

# Questioning the Efficacy of Medicalizing Mental Illness in Japan

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## Introduction

Depression in Japan is a big issue. In 2017, there were 1,276,000 patients being bothered by depression (Ministry of Health, Labor, and Welfare, 2019). Depression (major depressive disorder) is a common and serious medical illness that negatively affects how you feel, the way you think and how you act. According to the definition from American Psychiatric Association<sup>1</sup>, Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease a person's ability to function at work and at home. Although we define depression as a mental disease, it is vague to distinguish that if it's a social problem or a medical problem because there are many patients who have gotten worse by taking medical treatment and cured by using traditional medicines, such as Chinese traditional medicines or/and improving nutrition balance.

Japanese Society of Mood Disorders (JSMD) is an influential organization which researches general mental disorders and publishes guidelines about mental diseases for doctors and patients to be clear about the categories of patient's depression, give proper medications and points which should be kept in mind. The guideline for depression is used in hospitals to refer.

It is said that Japanese tends to be easily depressed because of the shame culture. The culture puts stress on us and many people who failed to follow our way become depressed.

Moreover, in Japan, depression patients are often looked on as weak people. It is difficult to confess that they have depression and they feel unpleasant to live in Japanese society. That is why about 20% of the reasons of suicide is depression (Ministry of Labor, Health and Welfare, 2019). Depression is also connected with “hikikomori” (people who stay in their room and don't go outside) and “karoshi” (people who die because of overwork). Those themes are big issues in Japan, and it is required to find a way to decrease the number of each.

For the proper treatment which include medical, physical and anything which is considered to be useful, we need to use a guideline which considered all possibilities and fit to Japanese culture. In this paper, we would consider the guideline which is published by JSMD and analyze that by using a report which is based on the experiences of ten patients who had gotten bad effect by using medical treatment and succeeded to conquer depression and side effects of drugs by decreasing and stopping drugs. Comparing the guideline and the real cases would be effective to see the gaps between them and find fail points of medical treatment for depression in Japan and how it is over-medicalized in Japan.

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<sup>1</sup> This definition can be checked at American Psychiatric Association's webpage, <<https://www.psychiatry.org/patients-families/depression/what-is-depression>>

## Medicalization and Over-medicalization

“Medicalization—defined as the processes through which aspects of life previously outside the jurisdiction of medicine come to be construed as medical problems.” (Clarke 2003). Medicalization can be a good thing if it refers medical, humanitarian, social and the other required contents. People don’t need to feel shame or get stigma and can get medical treatment. Medicalization has been expanding. Initial expansions around childbirth, death, menopause, and contraception in the 1970s, Post-Traumatic Stress Disorder (PTSD), Premenstrual Syndrome (PMS), and Attention Deficit Hyperactivity Disorder (ADHD) in the 1980s/1990s, and so on (Armstrong 2000; Conrad 1975,2000; Conrad and Potter 2000; Conrad and Schneider 1980; Figert 1996; Fox 1977, 2001; Halpern 1990; Litt 2000; Lock 1993; Riessman 1983; Ruzek 1978; Schneider and Conrad 1980; Timmermans 1999). But, these days, those subjects are over-medicalized. We could see this tendency from medical treatment for mental illness in Japan. From next, we would like to consider the situation of the medical treatment and see problems.

### Categorization

In the guideline (Japanese Society of Mental Disorder,2016), they firstly separate the kinds or level of depression, such as minor, middle, serious ones, mental, and adolescent depression. Because each depression is suggested different treatment and medications. Patients who meet less than five out of nine diagnosis standards are defined as minor level. Patients who meet obviously more than five are serious patients. Middle depression is between the minor and serious. Patients who are minor feel pain but don’t have serious functional disorder in their job or relationships with others. Patients who have serious depression feel strong pain and they obviously lack function. JSMD

suggests doctors to refer those following 9 things for making diagnosis for patients with depression.

- (1) physical findings
- (2) medical history
- (3) family history
- (4) life history: growth history, academic background, work experience, marriage history
- (5) tendency of personality before being depression
- (6) confirmation of adaptation status before being depression
- (7) evaluate stress factors
- (8) sleep conditions
- (9) check female patient’s physiological functions.  
(Because depression might be caused by irregularity of the curse or by climacteric)

Inspections such as blood, physiological, image, and mental are suggested. While inspection and medical treatment is underway, paying attention to suicide or/ and other possibilities, such as self-mutilation and body complication, is required. Although reasons of depression are different from person to person, the guideline define which level of depression the patient has by considering those nine diagnosis standards. It might be happened that even a patient has serious depression, because of the standard, he is recognized as a minor level, and vice versa. According to the guideline, it is suggested to use different medicine for different levels. Some medicine which is suggested to use for middle and serious depression have a possibility to cause some side effect such as sleeplessness and over calm. If the categorization goes wrong and a patient is categorized improperly, unpleasant drugs might be used, and depression would be worse because a doctor would prescribe other drugs to suppress the side effect.

## Drug therapy

As a medical treatment, JSMD suggest choosing from drug therapy, mental therapy such as cognitive therapy or cognitive-behavioral therapy or use both. However, for the minor depression, consideration that which medicine should be used has not done enough. It depends on doctors which medicine they use. Even the guideline categorizes patients, and suggest which kind of drug they should use, that is because it doesn't tell particularly which one should be used, there is a possibility drug will be used which is not good for the patient. That is why if the doctor chooses unpleasant medicine, depression-level might be changed to middle or serious. Also, whether we should use two or more kinds of anti-depression medicine or not has not considered sufficiently, they basically suggest using single anti-depression medicine, but it is only because there is no enough evidence in so far.

Something which is not clarified has been used in depression medication, as a result, although ,in 2012, Japanese Ministry of Health,Labor and Welfare provided a subtraction regulation for the case a doctor prescribes more than three medicines, some doctors who fulfill certain conditions, it is allowed to prescribe more than three anti-depression medicines (Sawada, 2016). There is no evidence how a combination of several medicines effect to body, however, because there is no clinical data to probe a bad effect and based on the historical experiences of massive multiple drug prescription, it is supported to use multiple drugs at the same time. This fact makes a structure that health hazard or/and death because of the massive multiple drug use is not judged as a medical accident. Those are the evidences of vagueness of this guideline.

## Ritualization of medical care for depression

Also, in the field of depression, medical treatment is ritualized. Most of times, it is because, generally speaking, doctors are recognized as experts and have proper knowledge more than patients, that is why patients believe the doctors and it is difficult to have doubts about medical treatments which doctors provide. They observe taking drugs because they think these are for their serious depression. However, in fact, side effects of drugs are similar to mental diseases and some drugs are for those side effects. This could cause a hopelessness of patients because even they take a lot of drugs, it takes long time to cure, or many times, they have to take drugs all their lives. At the end, it could become trigger to suicide.

The ratio of suicide of pauper is higher than the national ratio. In 2012, there are 1,047 paupers who committed suicide, and this number is as twice as the national ratio. Significantly, 684 of them were patients of mental diseases (Ministry of Labor, Health and Welfare, 2011). For example, a patient who has been taking the medical treatment for fifteen years had to be suspended from his job because of the side effect of a drug. And after a while, he got divorce with his wife, after three years, he was reinstated the job, but he couldn't work like before, and was dismissed the job. He decided to receive livelihood protection. But he lost job, family, money and hope, then as a result, he overtook drugs and tried to die. Fortunately, he was found and saved (Sawada, 2016). This is a case which miraculously be saved the patient, but there are many patients who killed themselves while the medical treatment.

## Dependency on drug

Compare to the other countries, we could see how much drugs are used for depression in Japan. In many countries, such as Australia, the US, the UK, and Italy, around 80% of patients use less than two kinds of anti-mental drugs, on the other hand, in Japan in 2000, around 50% of patients use more than three kinds (Ataru Inagaki, 2003). Also, it is said that there is no big change but make risks to cause side effects if patients intake more than 400mgCPZeq/d. However, in Japan, average dosage was 1400mgCPZeq/d in 2003 (Chong MY, Tan CH, Fujii S, Yang SY, Ungvari GS, Si T, Chung EK, Sim K, Tsang HY, and Shinfuku N, 2014). By using multiple drugs, the side effects could be more serious because the data is just telling about when we use one kind of drug.

We can say Japan has been depending on medicine to treat depression. It could be said also because when I searched about associations which helps depression patients from social and welfare perspective, I couldn't find much effective associations. JSMD might be needed to strengthen the perspective from humanitarian and social.

## Basic issue of medicalized depression

In the guideline, there is no mention about suggested number of drugs for each generation even though depends on generations, side effect caused by drugs are different. It could be a reason of negative effects which sometimes connected to suicide like the patient mentioned above. At the same time, it is suspicious that even the kind of disease is the same, depends on the generation, the drug which is useful is different. This might be a contradiction because It should be required

to mention the number of drugs and also ask why they use different number and kind of drugs, but this is one of the big issues of medicalization of depression.

We have not found a cause of depression. Without finding a cause, we could not find a specific drug which is for depression. That is why, nowadays, we have been using drug which ease depression but doesn't cure that. Perhaps, some patients are believing that those drugs effect to the disease and cure, but there is no enough evidence.

Most of them who realized that they didn't need the medical care said that what they needed was welfare and social supports. Medicalization of depression has been causing negative effects more than positive effects because of the lack of evidences. Therefore, other ways of treatment are required these days.

## Hospitalization

There is no suggestion about hospitalization in the guideline. They should mention about that because forced hospitalization is also a problem in medical care for depression in Japan. In 2014, 290,406 patients are hospitalized, and 142,597 out of them were forced to enter hospital. 10,673 patients got medical restraint. 64.2% of them had been stayed in hospital more than 1 year, and 34.8% stayed more than 5 years. Most of time, those are chosen by only one doctor. Osaka Psychiatric Human Rights Center says even it is not necessary, if the doctor decided to do that, almost 100% the patients have to go into hospital<sup>2</sup>. From humanitarian perspective, it is not acceptable because they ignore human rights. In any case, human rights should be protected. Only when patients have a possibility to commit suicide, they should force them to be hospitalized. However, with current regulation,

<sup>2</sup> This data can be checked on Osaka Psychiatric Human Rights Center, "Situation and subject of mental treatment in Japan", <https://www.psy-jinken-osaka.org/feature1/>

if a doctor requires them to stay in hospital until they cure depression, the patients should just follow the denotation. In the guideline, however, it is written just like if there is some possibility to commit suicide, doctors should consider about hospitalization. It is really vague the regulation with which standard the doctors should decide. The standard should fulfill demands from medical and, also humanitarian perspectives. It would be useful to set third person who is sophisticated with these categories and ask them to help the decision.

## Conclusion

Between the guideline and actual medical treatment, which is held in hospital, they have big gap. It might because doctors think that guideline is not well-organized, and they prefer to follow their experiences. The guideline is required to suggest the care for depression from multiple perspective. Current version is almost only from medical perspective, but they should refer humanitarian, physical, and social perspectives.

There are some reports that exercises are effective for mental diseases. Exercises stimulate nerves and it causes positive effect for anti-depression. Nowadays, some medicalized things have been sifting to be naturalized. It is because people are feeling non-natural. Moreover, people used to believe that medication is credible, however, by spreading internet and other information tools, they realized some doubtful and unhumanitarian behaviors. Also, the treatment of depression might the one of them, especially because, in so far, there is no evidence to probe that drug therapy is the most effective treatment for depression. From the results that there are many patients who have got worse depression by applying drug therapy and conquer by stopping them and use

more natural treatment.

Medicalization is not a bad thing. But when they medicalize, sufficient evidences are required. The guideline is lack of evidence for using drugs. As a result, the patients said, “psychiatric medicine should be misplaced because it has only harm.”. it would be mandatory to improve psychiatric medicine to remove creating iatrogenic harms. A renewed guideline should be the one which contains multiple perspectives and evidences. It would be a really useful guideline to remove non-uniformity of medical care and suspicions from patients.

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