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The Rebirth of Secrets and the New Care of the Self in Depressed Japan

Junko Kitanaka *

In Japan, until recently, mental health issues have been carefully guarded as personal and family secrets. In 2014, however, the government passed a revision of the Labor Safety Hygiene Law and institutionalized "stress checks" for all workers across the nation. This mental health screening was installed as a response to the high number of depressed and suicidal workers in a country plagued by recession since the 1990s. The screening was also prompted by a grassroots movement that helped establish state and corporate responsibility for protecting workers' mental health. These changes have initiated a web of corporate surveillance practices, pressuring workers to self-disclose, turning their psychology into a new object of rehabilitation and resilience training. At the same time, there are signs of the emergence of therapeutic spaces where psychiatrists and workers explore new forms of silence and ways of retaining a sense of a private, secret self, thereby enabling a "rebirth of secrets." By investigating the rise of depression as a workplace psychopathology and emerging forms of "care of the self," I ask what happens to people's subjectivities when their minds and bodies become a repository of valuable secrets.
Key words : psychiatry, medical anthropology, depression, suicide, surveillance

Health is often a sanctuary of personal secrets, yet its boundaries can differ considerably across nations, depending in part upon their respective ideas about collective responsibility and individual liberty.*1 Unlike in the U.S., where state interventions in the realm of personal health tend to trigger resistance among those who claim to cherish individual liberty over state intrusion (see Lupton, 1995), in Japan the state surveillance of workers' health has been widely accepted as a means of civil protection, even discussed as the historical fruits of people's struggles to attain health (cf. Brotherton, 2012). The Japanese state has long mandated large-scale corporations to hire occupational doctors and provide health measures for their employees (such as annual physical checkups and one-year maternity leave).

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Many corporations, operating under the lifetime employment system, have in turn devised various health programs, including sick leave up to a few years, daily exercise periods, weekend sporting events, and training programs, as opportunities for strengthening management-worker solidarity (Kelly, 1993; Rohlen, 1974; Waring, 1991). Such "holistic" corporate care has been generally welcomed by workers as a form of protection and self-cultivation (Borovoy et al., 2014). Given the excessive hours of overtime they are expected to endure (Harden, 2008), some workers I interviewed for my ongoing research on depression[1] discussed how these programs help affirm a feeling that they are not mere instruments of labor (cf. Fisch 2015).

Yet, one realm that Japanese companies had long hesitated to enter is workers' mental illness, which, up to the late 1990s, had been a no-touch zone, largely hidden away as personal and family secrets (Umegaki, 1989). When mental health became an issue in occupational medicine in the 1960s, prompted by the spread of psychotropic medications, some corporations in Japan began to provide in-house psychiatric consultations but under conditions of strict privacy. While this stance served as a protective shield for the mentally ill, its fatal flow was revealed in a 1982 Japan Airlines crash caused by a schizophrenic pilot who killed 24 people (Ogino, 2011). Though this tragedy brought about Japan's first national attempt to seriously address workplace psychopathology, lack of funding and a strong stigma attached to mental illness meant that little change was made. Psychiatric care continued to be demarcated as a space of privacy, where corporate surveillance was off-limits. This tradition of secrecy around mental illness persisted partly to avoid stigma but also because, for Japanese companies with their corporate culture of care, to be let in on such personal secrets was to assume partial responsibility for the worker's state of being. Workers' psychological health has thus marked the border of what can be imagined as benevolent surveillance over one's intimate, private life.

The idea of workers' psychology as a kind of sanctuary became fundamentally destabilized in 2014, when the Japanese government's revision of the Labor Safety Hygiene Law institutionalized "stress checks" for all workers, requiring corporations to provide not just physical but also psychological health monitoring of employees (*Asahi* 2014).[2] The government made this move partly in response to the high national rate of suicide (currently about twice that of the U.S. national rate) and depression, which has emerged as a quintessential "illness of stress" of the recession era. The stress checks are also an end-result of the politicization of depression, whereby a grassroots workers' movement has legally established that depression is not only an impediment to work but also a hazard of work itself. From the 1990s, workers and their families, doctors and lawyers have joined together to problematize what they term "overwork depression" (*karō utsubyō*) and "overwork suicide" (*karō jisatsu*). They helped bring about the epoch-making Supreme Court verdict in 2000 that held Dentsū, Japan's biggest advertising company, liable for the suicide of a young worker judged to have become depressed from chronic work stress (*Asahi* 2000). Publicly talking about mental illness and suicide, sometimes as a means of discovering the truth about the death of loved ones, families and distressed workers as well as lawyers and doctors involved in the movement have helped turn depression—a formerly stigmatized and strictly *secreted* illness in Japan—into a collective symbol of recession that signifies the psychological burden of

work stress and scars of emotional labor (Kawahito, 1998). In response, the government has implemented a series of important policy changes, all of which have helped establish the idea that psychopathology can be socially produced.[3] Particularly because both the government and corporations can now be held liable for failing to foresee the risk of employees' suicides—even in cases where employees themselves were not aware of their own psychopathology (Nihon Sangyo Seishin Hoken Gakkai, 2006)—they are searching for effective means of psychological management, even though they are alarmed by the public criticism that workplace intervention would constitute a violation of privacy (*Asahi* 2010).[4]

The politicization of workplace psychopathology is not restricted to Japan. Just as suicide emerged in the 19th century as a political problem triggering novel ways of understanding collective maladies (Durkheim, 1952 [1897]), work-related depression today is quickly becoming a new "social pathology" across the globe, providing a map of collective affect, quantifying (un)happiness, and profoundly *politicizing the private*. In France, where spates of suicides, including that of a worker who set himself on fire in his office parking lot, have shocked its citizens (Chrisafis, 2011), the rise of workplace psychopathology has been debated as an ill effect of neoliberalization that is destroying its traditional culture of work (Moerland, 2009). Italy has already experimented with "mobbing" experts in corporations to provide help to those workers who report depression or other psychiatric breakdowns caused by stress (Mole, 2010). Germany, in response to the suicidal act of a co-pilot in 2015 that led to 150 casualties, is searching for ways to intervene in the lives of "burned-out" workers without seriously violating their privacy (Goode & Mouawad, 2015). Taiwan, where leading corporations have been condemned for driving workers to overwork suicide, has also institutionalized a system for compensating workplace psychopathology (Lin, 2012). Across nations, formerly private and often secreted workers' mental illnesses have emerged as weapons of the weak, with which workers can demonstrate tangible damage of work stress and claim recognition (and compensation) for their suffering (cf. Kleinman, 1985, Petryna, 2002, Young, 1995). Yet, as in Japan, making workplace pathology visible can also heighten public awareness about the risk ill individuals pose to the social body (e.g., a mentally ill pilot), thereby initiating calls for closer scrutiny of private lives in the name of prevention and early intervention. As each society grapples with the boundaries between the public and the private as well as collective responsibility and individual liberty, the Japanese attempt to instill stress checks as a "protective shield" raises questions of whom is protected. It also prompts us to ask how it might be possible, and/or desirable, to truly care for distressed individuals, what that might do to their sense of private self and family life, and how, in corporate-medical contexts, one can separate care from surveillance (cf. Stevenson, 2014).

In this article, I investigate what happens to our sense of private self when juridical, medical, governmental, and economic forces come to intersect one another to promote the corporatization of psychological health. What complicates psychological surveillance (as opposed to the monitoring of the physical body) is the fact that there is more freedom for individuals to hide what they regard to be private information—more possibilities to choose what to tell and not to tell, to deliberately keep "secret" certain aspects of one's psychological profile while revealing others as a way of holding the state and/or corporations to account. By exploring the tension between individual freedom to conceal and societal

demands to reveal (even as a condition for caring for that person), I will illuminate how emerging state and corporate surveillance—an ironic result of the workers' movement—gives rise to what I refer to as the "rebirth of secrets." This process, featuring stress checks and medical diagnosis, firstly prompts workers with mental health issues to come forward and report them, while also generating, for others who had never looked at themselves in a psychiatrized way, a new realm of self-knowledge (Danzinger, 1997; Foucault, 1973; Rose, 1996). As Japanese workers adopt psychiatric language for scrutinizing their own moods, biorhythms, and cognitive patterns, they come to see themselves with a novel sense of health—and of self. Second, as such intimate monitoring becomes an aspect of the new culture of care and individual psychology becomes an object of rehabilitation and further (re)training, workers face increased demands for self-disclosure. This brings about a fundamental shift in ownership of self-knowledge, giving workers a new understanding of what counts as a valuable secret. Third, in their attempt to carve out new boundaries of privacy, workers come to generate a façade of self as well as forms of silence, thereby cultivating a realm of a secret—even *sacred*—self. By investigating the rise of the "caring" form of surveillance around depression, and consequent debates over the new corporate "care of the self" (Foucault, 1990, 1994), this paper asks what happens to people's subjectivities when their minds and bodies become repositories of valuable secrets.

Depression and the New Care of the Self

> Working from early morning until late at night, with every move being managed, criticized by those around me, I feel that I have lost myself. I don't know what kind of person I am, what I'm thinking, what I can express. [A scribble left by a worker in her 20s before she threw herself to her death. She had been working from 9:00 am to 10:00 pm daily, sleeping an average of 3–4 hours per day for 8 months.] (Kawahito, 2010, pp. 14–15)

Since its neurobiologization from the 1990s, depression has emerged as an important entry point for interrogating workers' subjectivities, anomalies of which are to be detected in low energy, lack of concentration, negative affect, and distorted cognition (Rose and Abi-Rached, 2013). What characterizes this so-called "neuro-turn" is its explicit link to economic rationality, where depression is increasingly discussed as an illness of productivity.[5)] Unlike the age of anxiety of the 1950s-60s (during which tranquilizers —the "housewife's little helper"—were often prescribed: Tone, 2009), the current neuro-turn transports depression out of the private realm into the public sphere (Martin, 2007), while also de-gendering what was formerly an "illness of emotion" (a subjective, psychological experience of sadness, mainly affecting women) to a "disorder of affect" and an "illness of inaction" (Ehrenberg, 2010; Metzl, 2003). Psychopharmaceutical interventions have been offered for the afflicted, generating hype around Prozac in the U.S. in the 1990s, when it was initially hailed not only as a cure for depression but also as an enhancement technology for people to transcend limits of their former selves (Elliott, 2003; Martin, 2007; Metzl, 2003). Similarly in Japan, where psychiatrists assumed until recently that depression was rare, the number of depressed patients more than doubled between 1999 and 2005, now recording over

a million, and sales of antidepressants grew five-fold between 1999 and 2006 (Tomitaka, 2009). With the rising sales of psychopharmaceuticals globally, critics have warned that such neurobiologization may serve as an apparatus of neoliberal capitalism by manufacturing constantly productive and "happy" workers who remain oblivious to the social roots of their distress and who operate with an illusionary sense of control (see Elliott, 2003; Elliott & Chambers, 2004; Healy, 1997).

Yet, to see depression as a collective pathology of labor is also to open up a political problem, generating novel meanings for workers' psychological secrets. In Japan, the neurobiologization of depression has not led to brain-centered, individual reductionism as North American critics have feared, but instead provided a condition for a new form of "local biology" (Lock, 1993; also see "situated biologies" in Niewöhner & Lock, 2015), in this case, a medico-legal understanding of depression as an illness rooted in both biology and society and a misfortune lying beyond workers' individual responsibility (cf. Kleinman, 1986; Ong, 1987; Young, 1995). This has helped turn workers and their families into moral witnesses of the potentially psychologically toxic nature of Japanese workplaces, testifying to their (or their loved one's) experiences of excessive overwork and/or psychological bullying (e.g., the Dentsū employee who was forced to drink sake out of a shoe) to the point of being driven to psychiatric collapse (Fujimoto, 1996). Depression has become a legitimate idiom of distress (evocatively termed a "cold of the soul" or *kokoro no kaze*), as apparent in my interviews in the early 2000s with depressed workers at various psychiatric institutions in the Tokyo vicinity. A 49 year old banker discussed a time when he was working daily from 7 am to 2 am, while his new boss repeatedly scolded him in front of his colleagues, one time throwing up in the air a document he had carefully prepared. A 50 year old civil servant talked about being yelled at and criticized by union leaders, and despite his dislike of alcohol, making an effort to join them every night in drinking in order to smooth things out, until one day he could not face work anymore. A 63 year old vice president of a construction company told me how, as the recession deepened, he was forced to accept contracts from large, powerful companies destined to suffer losses and how humiliating it was, after desperately trying everything he could think of to pay his employees every month, to be lectured by the judge in bankruptcy court about "collective responsibility." Many of the men with depression I met discussed the injustice of the government protecting big corporations in the recession while abandoning individuals like themselves. By publicly accepting a diagnosis of depression, a long-stigmatized psychiatric category that used to be strictly guarded as a personal and family secret, these workers asserted that their suffering was real, and that their subjective, emotional experiences should be recognized as tangible damage to the brain and the body. Indeed, the scale of their suffering is now validated by the "Stress Evaluation Tables" that were created by psychiatric experts for the Ministry of Labor in 1999 to measure the severity of life event stress in workers' lives and to determine their eligibility for worker's compensation. Providing a way to demonstrate how individual distress is also social suffering, psychiatry has emerged, somewhat unexpectedly, as an agent for social transformation, while helping lay the groundwork for mental illness secrets to be made into objects of public management. In order to demand recognition and accountability, workers have to accept the psychiatric idiom of distress and give up their psychological secrets.

But one also wonders what might be the ultimate effects of psychiatry-enabled recognition that leaves the politics of causality in the hands of biomedical experts, potentially transfers ownership of workers' secrets to state and corporate management, and may well give rise to a new system for gathering and processing health information as a kind of colossal repository of personal secrets. Such a biomedical system of surveillance—even with all the care it bestows on individuals and health and happiness it promises—may evoke dystropic fears partly because the history of biomedicine is known for its obsession with the objective and a certain disdain for the subjective. As with the "Stress Evaluation Tables" discussed above, when biomedical experts try to deal with the psychological, they tend to create standardized scales to translate the messy, ambiguous and contested world of the subjective into orderly and indisputable numerical terms amenable to biomedical and bureaucratic record-keeping. Such numerical representations—which remove the subjects from the deep and irrational realm of emotion as well as the immediate social environments in which workers experienced their distress—further generate a model for "quantified selves," which acquires a public life of its own (cf. Osborne, 1997).[6] A possible future offered by such a model can be glimpsed through the ongoing experiments in Japan and internationally with the so-called "Smart Wellness City," an urban planning innovation for managing the health of residents who voluntarily submit to an automated electronic system for the surveillance of their daily health information. This system employs heath tracking devices and other biosensing technology (including "smart houses" with "smart toilets") and media designed to monitor blood pressures, cholesterol levels and other bodily data. Researchers involved hope that these devices would soon be able to calculate on a daily basis residents' risks for various illnesses including heart disease, diabetes, and even mental illnesses such as depression and dementia. The ultimate aim is for a control system to monitor and intervene if it senses health in disarray in order to facilitate healthy living for all (cf. Lupton 1995).[7] Such a vision of 24 hour surveillance—even as offered for the benefit of the individual and the community—has triggered some public anxiety: it leaves little space to hide (cf. Bauman & Lyon, 2015).

For now, the psychological space—essential for a private sense of self—remains largely elusive for such surveillance technology.[8] But as health monitoring systems evolve, will such a realm of "self" continue to be set aside, either regarded as irrelevant to public surveillance and thus marginalized and devalued or, instead, be revered as a cherished embodiment of personal liberty? This would seem unlikely, as some of the biomedical experts involved in developing health-tracking devices, have pointed out to me in interviews how partial, incomplete, and unsatisfactory monitoring will remain unless they find ways to incorporate the psychological. Some of them have expressed expectations that in the future, psychiatry might develop technologies more sophisticated, precise, and reliable than existing psychotherapeutic and biological tools for effectively mining psychological secrets. Such innovation could then turn around the old model of secrets, where individuals might intentionally keep their secrets from their employers, enabling those who uncover secrets to gain fuller knowledge of the "self" than the individual persons the secrets are about. If psychiatry eventually does develop such technologies and further extends its capacity to work as a repository of psychological secrets, and if psychiatry

itself becomes further incorporated into systems managed by corporate and governmental institutions, how will it change the terms in which we conceptualize health as well as our sense of self? If a much deeper exploration of psychological secrets becomes possible and is coupled with a culture of risk aversion (Lyon, 2006) as well as forces of privatization and calls for early intervention (Singh & Rose, 2009), will it significantly limit the manner in which workers' experiences are understood and impoverish people's subjectivities, thereby violating their sense of privacy, or might it instead succeed in generating technologies used in genuinely "caring" forms of surveillance?

The Therapeutic Value of Non-Intrusion: Corporate and Biomedical Care for the Depressed in Japan

Despite the tradition of acceptance of corporate intervention into personal health in Japan, this has not applied, as noted previously, to the realm of mental illness. Corporations have generally adopted a "hands-off" policy when it comes to issues involving the inner realm of the private self, allowing psychological secrets to remain secret. To be sure, workers' psychological health has received some corporate attention and engagement: workers I interviewed discussed having benefited from holistic corporate care that offers, beside health promotions, training programs and encounter-type group meetings where workers are urged to ponder the meaning of their lives and ways to achieve happiness (also see Garon, 1997; Rohlen, 1974; Waring, 1991). They told me how they enjoyed being given a time and space to reflect on themselves without having to reveal the content of their innermost thoughts. Yet, until recently, comprehensive care was rarely extended to address the issue of mental illness per se. In many cases, workers who exhibited symptoms of mental illness were either urged (however indirectly) to quit work or—like some of the workers I met in the 2000s—compelled for years to keep their illness hidden from their superiors and colleagues (cf. Moll et al., 2012). Long debating how best to treat mentally ill workers, Japanese occupational doctors have generally adhered to the conceptual distinction between "diseaseness" and "caseness" in order to protect workers' privacy. That is, rather than actively detecting and uncovering workers' hidden psychiatric "diseases," occupational doctors have long made it a rule not to intervene unless workers exhibit maladjustment in the workplace and surface as "cases" (Katō, 1996; Ogino, 2011).

The corporate remove from workers' psychological issues is not surprising given that Japanese psychiatrists themselves have often expressed ambivalence, even skepticism, toward intruding into a patient's psychological interiority or *kokoro* (mind/heart/soul). Unlike in the U.S., where psychoanalysis has long penetrated popular consciousness, in Japan the Christian tradition of confession remains foreign and academic psychiatry from its inception in 1886 is steeped in the German neurobiological perspective with its emphasis on severe psychoses. In conjunction with this, psychotherapeutic exploration has been "viewed with deep suspicion" (Lock, 1980, p. 258) as therapeutically risky, intrusive, and mostly marginal to clinical practice. Even for the small number of psychotherapeutically oriented psychiatrists, the act of excavating *kokoro* for personal secrets has at times been met with interdiction in relation to the sacred nature of secrets, as suggested by a debate in the 1970s among leading psychotherapists,

who struggled to translate and implant psychoanalysis in Japan. They questioned the dialectic model of a psychotherapeutic encounter, where an increased awareness of the accumulating contradictions in one's life inevitably leads to a confrontation that allows the patient to face the secret as *hidden truth*. For instance, the highly influential psychoanalyst Takeo Doi critiqued the Western psychoanalytic obsession with revealing pathogenic secrets (such as unconscious desires, anxieties and conflicts thought to be deeply rooted in childhood experiences) and pointed out the therapeutic value of kept-secrets by discussing *himitsu* (secret), originally a Buddhist term referring to esoteric knowledge and hidden truth not easily attained (Doi, 1972). In so doing, Doi cautioned other doctors and therapists of the fundamentally abstruse nature of self-knowledge and pervasive sense among lay Japanese that there is something sacred about the inner self that doctors should not carelessly intrude upon. Legendary psychiatrist Jōji Kandabashi elaborated on how to advise (particularly psychotic) patients to keep their own secrets to themselves as a way of protecting their self-boundedness and encouraging self-growth through social withdrawal (Kandabashi, 1988 [1974]); cf. Corin & Lauzon, 1992), thereby asserting the therapeutic importance of being left alone. These doctors helped elevate psychological secrets to an essential element for a healthy sense of self.

This therapeutic caution against intruding into the psychological space as a quintessentially private realm has been extended particularly to care for the depressed. In the early 1970s, when the initial hope waned that newly introduced antidepressants would cure depression, Japanese psychiatrists began to experiment with existential/phenomenological psychotherapy with the depressed, only to find, by the end of the decade, that such psychological probing often left patients worse off than before (Kasahara, 1978). Some doctors attributed failed treatment of depression to the rigidity of the personality structure of the depressed, long theorized in Japanese psychiatry as "melancholic premorbid personality" and characterized as showing high levels of diligence, responsibility and consideration toward others—i.e., an embodiment of the idealized Japanese work ethic (see Hirasawa, 1996). Others blamed themselves for mistreating those who were otherwise well-adjusted to society, by exposing hidden conflicts and destabilizing the culturally engrained assumptions on which their patients had built their lives (e.g., Iida, 1973). This observation that psychological treatment destabilized the self was shared by many of the female patients with depression I met throughout the 2000s, who criticized what they saw as the intrusive, even violent, nature of psychiatric inquisition, associating it with unexpected harm resulting from well-meaning but over-probing and therapeutically-ineffective doctors. These women articulated their ambivalence toward dependency on doctors through one-sided psychological exploration and emphasized the importance of guarding secrecy, particularly in a psychiatric encounter. Not surprisingly, then, caution on the part of psychiatrists was apparent in my fieldwork in Japanese psychiatric institutions in the early 2000s, when I would hear veteran clinicians talk of insight-inducing psychotherapy a "taboo" for depression.

Given such principled hesitancy about intrusion into the sacred space of the inner self, the psychiatric biologization of depression has likewise worked, in Japan, to allow patients to maintain a sense of self as secret. Psychiatrists I talked to during my fieldwork emphasized that biomedical jurisdiction extended

to only certain aspects of patients' whole being and that their own expertise lay not in attempting to excavate patients' hidden psychological secrets, but in attending to and fostering changes in patients' conditions at the somatic level, which they hoped would be accompanied by changes at the psychological level (cf. Good, 1984; Luhrmann, 2000). In addition to prescribing medication and ample rest, they encouraged patients to monitor their own somatic conditions, such as how fatigued their body had become, and systematically develop a kind of "bodily insight." While cultivating such somatic awareness, psychiatrists also utilized the notion of melancholic premorbid personality as a therapeutic social narrative to suggest that depressed patients are, if anything, idealized Japanese whose strong sense of selfless devotion is what led them to psychological collapse. By pairing the biological and social in this way, psychiatrists sought to provide care for the depressed without intruding into the psychological, secret self. Yet, this therapeutic approach, together with the "hands-off" policy generally followed by corporations, has come under strain as psychiatrists and companies have both been confronted with a substantial number of depressed workers and growing assertions that patients' interiorities are, in fact, in need of attention.

Further Transformations of the Depressed: From Moral Witness to Corporate Risk and Collateral Damage

Public interest in interpretation of workers' subjectivity emerged as a focal point of legal disputes regarding overwork suicide in Japan. In the 2000 Dentsū case, noted above, judges, lawyers, and psychiatrists heatedly debated what to make of the fact that the worker had exhibited a melancholic premorbid personality, which seems to have led him to take up more responsibility than he was able to cope with. The debate over workers' subjectivities—legally and medically reframed here as "vulnerability"—resurged in a 2001 Toyota case in which the employee in question was reportedly an "ideal Toyota man," highly diligent, responsible, and considerate, who seemingly drove himself to excessive work stress and eventual depression and suicide (*Asahi,* 2003). Yet, because the reported hours he spent in the office did not seem much longer than those of his peers, the plaintiff argued that it is not the quantity but rather the *quality* of work that should be considered, and how the man (who showed every sign of melancholic premorbid personality and was thus deemed vulnerable to depression) experienced the stress more keenly than others. Judges accepted this argument and declared that work conditions should be set to accommodate those who are "most vulnerable to stress."[9] Even though the government questioned this radically "subjectivist" approach, they complied with the juridical decision that worker personality could not be wholly responsible for suicide and installed policy changes that emphasized environmental stress over individual vulnerability (Okamura, 2002). In 2006, the government also recognized sexual harassment and "power harassment" (signifying a wide range of harassments that occur particularly in workplaces and often take the form of verbal abuse) as causes of psychopathology. This further legitimized depression as a means of embodying social injustice. The media was awash with testimonies from burned-out workers, bullied, humiliated, and exploited in their workplace, who expressed their chagrin, resentment, and anger in talking about their experiences of depression. As

they emerged as moral witnesses of the condition of Japanese workplaces, depression also became one of the most frequently cited reasons for taking extended sick leave (Tomitaka, 2009), raising public controversies about what has caused the nation's workforce to be so depressed.

The debate over individual vulnerability intensified in the mid-2000s, when, with the increasing prevalence of depression in society, the nature of depression itself began to change and the discourse around it took on moralizing overtones, setting in motion a kind of "looping effect" (Hacking, 1999). Most depressed patients I met in the early 2000s told me they had never imagined that their low energy and dejected mood was a psychiatric malady, nor had they ever really thought about such things as their biorhythms, affective patterns or distorted cognition. But as people heard more about depression from doctors, the media, the pharmaceutical industry, and the government and gradually became more aware of their mental and bodily conditions, they more readily began to think that they might be "ill." As people began to excavate their psychological secrets and voluntarily seek medical care, psychiatrists and other doctors faced many patients afflicted with milder forms of depression who often did not respond well to the traditional psychiatric treatment of medication and rest; in some cases, this treatment was even found to be detrimental. In the latter half of the 2000s, the potentially serious side effects of antidepressant medications were reported in the media, as were the chronic and protracted forms of depression with which some were affected (NHK, 2009). Psychiatry has therefore come to be seen as unable to provide a straightforward, linear path to recovery from depression. To make matters worse, the typical depressed person—a burned-out middle-aged man with a traditional work ethic—was identified as a root cause of Japan's lagging status in the neoliberal global market; his diligence, tenacity, and dutifulness came to be seen no longer as virtues but as inflexibility and lack of skill (impressions that, according to psychiatrists, were increasingly expressed by patients themselves). At the same time, younger people with depression became subject to moral blame in media stories that asserted that the afflicted were not suffering true depression (supposedly affecting those who are hardworking and responsible) but were experiencing "new-type depression," the cause of which lies in patients' "immature" personalities. While experts representing the Japanese Society of Depression rebutted this dangerously moralizing discourse,[10] such characterizations renewed the questions of how to conceptualize depression and treat the depressed beyond neurochemical interventions, and provoked corporate interest in closer inspection and reclassification of workers' subjectivities.[11]

The limits of the government's biosocial approach to depression were further exposed as the depressed in the workplace came to be seen, by the late 2000s, as collateral damage. An important factor in this idea of the depressed as collateral damage was increase in claims for workers' compensation, which introduced another logic of joint liability: the burden of individual depression as dispersed and collectively shared (Ewald, 1991; Mima, 2012).[12] Particularly as some depressed workers took unexpected absences, went on extended sick leave, and made slow recoveries, they could no longer be straightforwardly seen as innocent victims but instead began to be criticized as perpetuators of stress since their actions imposed extra labor on others, increasing the overall stress level of the workplace, spiraling into yet more depression among their colleagues.[13] As the depressed were turned into a "risk" not only to

themselves but also to the community, I began to hear lay people speak of depression as "contagious," as if the social body of the healthy workplace needs to be protected against its threat. This can be seen as an unintended effect of a shift in the ownership of depression from a personal and family secret to public knowledge; the "secret" of depression, once shared, began to take on new meanings, including a danger to society. As the nature of the secret changes, a mix of juridical, governmental, corporate, and medical forces are at play together to explore new ways of restoring workers' productivity by scrutinizing their subjectivity.

Reprogramming Workers through Rework

One psychiatric response to these therapeutic demands can be found in a new regimen called "Rework." A crossover between medical treatment and occupational training, Rework has been increasingly adopted by many companies to help depressed workers to return to work. In contrast to the legal conceptualization of the depressed as passive victims, driven to depression by stressful social relations, Rework borrows from cognitive behavioral therapy to re-define patients as active agents who are complicit in driving themselves to depression through distorted interpretations of their social relations. At leading institutions of Rework, patients are urged to manage their depression by closely keeping track of their biorhythms and affective changes, and to engage in communal tasks in order to correct patterns of miscommunication and distorted cognition. Programs vary across clinics and can include ping pong, calligraphy, painting, yoga, SST (social skill training), debate, and PowerPoint presentations, all of which are employed to increase patients' awareness of their own physical and psychological strengths and weaknesses. Through such daily activities, Rework therapists carefully control the level of stress that patients are exposed to and gradually increase this level to test the developing limits of each individual (Utsubyō Riwāku Kenkyūkai, 2011). Rework thus seeks to instill in patients a new technology of self-governance as a way of enhancing their human capital.

Rework also sidesteps the problem of intrusion on the private self by strictly limiting its interest in workers' "self" and its secrets. As with cognitive behavioral therapy in general, Rework does not assume that there is no deeply-hidden realm of the self, but this interior aspect of human experience is seen as mainly irrelevant for its aims (cf. Lemov, 2005). This is because the depressed are generally regarded by the leading Rework doctors I interviewed to be, as one put it, "well-adjusted people who can achieve self-improvement by mere suggestion," who need to be not so much "saved" (as might be expected of a genuinely clinical encounter) as to be "equipped with a set of survival skills to protect themselves."[14] Rework's focus remains on patients' cognitive/affective malfunctionings, especially their failure to deal with their own negative emotions including anger and resentment. Doctors say that while some patients are tormented by a sense of guilt—often disproportionately—others feel too angered and victimized to grasp that they themselves may be regarded as perpetuators of stress, burdening their colleagues and accumulating affective debt in everyday social interactions. Many others fluctuate between these poles. They are thus unprepared, when they return to work, to deal with how others' feelings and resentment can haunt them. To facilitate insight, Rework patients are placed together with other patients in a

mock-office environment that serves as an experimental lab (which turns into an emotional theater at times), where they are urged to reenact the scenes of their cognitive and affective malfunctioning that originally drove them to depression. They are then asked to analyze, discuss, and understand how they may appear in the eyes of others so that they can better protect themselves and support neutral to positive social engagements. In this regard, the therapeutic regimen reproduces the Japanese corporate ethos, where depression becomes an entry point through which workers are made to own up to their shortcomings, regain a sense of social embeddedness, and start repaying their affective debts.

The aim of such a therapeutic process, one may argue, is to provide a kind of "care of the self" without providing—or even working from —a "sense of self." By the time workers graduate from Rework programs, they are expected to be in control of their emotions and reveal just enough of themselves to maintain smooth work relations, even generating a façade of self, if necessary. This process may open up a new space for workers to regain a sense of private self, thereby laying the groundwork for a rebirth of secrets. Rework psychiatrists I talked to said they hope to redefine the depressed from a burdensome "corporate risk" to "human beings with full potential for growth" in terms of both psychosocial maturity and economic suitability (cf. Martin 1994), thereby reactivating a culture of care, a source of pride for Japanese corporations. Yet, without a definitive idea of what it means to be mentally healthy, psychiatrists involved in Rework may inadvertently let a corporate logic slip in to fill the philosophical vacuum that might otherwise mandate a certain kind of "recovery" for depressed workers. Such an elaborate ritual of reintegration and social engineering—which shifts people's attention away from the societal factors contributing to mental health issues—can be problematic, particularly if we believe government-commissioned research that suggests that all that some workers may need in order to avoid depression is a few more hours of sleep each day.[15)]

Yet, a therapeutic space is rarely deterministic and is often full of surprises. During fieldwork carried out in the 2010s, I met some Rework psychiatrists who were experimenting with ever-more diverse forms of therapeutic programs. They were seeking to reclaim, on behalf of patients, psychological interiority—as a territory of personal secrets—from being a target of cognitive/affective monitoring to being a realm of individual liberty. Some of these doctors' attempts reminded me of a general depression support group I participated in for over a year, beginning in 2001, that had been formed by patients of a prominent doctor trained in Morita therapy (described by many scholars as having a philosophical resonance with Zen Buddhism). In this group, patients were given an opportunity to disengage from pathological social relations, critically examine the nature of their self-subjugation, and ask if their happiness really lay in pursuing the kind of life they had taken for granted. These patients, including many from the "elite" tier of society, tried to experiment with alternative ways of being, while embracing the Morita philosophical stance of "let it go." That is, they were prompted to admit their imperfections and abandon the illusion of self-control in order to accept themselves "as they are," thereby creating a vision of "self-transcendence" that probably would not easily be endorsed in the mainstream form of Rework, with its principle of self-enhancement and maximum-optimization for the workplace. As some Rework psychiatrists begin to question the "capitalization of the meaning of life" (Gordon, 1991,

p. 44) and avoid channeling patients to think narrowly inside the corporate box, they were—in ways like those I encountered in the 2001 depression support group—more respectful of patients' needs for silence as well as attentive to their desires to disengage and explore alternative ways of living and find their own paces for recovery (cf. Nakamura, 2013; Ozawa-de Silva, 2009; Zhang, 2014). Yet, as doctors are also pressured by corporate demands for quickly restoring workers' productivity, it may well be that Rework is destined to serve primarily as a means of reclassifying apparently dysfunctional workers and restoring productivity, assisting corporations that no longer consider it their responsibility to care for the worker as a whole person. It thus remains to be seen whether Rework can provide a more truly "caring" form of surveillance and an alternative place for recovery—even for nurturing a sense of secret and sacred self—by recultivating workers' critical awareness regarding their own health and happiness.

The Rise of Resilience

A national desire for controlling psychological health—as seen in the rise of mandatory stress checks and regimens like Rework—might provide fertile ground for preemptive medicine to transform and prevent people from becoming mentally ill, rather than simply treating those who already are. Outside of Japan, such a therapeutic ethos is already found in resilience training, promoted by the U.S. military since the September 11 terrorist attacks. As discussed by Allan Young (2012, 2014), resilience training is an instrument for encouraging soldiers to adopt positive mental health as a way of increasing their psychological fitness so that they can either overcome or prepare themselves for war-inflicted trauma, including haunting memories of atrocities they might experience in the line of duty. Yet, underpinning the disarmingly benign-sounding notion of "resilience" is that its appeal lies largely in glamorizing the transcendental power of the individual while it masks the absurd predicament of war and the geopolitical implications of economic neoliberalism (Howell & Voronka, 2012). Moreover, as the concept of resilience is adopted in many countries, including Japan, and applied to non-military contexts, it renders what was once assumed to be a natural ability of people in adverse situations to recover from traumatic experiences on their own and lead a healthy life into a process to be managed with therapeutic technologies. Increasingly, dealing with life stress and trauma is being redefined as "something to be achieved with the help of experts," to the extent that resilience may soon come to "displace effortless 'normality' as the default condition of human life" (Young, 2012: also see Young, 2014; MacLeish, 2013, 2015). Seen in this context, the Japanese government's calls for nationwide stress checks of workers may be an ominous sign of a coming global age of "positive mental health" with its sights set on far more than merely caring for the mentally ill.[16)]

In this new care of the self, what happens to people's sense of self when they feel eroded by demands to record their every move and mood, even to predict how their future selves will react to stressful events? While there is certainly apprehension about being seen and having oneself exposed, there is for some also the opposite desire to "escape from freedom" or rather escape from the responsibility of self-surveillance by means of active self-disclosure, and to be again holistically cared for (as in the

paternalistic corporate welfare of the pre-recession era in Japan). Moves to reveal and manage the self in corporate settings—including depressive affect as well as intimate domains of personal health through stress checks—may be understandable given that individuals are increasingly bestowed with a responsibility for "self care" at a time when, structurally, they lack the power to do so. One person I interviewed, a highly overworked but seemingly healthy employee of a leading electronics company, discussed her experience of routine mental health checks at her company and told me she always marks "feeling suicidal" in her stress check even without actually feeling that way at all. She does this to indicate her vulnerability and therefore secure a consultation; she believes that this "data double" of herself can serve as a shield of protection and proof of her stress in case she does become depressed. As Bauman and Lyon (2012) point out, to expose and leave a record of one's own vulnerability in the networks of ever-expanding digital monitoring may well be the best self-protection amid increasingly sophisticated systems of surveillance and control. Yet this can go both ways, as her revelation of suicidal feelings also raises a red flag to management that indexes her as a potential candidate for future layoffs. Furthermore, while her self-impression management (Goffman, 1959) is a mere response to the tightening web of corporate surveillance, the façade of the self the worker presents would likely evoke confusion and mistrust among health professionals, many of whom continue to regard themselves as caregivers rather than surveillance officers. In the emerging surveillance system, individuals are pressed to choose whether to give up their secrets without knowing if doing so will work for or against them.

For the time being, the state and the corporate world still require workers, as agents of their own emotional self-knowledge, to report their malfunctions; the old technology of self-disclosure and self-disciplining still remain key means for enacting care of the self. But what will happen in the coming age of preemptive medicine and its technologies of mass screening via neuroimaging and genetic testing—when everyone becomes identifiable as "pre-symptomatically ill" (Rose, 2007), and the brain and the body are further turned into the seat of valuable secrets? Even as preemptive medicine has been criticized as premature for psychiatry (which, after all, lacks such essential tools for early detection as solid disease categories [Frances, 2013]), in Japan, where it is estimated that the total number of mentally ill patients (including dementia) is double that of cancer patients (*Nihon Keizai,* 2011), the government's desire for efficient biomedical containment runs high. As the state and health professionals desperately search for more objective, biological means of diagnosing and screening for depression (with grants going to the development of a wearable optical topography system for mapping prefrontal cortex activation, for instance) in place of the Stress Evaluation Tables, it might not be long before this newly opened-up psychological space of depressed workers becomes replaced by thoroughly biological stress management. Such surveillance would likely shift attention away from workers' social experiences and emotions to objective signs of stress as neurological abnormalities to be detected at the level of cells, even though some leading neuropsychiatrists have expressed to me skepticism and fear that such technology engenders unrealistic expectations and potential for abuse. As with the Smart Wellness City, what is also troubling about digitalized psychological surveillance—as it shifts its primary concern from individuals to combinations of "factors [and] statistical correlations of heterogeneous elements"—is the

ways in which it could not only dispense with the subjective but also devalue the reciprocal relationship of "the carer and cared" (Castel, 1991, p. :288). An overwhelming collective fear of the irruption of the unpredictable could sever human reciprocity, bring a death to individual privacy as we know it, and fundamentally transform the material and social life of the secret.

Alternatively, the process of creating the means of collective psychological management could lead to a kind of "ecological" perspective (Lupton, 1995; also see Raikhel's [forthcoming] reconceptualization of Bateson 1972)—attentive to the fact that collective mal-affect is not simply reducible to an aggregate of individual mal-health—and calls for structural transformation (Béhague, 2009). If so, this could help generate new ways of diagnosing and intervening in the health of the social body in order to address both forms of vulnerability—individual and environmental—and their interactions with one another, which in turn may lead people to problematize the increasing expectations placed on workers' self-governance as a panacea for structural malfunctions. I have often been struck in my interviews with doctors involved in preemptive psychiatry by the fact that some of them are direct descendents of the 1970s antipsychiatry movement, and are explicit about needing to address both individual biology and societal problems—even if their aggressive (and often heavily pharmaceutical) interventions have raised public concern. Their zeal is also echoed by some occupational doctors who are now requesting that the government include questions in their health checks not just about workers' stress levels but about problems of the workplace, as they search for ways of using surveillance of individuals as a way to do surveillance of the workplace itself. Their hopes may well be realized as the Diet recently enacted the Overwork Death Prevention Law in an effort to prevent further tragedies (*Yomiuri,* 2014). As silence around mental illness is broken, and as the nature of secrecy radically changes in the workplace, could it be that the psychiatrization—and further neurobiologization—of workplace psychopathology will help develop a novel and truly caring form of surveillance that leaves workers feeling both left alone and cared for? Psychiatric screening and early intervention are still experimental so it is too early to tell. But one cannot help hoping that out of such collective attempts to engage with the realm of workers' secrets will come a way to strike a balance between the constraints of the neoliberal workplace that demand resilience and a more caring system of health protection that will recognize, even cherish, fundamental human vulnerability.

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Notes

1) This article is based on a more than a decade of ongoing research on depression in Japan. This consists of: 1) archival research on psychiatric, legal, and popular books and articles on depression; 2) participant

observation in various psychiatric institutions in 2000–2003 and again in 2008; 3) in-depth interviews with more than 50 psychiatrists and 30 patients, as well as informal conversations with numerous others at psychiatric conferences and on other occasions (more recently including those working in occupational medicine, early intervention, and Rework); and 4) participant observation of mental health training for human relations staff and interviews with five workers about mental health checkups in 2013–2014, supplemented by research on ten blogs written by depressed workers who have experienced Rework (for further details, see Kitanaka 2012).

2) The official stress checks are to begin in December 2015, even though many corporations, following the government's announcement in 2010 that it planned to install mental health screening (Asahi 2010), have already implemented e-learning and digital screening for the mental health of their employees.

3) This shift started with the 1999 development of the Stress Evaluation Tables listing 62 stressful life events assigned specific scores, with which experts can "objectively" measure workers' stress levels (Kuroki, 2002). This was followed by the creation of the Basic Measures for Suicide Prevention (2006) as well as revision of the Labor Safety and Hygiene Law (2014).

4) Some workers and doctors are suspicious of the government's claim that the stress checks are simply a means of promoting workers' self-awareness about their mental wellbeing and thus should be conducted (and their "secrets" shared with their employers) only with an individual worker's consent.

5) This reconceptualization has been accelerated by the fact that the World Health Organization (WHO), in collaboration with World Bank, has placed depression high on the list of what it calls the "global burden of disease," affecting more than 350 million people worldwide.

6) Note that whatever universal and objective scales or terms are adopted to define and examine mental health, these limit its definition by what they leave out.

7) Information on the Smart Wellness City effort in Japan is available at: http://www.swc.jp.

8) There is, however, increasing research on how to read subjectivity via neurobiology, such as in the decoding of dreams.

9) That is, as long as their personalities remain within an acceptable range found among the workers doing the same kind of jobs (Asahi, 2001).

10) For the Japanese Society of Depression's objections to the term "new-type depression," see \url{http://www.secretariat.ne.jp/jsmd/qa/pdf/qa4.pdf} (Last accessed on May 29, 2015).

11) Some corporate personnel department staff and occupational psychologists I interviewed in 2012–13 had developed their own categories to classify the depressed. A psychologist working for an EAP (Employee Assistance Program) company told me they recognize three categories of depressed workers: traditional, new-type, and those with developmental disorders. While traditional depressed workers can be expected to recover and return, those with new-type depression are implicitly encouraged to seek jobs elsewhere where they may be able to fulfill their potential. Then there are those whose "depression" is caused by inherent inabilities to communicate effectively. Those individuals are not expected to change fundamentally, and the company has little choice but to accommodate itself to their disabilities for the time being, even as it seeks ways to retrain them and make best use of the abilities they possess.

12) The impact of the labor policy changes has been profound. Prior to 1999, cases of workers' mental illness were rarely approved for workers' compensation and few workers could even imagine holding their company legally liable for psychiatric breakdown. After the Stress Evaluation Tables were established in 1999, the number of approved cases (a significant portion of which involves depressed workers) increased to 100 (43 suicides) in 2002, 269 (66 suicides) in 2008, and as many as 475 (93 suicides) in 2012. See: http://www.mhlw.go.jp/file/04-Houdouhappyou-11402000-Roudoukijunkyokuroudouhoshoubu-Hoshouka/seishin_2.pdf (Last accessed on May 29, 2015).

13) Because large-scale companies tend to be gravely concerned about damaging their corporate image by firing mentally ill workers and being legally challenged by them, some of them, in search of "safer" and more efficient means of psychological management, have reduced their traditionally in-house psychiatric consultations and

begun outsourcing care to EAP (Employee Assistance Program) companies featuring various psychological tests and mental training.

14) Psychiatrists are certainly sensitive to the growing criticism that Rework—with relatively little personalized psychotherapy and an emphasis on individual responsibility to adjust and cure one's self—is a machine for "quality control" and "cream skimming," revitalizing only those competent and competitive enough to survive the rigorous program (Saio, 2012).

15) See research on sleep and mental illness by the National Center of Neurology and Psychiatry: http://www.ncnp.go.jp/press/press_release130214.html (Last accessed on May 29, 2015).

16) In Japan, particularly alarming is that contemporary "resilience" discourse (e.g., Fujii, 2013) has been used by some to advocate a strengthening of the country in ways that echo the nationalistic and eugenic discourse of the pre-WWII period in Japan (see Matsubara, 1998), when the state spoke of strengthening citizens' bodies and minds in order to bolster national security.

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