has focused on producing social inclusion but has discouraged citizens from being labeled as different, even when such a distinction may help them” (2008: 552). Along with diagnosis, treatment too can have uneven gendered outcomes.

The master narrative of overwork depression can often produce narratives that are surprisingly uniform and consistent (Kitanaka 2008: 171; 2012: 133) which can
reflect, together with the patients’ own explanations, the psychiatrists shaping of these narratives. In gaining this level of understanding and conformity, it allows psychiatrists to translate this narrative into one of recovery, which is largely that of relinquishing control. This approach is intended to relieve the patient of the stress and social pressure for a time, in other words to “drop out” in order to recover. Although middle-aged women often mirror men in this narrative and respond seemingly positively to it, younger women, who are often in the early stages of their career are often unable to adopt this narrative as their own (Kitanaka 2012: 145). Depression as caused by the stress of overwork has been internalized within the mental health sector in Japan and can be seen to pervade almost every aspect of the mental health care process, from self-recognition to diagnosis and recovery. This has had an uneven hegemonic effect on men and women.

**Conclusion**

Although it is widely accepted that women are twice as likely to suffer from depression than men (Kitanaka 2012; Inaba et al 2005; Tiedt 2010), in Japan depression is represented not only in popular culture but also among medical professionals as a “male malady” (Kitanaka 2012: 130). This has translated into a hegemonic master narrative of a depression caused by the stress of overwork. Despite at first glance the Japanese social structure conforming to a model of “Westernization” including, but not limited to a feminization of the labour force, there still remains a gendered division of labour and strong gendered cultural and social imperatives. Thus as gender is the lens through which social and cultural values, obligations, and expectations are mediated, subjective experience, diagnosis and treatment of depression must too be viewed through this lens (Tiedt 2010: 240).

I have shown that the hegemonic cultural master narrative of overwork depression has led to the under-recognition of depression among women. It is a narrative that has pervaded every aspect of the mental health care process. It is apparent in the ways in which it is subjectively understood and recognized, often leaving women without the “culturally fitting terms to articulate their plight” (Kitanaka 2012: 147); it can be seen in under-recognised of suffering by family and friends, as epitomized in the case of Aoki-san whose family insinuated that she was simply lazy; through misdiagnosis or non-diagnosis of the illness in large part due to the lack of recognition or acknowledgement of the psychological or existential realm; and the ways that it shapes paths to recovery by shaping narratives of relinquishing control. There is a
clear uneven hegemonic effect on men and women and it is imperative when approaching mental illness to utilize a multifaceted and holistic approach that does not rely on a master cultural narrative and conformity to such for appropriate diagnosis and treatment.
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