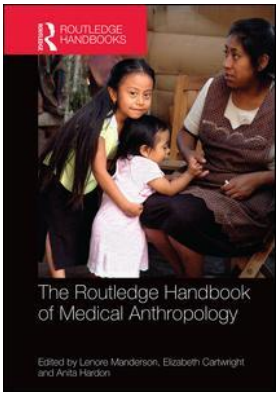

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Stress in Everyday Life

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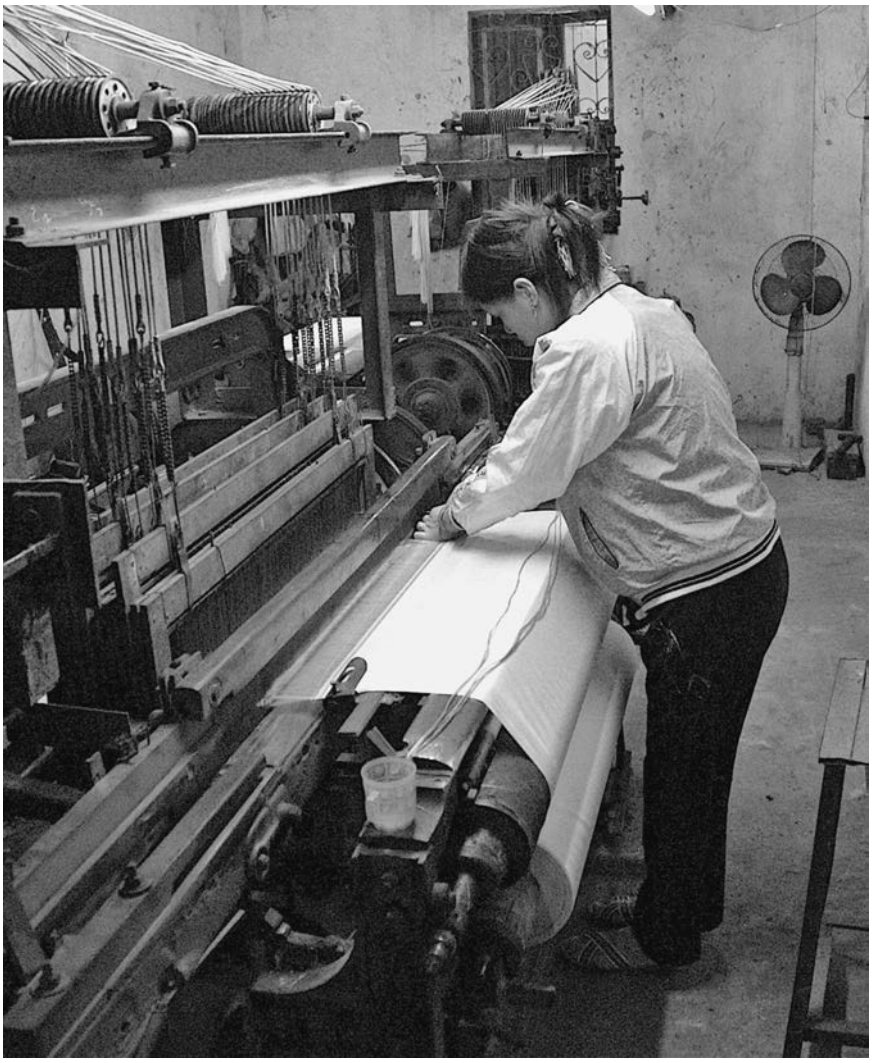

Girl Working in Silk Factory, 2006. Hanoi, Vietnam.

About the photograph

Silk is still an important part of the economy in small villages outside of Hanoi. Like many places around the world the working conditions are terrible. Young women made up the majority of the workers in this particular factory. The machines, many of which were over 100 years old, made an earsplitting noise, and only the most minimal ear protection was being used. Exposure to high noise levels, suffocating dust, and long hours standing over the machines makes this a difficult job, especially for young women like this one pictured, who continue to work late into their pregnancies.

—Elizabeth Cartwright

5

Stress in Everyday Life

Anita Hardon, Elizabeth Cartwright and Lenore Manderson

People express, experience, and manage the stresses of everyday life in many ways. Stress can be defined as the response of humans to environmental demands, also referred to as a biological 'fight or flight response.' Some stress is good: it increases alertness and performance, enabling people to adapt to the needs of a given situation. But when people are subjected to a continuing assault of stressors, they can become exhausted and sick. Social epidemiologists assert that stress is exacerbated when people experience ongoing unpredictable circumstance and a lack of control (Brunner and Marmot 1999).

Stress has become a popular topic in talking about health and wellbeing among relatively well-off people in global cities, who feel economic and social pressures to perform and are exposed to the many different stimuli of the current digital age. Popular magazines and websites encourage people to test their stress levels by answering questions such as "Are you irritable?" "Do you sleep well?" and "When did you last have a good laugh?" They advise people to stop fretting, concentrate on breathing, undertake mindfulness training, and go for walks. Urban yoga studios, massage parlors, and nail spas all invite people to take time out in order to de-stress, not only in cities in the global North, but also in most cosmopolitan centers worldwide.

Expressions of stress are not new, and they are not associated only with the upwardly mobile middle classes and the well-to-do; the discourses of stress have all over the world penetrated everyday discussions of fluctuations in health, wellbeing and mood. In this chapter, we present anthropological accounts of the ways in which people live with and talk about stress in a variety of sociocultural and economic settings, and we reflect on the diverse ways that people strive to manage or cope with stress. Worldwide, cultures have ways of diagnosing and treating stress that have been handed down over generations, that have specific local meanings, and that are often effective in ways that may be illuminating for biomedical practitioners who so often rely solely on psychiatric manuals and pharmacopeia.

Diverse Idioms of Distress

What are the common ways of talking about, or otherwise conveying, stress, tension, and negative emotions in a given society? How do people typically respond to, handle, or attempt to reduce such stresses? We can think through these questions with the notion of 'idioms of distress,' in reference to the ways that people make sense of and express such feelings, and the ways that they work to alleviate them. For example, although the term *stress* exists in Bahasa, the official language

of Indonesia, when doing fieldwork in Makassar, Anita Hardon observed that her female friends more often used the term *pusing* (literally translated as 'dizzy') to express a general feeling of malaise associated with all kinds of stress, in the family, at work, or otherwise. When one declares that one is pusing, it is understood that one should take a good rest. Friends and colleagues will send you home, urging you to get a traditional massage. After a while Hardon started describing herself as pusing too, even if she was only slightly tired. Doing so changed her lifestyle, as her Makassar friends encouraged her to do such things as take some time off and to have regular massages at a local women's wellness center; she had effectively entered into the local logic of maintaining her health and wellbeing.

More than 30 years ago, Mark Nichter (1981: 379; see also Nichter 2010) called on anthropologists to examine such idioms of distress as ethnopsychiatric phenomena, arguing these idioms are "underscored by symbolic and affective associations which take on contextual meaning in relation to particular stressors, the availability and social ramifications of engaging alternative expressive modes, and the communicative power of these modes." He illustrated this by presenting alternative idioms of distress among Havik Brahmin women in South India, who face tensions when they marry and go to live with their husbands and mothers-in-law. Family tensions were expressed through purity discourses, and these tensions were exacerbated as more young women pursued higher education. Nichter showed how young, well-educated wives often purposefully neglected purity rules regarding food preparation and serving when they were unhappy with their husbands, and how mothers-in-law criticized their behavior and its impact on the prestige of Brahmins. These forms of resistance bear interesting similarities to some of those we discuss in Chapter 6.

Elsewhere, anthropologists have observed that social tensions and distress caused by family and community conflicts are expressed through accusations of witchcraft. Peter Geschiere, for example, observed in Cameroon that local witchcraft narratives offer a "seductive discourse to address the riddles of modern development: the rapid emergence of shocking new inequalities, the enigmatic enrichment of a happy few, and the ongoing poverty of many" (2013: 5). Jeanne Favret-Saada (1980), in a seminal study of sorcery in a rural farming community in Normandy in the late 1970s, describes how accusations of witchcraft are related to struggles between households stretching over years. She noted that generally neighbors are identified as witches, not relatives or people living under the same roof. Favret-Saada (1980) was able to explore the world of sorcery in rural France by taking on a role of being bewitched, and enrolling in a therapeutic process with a local healer.

Thus, idioms of distress may appear very differently from place to place. They may be encapsulated in a word or simple phrase directly related to physical feelings, like being 'pusing'; they may be ways of defining or responding to social relations or events, such as the purity discourses mentioned above; they may be invoked in connection to other key frameworks and systems of belief; or they may be expressed through accusations of witchcraft.

Byron Good has argued that "a semantic network analysis conceives the meaning of illness categories to be constituted not primarily as an ostensive relationship between signs and natural disease entities but as a 'syndrome' of symbols and experiences which typically 'run together' for the members of a society" (1977: 25). He suggested that such an analysis could draw attention to configurations of social stress that are embedded in such a syndrome. During his fieldwork in Iran in the early 1970s, he found through such semantic network analysis that stress was located in the heart, with many different kinds of expression: 'my heart is pounding,' 'my heart is trembling' (*qalbim tittirir*) or 'fluttering,' or 'beating rapidly,' and 'my heart feels pressed' or 'squeezed,' 'bored,' or 'lonely.' Focusing on semantics and meanings, Good does not relate these embodied experiences to biological stress responses. Rather, he sticks to the analysis that his respondents

make, pointing out that women related heart distress to their use of the contraceptive pill, and that because it affected their menstrual cycle, they worried about future fertility. Men related heart distress to tense interpersonal situations that were also often closely associated with complaints of weak nerves (Good 1977).

A more recent example of this kind of research is that undertaken by Mysyk and colleagues (2008) in Canada. They describe the occurrence of 'nerves' (*nervios*) among Mexican agricultural workers who enter Canada as seasonal agricultural laborers, under a bilateral agreement that is seen, at least by the governments involved, as solving both the problem of unemployment in Mexico and the shortage of agricultural laborers in Canada. Mysyk and colleagues describe how Mexican men feel uprooted from their families, fear becoming ill, and suffer from language barriers when trying to interact with angry bosses. As one young worker explained, "Sometimes with the boss, you can't understand very well. . . . They don't understand Spanish either. And sometimes, maybe you don't do things like he wants and sometimes he gets angry, he gets annoyed, and sometimes your morale falls because you'd like to do things well" (Mysyk et al. 2008: 390). Another interlocutor explained: "Nerves betray you, no? Because I've seen, in the four seasons I've come [to Canada], I've seen cases of co-workers who sometimes start to cry. . . . 'I want to go back because my son is sick,' 'My wife is sick,' or 'I can't [stay] here any longer.' And nerves betray them and they start to cry" (2008: 397). The participants in the migratory worker program have to receive a positive evaluation in order to be allowed to work in Canada the following year, making it especially hard for newcomers who have less experience and lower English-language skills. Mysyk and colleagues argue that, in this context, nervios "embodies a general lack of control over their lives" (2008: 396). Other anthropologists have described nervios and *susto* (fright) as illness terms that express stress and depression (Baer et al. 2003; Cartwright 2007; Guarnaccia et al. 2003; Weller et al. 2002).

Kaiser and colleagues (2014) also discuss how a lack of control relates to feeling distressed in the context of work, as they unravel a Haitian idiom of distress described as *reflechi twop* ('thinking too much'). This syndrome is associated with sadness, suicidal ideation, and social and structural hardships such as unemployment and poverty. As one of the community leaders explains, "There is no work! It is the impossibility; it's poverty that puts everyone in all these things because people are sitting down, only sitting down, eating. And the food, they don't know where it will come from, and they are thinking about how to get food. . . . You can't think of anything else" (2014: 458).

Kirmayer and Young (1988) argue that cultural models supply individuals with a 'vocabulary' of symptoms and provide explanations for these symptoms and associated suffering. One could add to this line of thought that new patterns of stress lead to new forms of somatization, such as those experienced by factory workers in Malaysia in the 1970s when jobs became more routinized and sedentary, as described by Aihwa Ong (1987). Similar examples of workplace 'hysteria,' or in the case study by Ria Reis in Chapter 2, of hysterical responses in schools, further illustrate the ways in which people enact and express feelings of stress, distress, and loss of control over their everyday lives. While transcultural psychiatrists have conducted epidemiological studies to find associations between cultural expressions of stress and psychiatric conditions, Kirmayer and Young emphasize that it is important for medical practitioners to listen to how patients describe their illness, in their own terms, in order to understand the way idioms of distress are linked to "social predicaments, moral sentiments, and otherwise unexpressed emotions" (1988: 424). Listening to the stories of somatized stress can provide clues to non-medical solutions that could prevent—or at least acknowledge—the underlying causes of the physical stresses individuals are experiencing.

Managing Stress

Anthropologists have long observed that spiritual healers, diviners, and shamans mediate tensions of everyday life through rituals and collective healing sessions. They do so, for example, by going into trance states, speaking in a special vocabulary and tone, and answering questions about misfortunes (Beattie 1967). A key characteristic of such healing sessions is that they are social events, involving patients, friends, and relatives. Geschiere (2013: 527) describes how in Cameroon, spiritual healers called *nganga* can solve problems, because they can 'see' the witches, 'fall upon them,' and force them to deliver their victims to safety. Through diagnoses of distress, such healers are able to prescribe appropriate healing acts: a gift to an ancestor, the payment of reparations, a special feast. In Tim Asch, Linda Connor, and Patsy Asch's classic films, *Balinese Trance Séance* and *Jero on Jero* (2015 [1980–1981]), and associated text (Connor et al. 1996 [1986]), the filmmakers richly illustrate how Jero, a Balinese trance healer, manages family distress and helps family members come to terms with a child's unexpected death.

Critical medical anthropologists worry that such social healing approaches may be replaced by biopsychiatric models of healing, which are increasingly dominant all over the world, in part due to the flow of these therapeutic regimes through aid efforts in areas affected by conflicts and natural disasters (Good 2010; Watters 2010). Anthropologists are critical of the global applications of the American *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the current version of which is called the *DSM-5*. These manuals provide psychiatrists and other biomedical practitioners with diagnostic tools that are assumed to be applicable and valid in any cultural setting. Watters shows how American definitions of depression, anorexia, and post-traumatic stress disorder, among other states, are spreading worldwide; that local expressions of distress are being discounted; and that, as a result, "indigenous forms of mental illness and healing are being bulldozed" (2010: 3).

The attention to mental health is part of a more general recognition among global health planners of the importance of non-communicable diseases—a domain that was neglected in the past when programs were mainly directed at the control of acute infectious diseases (see Chapter 7). Up to 30 percent of the global population experiences a mental health condition every year (Prince et al. 2007), and mental health problems are increasingly prevalent compared with other conditions. Some anthropologists fear that this recognition will further fuel the use of psychopharmaceuticals in the treatment of all kinds of symptoms of distress, thereby medicalizing social suffering (Ecks 2014; Watters 2010). Others have pointed out that it is important that mental needs enter the global health agenda (Summerfield 2012). Good takes this latter view, and argues that in settings like Indonesia, "the salient issues seem to be the scarcity of mental health resources, including access to pharmaceuticals, the poor quality of care for those seeking treatment, and the utter indifference to mental health services among many ministries of health" (2010: 121). Elsewhere, however, Good also draws attention to the different ways in which mental health states are understood, and hence the different expectations of the chronicity of conditions and the relationship of this to treatment, recovery, and social inclusion (Nichter 2010).

The first case study in this chapter outlines how in Japan, a country hit recently by a severe economic recession, psychiatric diagnosis, treatment, and the prescription of antidepressants have played an empowering role in helping people deal with the pressures of work and the stresses of unemployment. Junko Kitanaka describes how the biomedical diagnosis of depression as a work hazard gives men (more so than women) recognition that they have suffered injustice. Psychiatrists have played a key role in creating a socializing discourse, Kitanaka maintains, by providing powerful testimonies for depressed workers, showing that depression is not only a pathology of

the brain but is also rooted in the stress of losing one's job or of having to work excessively long hours. Thus psychiatrists in Japan articulate depression as an affliction of hardworking people, who, unable to sense their own fatigue, end up being completely exhausted. While this definition of depression has resulted in large increases in antidepressant sales in Japan, Kitanaka states that depression is not seen in the local setting as the medicalization of mood, but as the result of precarious economic conditions.

5.1 A Cold of the Soul

Junko Kitanaka

In 2001, at a psychiatric hospital in Tokyo, I met Kobayashi-san, a civil servant in his fifties, working for the central government. After we exchanged our business cards, he began sketching out the timeline of his illness. He told me how, on a Sunday when he was in the office, his mind suddenly went blank. He had been involved in an intense budget negotiation with the Ministry of Finance and had been sleeping only three hours every night, continuously working on weekends. At the time, it was not unusual for people in his ministry to work more than 100 hours of overtime per month—"If someone dropped dead, then superiors would talk about giving the family a workers' compensation but that was it." Even when he felt exhausted, he blamed his own 'weak' personality, feeling that he was doing a job that was beyond his capabilities. He had heard about cases of other employees throwing themselves out of an office window in the high-rise government headquarters. That day, a thought occurred to him that he might just do the same . . . he just wanted to escape from it all.

Such was a typical story I heard from the people with depression whom I met in psychiatric hospitals and clinics in and around Tokyo in the early 2000s. Many of these were men in their prime, hard hit by the recession that had triggered high unemployment rates and record-high national suicide rates. As banks went bankrupt and companies that had prided themselves on their lifetime employment system began to resort to massive layoffs, Japanese people's belief in their society's stability was fundamentally shaken. In this context, Japanese people began to talk about depression as an illness of stress and overwork, a theme that consistently appeared in almost all the narratives I heard from patients with depression. Takashima-san, a businessman in his forties, said he was regularly working from 7 AM to 2 AM when he developed this ailment. Enduring an abusive boss who scolded him in front of his colleagues, Takashima-san began to lose confidence and did not know what he was doing anymore. His own children discovered him, at home, when he was trying to hang himself with a rope. Machida-san, a former executive director of a construction company in his sixties, bitterly described how, after the burst of the bubble economy, his parent company began to dump unprofitable projects on his firm. While striving to survive by scrambling for funds day and night, ensuring that his employees were paid every month, he said he didn't even realize he had become depressed. He recalled how humiliating it was to be in the bankruptcy court that had confiscated his house and every other asset, while being condescendingly lectured by the judge about the meaning of 'collective responsibility.' He criticized the government for promoting rhetoric like 'sharing the pain' to protect big businesses in recession while doing little to save little guys like himself. For these men, the diagnosis of depression as a work hazard seemed to give some recognition of the structural injustice they had endured, and allowed them to recover their impaired sense of self through the care of a psychiatrist, who often served the role of a benevolent superior by not only prescribing medication but also ordering ample rest.

The global rise of depression since the 1990s, spearheaded by the advent of new antidepressants, has often been discussed as a new era of biological management of everyday distress. In the way that the medicalization of depression has prompted workers to pharmacologically control their negative affect, some critics argue that psychiatry might be serving as an insidious tool for manufacturing productive and delusionary happy workers, oblivious to the social roots of their distress. This view, however, fails to capture the complexity of what has been happening in Japan, where the rapid medicalization of depression has coincided with—in fact has been spurred on by—a new type of workers' movement. Through a series of litigations over what Japanese now call 'overwork suicide'

and 'overwork depression,' depression has emerged as a much-politicized biomedical category used by burned-out workers and their family members as a basis for economic compensation for their suffering and sometimes death. Japanese psychiatrists have played a pivotal role in creating this 'socializing' discourse by providing powerful testimonies for depressed workers, showing how depression is not only a pathology of the individual brain but is also rooted in workplace conditions. Their arguments have prompted the Japanese government to change its traditional stance that mental health is a private matter, and to officially adopt a stress-diathesis model that clearly defines mental illness as a product of interactions between the individual and the environment. Psychiatrists have also aided the government in establishing Stress Evaluation Tables, which list 62 stress events as potential causes for psychiatric breakdown; these tables are now routinely used by medical experts for determining if a worker's mental illness has been caused by work stress. As a result of these changes, almost all forms of psychopathology—including schizophrenia—can now be administratively examined in terms of social causes and are subject to workers' compensation (Kitanaka 2012). By depicting depression as both a neurobiological and social pathology, psychiatrists, industrial leaders, and the government have seemed as if they are trying to lift the nation out of economic depression by turning its attention to individuals' clinical depression.

This particular rendering of depression in Japan as an illness of stress—even evocatively called a 'cold of the soul'[1] that one catches in a time of hardship—is based upon a century-old theorization about the relationship between overwork and psychopathology. Japanese psychiatrists have long noted how the depressed tend to be hardworking people who seem unable to sense their own fatigue and end up breaking down at the height of their exhaustion. Understanding depression as a somewhat adaptive mechanism for self-preservation, psychiatrists have also discussed this ailment as a product of a particular personality (called *Typus melancholicus*), shaped and reinforced by a Japanese work ethic. Psychiatrists I observed in their everyday clinical practice in the early 2000s would often assure patients that their overwork—marked by their own diligence, strong sense of responsibility, and consideration for others—had driven them to a psychiatric breakdown. This therapeutic narrative seemed to be embraced by all the patients I met, many of whom talked about depression as not simply a biological defect or a distortion in cognition but a bodily insight that is calling for change in the way they live. Some saw this ailment as an opportunity to retreat from excessive social obligations and even contemplated the nature of their own self-subjugation. Their critical awareness became reflected in revised labor laws in the 2000s, which seemed to provide structural possibilities for Japanese to distance themselves from a cult of overwork that had bound them.

Reconceptualizing depression as an illness of stress has thus brought about a new sensibility in Japan about the burden of affective labor. It has also created 'gender equality' in the medical and popular discourses about psychiatric suffering. Curiously, female depression had long been underrecognized in Japan. Although the theory of *Typus melancholicus* and its emphasis on work were not necessarily gender-bound, given men's prominence in workplaces (and the social visibility of the 'public' work in which they are often engaged), it seems to have contributed to foregrounding men's suffering. Some of the veteran psychiatrists I interviewed pointed out that their model of depression had traditionally developed around male depression and women's depression defied easy classifications. Psychiatrists thus used to be much less eloquent about the plight of depressed women, as if the doctors themselves could not quite grasp or explicate the nature of these women's suffering. This gender bias was reflected in the narratives of the depressed women I met, some of who discussed how their complaints had been dismissively treated as 'psychosomatic' both by family members and doctors. Such stories were quickly becoming a thing of the past in the early 2000s, however, when the media began to emphasize that 'even women become depressed,' and depression was becoming a top reason for both women and men taking sick leave.

Yet, using a biomedical category to mediate social injustice and to claim a status of victimhood—especially to secure one's place in the rapidly changing labor force—is fraught with moral and political ambiguities, as it often leaves those people vulnerable to the instability of biomedical (re)definition of their suffering (Petryna 2002; Young 1995). This was the case in Japan through the 2000s, as contradictions in the simplified notion of depression began to be exposed. First, psychiatric campaigns depicting depression as an illness of stress helped prompt a sudden increase in the number of people seeking and receiving this diagnosis, resulting in an unprecedented number of people with depression. Sales of antidepressants rose from approximately 17 billion yen in the 1990s to reach 90 billion yen by 2007, and the number of depressed patients more than doubled over a ten-year

period, exceeding one million by 2008 (Yomiuri 2010). (This was remarkable given that psychiatrists themselves had assumed until the mid-1990s that depression was a rare occurrence.) The patients I met told me that, prompted by psychiatrists, media, the pharmaceutical industry, and the government to become aware of their mental state, they began to realize how 'depressed' they had been. This change in people's self-awareness set in motion what Ian Hacking (1999) calls a (bio)looping effect; the rise of an illness category, as it becomes embraced and internalized by those afflicted, begins to change the manner in which the illness itself is expressed and experienced. In Japan, as people voluntarily sought medical care, psychiatrists and internists began to see people with milder forms of depression, for which traditional psychiatric treatment proved ineffective, even detrimental. As some patients began to suffer severe side effects of medication, developing chronic and protracted forms of depression, people's initial hope for their linear, straightforward path of recovery collapsed, unsettling the public's expectations for psychiatry's efficacy.

The patients I interviewed in 2008–2009 lamented how they had casually begun taking antidepressants and thought little about the consequences of carelessly adopting a psychiatric identity and the effects of long-term psychotropic use. Kawai-san, a nurse in her thirties, told me how she was surprised to receive a depression diagnosis (particularly because she suspected that her problem stemmed from years of marital conflict), but nonetheless embraced it as a way of obtaining sick leave. A year after treatment, however, she found herself uncured, divorced, and unemployed, while suffering severely from the side effects of heavy medication. After three years of struggle, she met a psychiatrist who gradually took her off all medications, only to find that she was 'hardly depressed at all.' As this case and many others like hers attest, contrary to the then-popularized image of depression as an illness of stress, depression is far more complicated in its etiology and often leaves a mark on the afflicted, at times fundamentally altering their sense of identity. This is especially the case with chronic patients, for whom 'depression' often remains irregular, irrational, and unpredictable, and for whom a certain period of social disengagement may be crucial for recovery. Yet, because of the generally simplified and optimistic understanding of depression, people who long remain depressed may appear to others (particularly personnel staff at the workplace) as puzzling and unpredictable. Thus, the overly normalized understanding of depression is beginning to generate new forms of disability and stigmatization against those who remain uncured. By remaining disengaged for too long, they risk being stigmatized as suffering a 'new type depression'—a sign of personal immaturity—and reclassified as a moral threat to the labor-obsessed society.

Partly in response to such confusion, corporations and the government have begun to approach depression as a form of risk to which every worker is subject, which should come under rational management rather than strictly traditional psychiatric practice. Increasingly, the care of depressed workers is being outsourced to specialized clinics that provide not only medical care but also occupational training and group cognitive therapy designed to rehabilitate—even improve—the work skills of the depressed. As depression becomes an object of corporate risk management, companies are beginning to scrutinize workers' mental health and monitor their recovery in order to promptly restore their productivity. Given the prolonged recession, where both industrial doctors and personnel staff are coming under increasing pressure to return the afflicted to a healthy state, some doctors seem to be moving away from the former ideals of *clinical time* that prioritizes a 'natural' recovery, and are adapting to the demands of *industrial time* that constantly seeks, even for a therapeutic process, the principle of *efficiency*.

Under these new circumstances, the clinical principle of *Typus melancholicus*—which recognizes depressed patients' diligence and strong sense of responsibility, and 'rewards' them by prescribing ample rest in the form of long-term sick leave (at times even a few years)—no longer seems to have the therapeutic validity it once held. In fact, people identified as *Typus melancholicus* are quickly losing their legitimacy as model workers and legitimate victims, and are increasingly regarded as simply 'stubborn, inflexible, and outmoded'; they are now expected to overcome their depression and adopt, through cognitive enhancement and affective management, a more 'malleable, adaptable, and ambiguous' self, as one psychiatrist put it. Given the new corporate demands, psychiatrists themselves often appear uncertain, beyond prescribing antidepressants, how to help these people reclaim their place in the rapidly changing landscape of work while trying to recover a secure sense of self. This heightened uncertainly in the clinical sphere, and increasing confusion in the realm of industrial health, makes one wonder if the Japanese form of medicalization of depression may have simply served to make people's sense of anxiety and vulnerability even more imminent and ingrained, while the socializing discourse about depression has functioned as a tool utilized by the pharmaceutical

industry for cultivating the market for antidepressants—even though it is now painfully apparent to both doctors and patients how partial their effects may be.

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The situation in Japan prompts us to ask how psychiatry can go beyond being a mere apparatus for managing negative affect and boosting productivity, at a time when depression is increasingly and globally regarded as a problem of labor. While recent developments in Japan suggest that there are no easy answers, what may give us hope is the fact that the kind of socializing discourse about depression in Japan is not an isolated occurrence but part of a global movement that is increasingly problematizing the psychopathology of work. In the 1990s, when I discussed overwork suicide with audiences in North America, it was often regarded as a kind of cultural exoticism, prompting listeners to ask me how Japanese could be so unreflective as to work themselves into depression, even suicide. In 2009, however, a spate of suicides among employees of France Telecom made news headlines internationally, as suicides attributed to work stress and the increasing pressure faced by the company's employees. Rising rates of suicide and depression in the workplace have also raised concerns elsewhere in Europe—including Germany, Italy, and Greece—prompting a debate about the rapid changes brought on by globalization and neoliberalism, the perils of privatization, the collapse of lifetime employment, and the crisis in social welfare, all of which some see as destroying their way of life. An idea that seemed strange to many in the 1990s—that one could be driven to depression by work stress—is now becoming recognized as a global reality, as people increasingly experience the effects of economic meltdown with a resulting "sense of vulnerability in being part of a world system" (Lupton 1999: 49). Given such concerns, we have to ask what kind of role the socializing language of depression can play in the expanding web of psychiatric practice, what place it has in the emerging movement for 'global mental health,' and what possibilities exist for local articulations about everyday distress to help generate a new theoretical framework in psychiatry to address the *social* nature of depression.

Acknowledgments

This chapter is adopted from my book *Depression in Japan* (2012), which is based on ethnographic fieldwork I conducted in and around Tokyo in 2000–2003, when I did interviews with patients and doctors and participant-observation of everyday clinical practice at various psychiatric institutions. This was complemented by follow-up interviews in 2008–2009 as well as a decade of close observation of the changing scenes of depression in Japan. This study was supported by JSPS Grant-in-Aid for Scientific Research (No. 24300293).

Note

1. '*Kokoro no kaze*' (a cold of the soul) is a term that was used to popularize the idea of depression in Japan in the early 2000s. '*Kokoro*' in Japanese denotes soul, mind, and heart.

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Both the expression and management of distress need to be understood in relation to the specificities of healing and care in local contexts. While the diagnosis of depression and its treatment with antidepressants may help to change working conditions in Japan, scholars point out

that in the United States, the individualized management of 'neurochemical selves' (Rose 2003) serves to reinforce existing social structures (see also Dumit 2010; Jenkins 2010). The United States has the highest use of psychopharmaceuticals worldwide. People use pharmaceuticals to feel happier or less anxious, to have more concentration and stamina, and to unwind during a night out. Emily Martin shows that even sleep has become "a complex management project" (2010: 205; see also Wolf-Meyer 2012).

Sue Estroff's seminal ethnography, *Making it Crazy* (1981), illustrates how the side effects of psychopharmaceuticals have contributed to local understandings of stigmatized mental illnesses. This ethnography describes the late 1970s in the United States, when many people with mental health problems were de-institutionalized and heavily medicated. Estroff's unconventional field method of taking the drug Prolixin, so that she too would display the extrapyramidal symptoms of foot stomping, tongue thrusting, and uncontrolled limb movement, allowed her to emically experience people's negative reactions and therefore, to more fully understand the experience of being mentally ill and out on the streets. Estroff was able to show that part of what the general public considered to be the outward appearance of a 'crazy' person was, in fact, the side effects of the medications they were taking to control their conditions. The stigma of mental illness, as it was understood at that time, developed simultaneously with the increased prescription of Prolixin.

Talking Therapy

The second case study in this chapter brings us to a very different setting. In Argentina, well-being is promoted through psychotherapy rather than through the use of pharmaceuticals. P. Sean Brotherton describes how in Buenos Aires his informant Gaston, who moved from a small rural town where he had been prescribed antidepressants, was advised by his psychiatrist to go to a psychoanalyst. While in many settings counseling, psychotherapy, and psychoanalysis are unfamiliar and may not be considered appropriate interventions, Brotherton explains that in Buenos Aires, there is a very high concentration of practicing psychoanalysts, and so seeing an analyst is a normative practice in the city: it is seen as a tool for general wellbeing. As Gaston says, "It's about learning to live your life."

5.2 Psychoanalysis in Buenos Aires

P. Sean Brotherton

"There was just a dark cloud that seemed to perpetually hover over me," said Gastón Fernández, 38, who moved to Buenos Aires in the mid-1990s from a small town in Santa Fe Province. "I just didn't care about anything or anybody," he lamented. After diagnosing Gastón with manic depression, a psychiatrist from his hometown put him on several medications. Notwithstanding the fluctuating dosages and changing medications, his general feelings of apathy never abated.

Shortly after arriving to the city to pursue university studies, Gastón sought out a new psychiatrist at one of the local public hospitals. "Do you have a therapist?" the psychiatrist asked during their first consultation. The question caught Gastón off guard. "I had always heard and read about psychoanalysts. I had seen them on TV and in newspaper articles. In high school, we were required to take psychology courses, which covered Freud's work fairly extensively," Gastón recounted. "But being from a small town, there was not really much access to that kind of therapy there." The psychiatrist explained that while medications could prove efficacious for certain people, psychotherapy could perhaps address other root causes that contributed to his illness. Gastón thus began attending biweekly sessions of psychotherapy.

A self-described Freudian analyst, the psychotherapist used their sessions to explore Gaston's inner experiences and thoughts to gain insight into the unconscious determinants of his behavior and how

his past might be influencing the present. This clinical approach echoed the teachings of Sigmund Freud, who began developing the field of psychoanalysis at the turn of the twentieth century. In *Introductory Lectures on Psycho-Analysis* (1966 [1915]), Freud outlined his theory and therapeutic method for addressing how human behavior, experience, and cognition are largely determined by irrational drives that reside in the unconscious mind. According to Freud's model of the human psyche, conflicts that arise between the conscious view of reality and unconscious (repressed) drives result in psychological phenomena such as narcissism, hysteria, dreams, and the development of sexuality. Treating such psychopathologies, Freud advocated, could be achieved through the skilled guidance of an analyst, whereby a patient could gain 'insight' into bringing irrational (unconscious) material into consciousness. Freud made clear that as a clinical methodology, "(n)othing takes place in a psychoanalytic treatment but an interchange of words between the patient and the analyst. The patient talks, tells of his past experiences and present impressions, complains, confesses to his wishes and his emotional impulses. The doctor listens, tries to direct the patient's process of thought, exhorts, forces his attention in certain directions, gives him explanations and observes the reactions of understanding or rejection which he in this way provokes in him" (1966: 20–21).

Although psychoanalytic approaches have declined steadily worldwide, Argentina boasts the second-largest community of practitioners affiliated with the International Psychoanalytic Association (IPA), and has the highest number of Freudian analysts, with an equally high number of analysts who follow the doctrine of Sigmund Freud's disciple, Jacques Lacan. Only 19 years after the translation of Freud's complete works into Spanish, the development, integration, and proliferation of psychoanalysis in Argentina can be traced to the founding of the Argentine Psychoanalytic Association (APA), on December 15, 1942, as a non-profit academic institution. The founding members of the APA, including Argentine nationals and immigrants who had fled persecution in war-torn Europe, were shaped by a philosophical approach "in which individuals interested in the social as well as the personal domain of human liberation [turned to] psychoanalytic theories, including Marxism, to provide an understanding of the institutional and subjective limits on human productivity and pleasure" (Hollander 1990: 894).

Given the prestige of psychotherapy in Europe, it quickly became an "accouterment of upward social mobility and status" in Buenos Aires in the twentieth century (Hollander 1990: 897). Significant portions of the urban middle and upper classes sought out private sessions. Many of the analysts of the APA, however, also worked in public hospitals, and thus were able to utilize their training and expertise with patients from working-class backgrounds. More than a century after Freud's writings, the field of psychoanalysis has significantly transformed to include a diverse assemblage of theories, methods, treatments, concepts, and applications. It incorporates different schools of thought and methods (such as psychological stages, theory of archetypes/collective unconscious, death drive/jouissance, gestalt therapy) developed by different psychoanalytic theorists and practitioners in different countries.

Universal diagnostic categories for mental health, such as those found in the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM), often emphasize behavioral therapy and medical, surgical, or pharmaceutical interventions. Given that scientific medicine, neuroscience, biopsychiatry, and genetics have become the dominant models and organizing logics for mental health interventions in much of the world, how do professionals and laypeople in Buenos Aires develop alternative notions of what constitutes health and wellbeing?

Psychoanalytic Culture in Buenos Aires

"[G]hosts appear when the trouble they represent and symptomize is no longer contained or repressed or blocked from view" (Gordon 2008: xvi). Such 'ghosts,' to borrow sociologist Avery Gordon's (2008) conceptual trope, abound in countless Argentine narratives of suffering and trauma, personal and collective, and in various public and private testimonials of loss, betrayal, longing, and nostalgia. While some of these sentiments are consciously articulated, others circulate at the level of repressed thoughts, sublimated feelings, and artifacts and fragments of past experiences. Argentina's history is characterized by prolonged and cyclical periods of economic growth and bust, militaristic violence, state-engineered disappearances, political instability, and debilitating austerity measures. Such apparitions, sometimes fleeting and intangible, are made visible and find fertile ground in psychoanalytic sessions.

The practice of psychoanalysis is almost ubiquitous in contemporary Argentina (Plotkin 2001). The leading authority on the history of psychoanalysis in the country, Mariano Ben Plotkin, argues

that "(t)he culture of psychoanalysis runs so deep in Argentina that Argentines seldom reflect about it" (2003: 2). For instance, in January 2014, Argentina's Minister of Economy, Axel Kicillof, addressed the media about the country's rampant inflation and speculation on an impending economic meltdown. He accused the opposing political parties of generating 'psychosis.' Referring to the capital flight from the country's banking system, he said: "Economic phenomena can have this magic. . . . They are self-fulfilling prophecies, results of a herd mentality which have no real cause" (Romero and Gilbert 2014). Kicillof's psychoanalysis-inspired diagnosis of Argentina's economic problem was intelligible to a population for which the "everyday use of psychoanalytically inspired neologisms and the explicit references to psychoanalysis made by politicians and even generals . . . has become a *weltanschauung* [philosophy or view of life]" (Plotkin 1998: 271).

Argentina's psychoanalytic *weltanschauung* is particularly salient when read alongside empirical figures by the World Health Organization showing that the country has the highest number of practicing psychologists per capita in the world. Buenos Aires, the country's capital and largest city, has the highest concentration of practicing psychoanalysts; a residential area known as 'Villa Freud' is so called for its high concentration of psychoanalysts and psychiatrists. According to a 2009 national survey conducted by TNS Argentina, 32 percent of respondents have had a psychological consultation at some point (Moffett 2009).

Since the inception of the APA in the early 1940s, psychoanalytic approaches have been integrated into the facets of contemporary everyday life in the country, from the mundane to the spectacular, in the media, popular culture, political speeches, medical discourses, discussions of politics and the economy, and individual narratives about the body, health, and the state. Seeking psychotherapy is a normative practice. Dominant references from psychoanalytic theory—the unconscious mind, hysteria, defense mechanism, theory of the personality structure, Oedipal complex, fetish, and so on—have been popularized and incorporated into everyday idioms in myriad social contexts. Prominent psychoanalysts are quoted in newspaper articles, comic strips depict characters receiving therapy, magazines have columns dedicated to psychotherapy, the daily news includes psychoanalytic commentary on political and economic affairs, and popular reality TV programs show celebrities being psychoanalyzed.

Beyond popular culture, the various mechanisms through which the discourses and practices of psychoanalysis are reinforced, evaluated, transformed, challenged, spread, and inserted into everyday social interactions are, in part, influenced by institutions for public and private education. Psychology as a unique discipline and profession was introduced in Argentina in the mid-1950s. The original curricula focused on educational, industrial, and clinical psychology to train specialized professionals to work on individual and social development. In the mid-1960s, psychoanalysis became more embedded in the curricula as more APA-trained teachers took up positions in higher education. From the 1960s onward, Freudian, Lacanian, and Marxist philosophy intersected, which was represented in significant changes in the psychoanalytic community in Buenos Aires; this included in the academy (e.g. Faculty of Arts and Letters, University of Buenos Aires), in professional organizations (e.g. Argentine Psychiatric Association), and in political organizations (e.g. revolutionary Peronism). At that time, the political neutrality of orthodox approaches to psychoanalytic treatment led to accusations of the leadership of the APA conniving with the rise of the authoritarianism (which took hold of the country in the last military dictatorship, from 1976–1983). This culminated in the splitting of the APA in 1971, and the founding of two new groups, based on ideological differences.

Juridical changes also granted more authority to psychologists to participate in the mental health field. Prior to 1985, psychotherapy was restricted to the practice of physicians. In 1985, a new law loosened this restriction to allow psychologists (with undergraduate degrees) to also practice, although there are still no regulations on the national level for the accreditation of psychotherapists or the regulation of their practice. Despite these juridical changes, there remains a clear epistemological distinction in the training and clinical practice of psychologists and psychiatrists. Not all psychologists or psychiatrists in the country are sympathetic to psychoanalytic approaches, nor are the relationships between the different professional groups always antagonistic (Lakoff 2005). Gaston's psychiatrist, for example, was very comfortable in recommending him to a psychotherapist.

Buenos Aires is thus home to a very heterogeneous field of therapeutic techniques yet to be fully documented. Psychoanalysis in Buenos Aires forms part of and has produced a distinct 'epistemic culture,' a term coined by sociologist Karin Knorr-Centina (1999) to describe a specific body of knowledge, values, expertise, and practices. Given the impossibility of presenting a definite or authoritative account of the Argentine (or more specifically, *porteño*, a person who lives in the city of

Buenos Aires) experience of psychotherapy, I draw on Gastón's singular experience because it reflects many of the themes in other interviews I conducted in Buenos Aires in 2011 and 2013. These interviews revealed how psychoanalysis provides an interpretative and therapeutic framework through which individuals can come to imagine, narrate, and understand their bodies, health, and wellbeing in highly specialized ways. Through an ethnographic examination of psychoanalysis, I engage with Freud's position that "you cannot be present as an audience at a psycho-analytic treatment. You can only be told about it, and, in the strictest sense of the word, it is only by hearsay that you will get to know psycho-analysis" (Freud 1966: 20).

Psychoanalysis as a Tool for Wellbeing

"I have been with my therapist for more than 10 years now," Gastón remarked. "Of course, this is an out-of-pocket expense for me because my therapist works in the private sector. But she has a sliding scale for payments for people like me, with low incomes. We have worked through so many things together, more than just my depression. My therapist is in regular contact with my psychiatrist to talk about my breakthroughs and progress. These sessions are not about *fixing me.*"

As Gastón explained, his biweekly sessions, each 45–60 minutes, were open conversations. He did not attend each session with the intention of 'treating' something or with a specific goal in mind. Sometimes he recounted events or thoughts he had been contemplating since they had last met, and the dialogue proceeded very organically. His analyst often reminded him of things he had previously said, many of which he did not remember. They would dwell and reflect on these moments. Gastón felt the sessions provided him with an empathic space to express himself freely, uncensored; there he could be heard, learn, and, in his words, "move away from the literal facts of what I say to reflect on what structures those very words, and my own way of reacting to that structure. You learn that repeated behavior can be a product of this structure, in your unconscious."

"Psychoanalysis is one way to produce self-knowledge (*autoconocimiento*)," Gastón replied when I asked why he pursued this form of therapy. He had also tried Lacanian therapy and cognitive behavioral therapy. But he was adamant that, although he did not accept the entire 'Freudian package,' his Freudian analyst worked the best for him. His analyst made it clear that there was no true interpretation of Freud, and the model itself was malleable. Gastón told me that his sessions were central to his weekly schedule; even when he traveled for work he used Skype to keep his appointments.

> It is about learning to live your life, and how to interpret things that happen in your life. Going to therapy is part of my life now. It is part of the way I think. You reflexively learn about yourself through your own experiences. This is not knowledge produced by hearing or learning 'what you are like' from other people who may know you, and, perhaps, are too lenient with certain aspects of your behavior—or from those who don't know you and have preconceptions of what you are like or, worse, make superficial judgments about you. My psychoanalyst presents no solutions and offers no absolute answers, although she definitely proposes alternatives that can produce healthy outcomes. That is why I think it is a major part of my overall health.

What crystallizes in Gastón's narrative is the way in which psychotherapy is both a comprehensive *theory* about human nature, experience, and development, and a method of *treatment* for psychological problems.

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Shortly after World War II, the World Health Organization defined health as a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity. While much debate and controversy has ensued on the feasibility of such an idealist conceptualization of health, we need to account for the diverse experiences, like Gastón's, whereby health is not merely a desired outcome but a process that one actively works towards. This provokes us to ask: in the psychoanalytic tradition, what constitutes health, or the notion of a healthy subject, why, and to whom? This case study addresses this by exploring the complex entanglements of different therapeutic regimes of care in the field of mental health and physical wellbeing.

Since its inception, psychoanalysis has always had its detractors. As Freud cautioned, "Persons who are impressed by the visible and tangible . . . [n]ever miss an opportunity of voicing skepticism

as to how one can 'do anything for the malady through mere talk' " (1966: 20). However, Gastón concluded, "Luckily, I think Argentine society is increasingly open to considering the individual as a whole, comprised of body, soul, and mind. Physical health and mental health are intertwined; you need to have a balance. For me, being in touch with my psyche is important to my physical health." Psychoanalysis and the associated therapeutic techniques, which identify diverse psychopathologies and offer circumscribed interventions to address them, have produced an idiom through which different social actors and institutions articulate concerns about physical and mental wellbeing, as well as address social, economic, and political change.

Diverse psychoanalytic traditions in Buenos Aires offer a critical space for collective lament, at times in a highly politicized fashion. The ghosts that haunt Argentine narratives often move beyond discussions of the individual psyche to implicate the state, governance, questions of social justice, and the collective unconscious. Narratives such as Gastón's offer important insight into how psychoanalysis as a practice and 'epistemic system,' broadly speaking, can be a conceptual tool for thinking cross-culturally about health and wellbeing.

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Escape

Beyond the use of pharmaceuticals and the use of psychotherapy, as described in the first two cases, social suffering and distress associated with living under difficult conditions, over which people have very limited control, have been associated with the widespread use of alcohol, tobacco, the irregular use of prescription drugs, and the use of illicit drugs, resulting in addiction and premature death (Raikhel and Garriott 2013; Singer 2008). Singer (2008) argues that in aggressively pushing a means for escape, the producers of both legal and illegal psychotropic drugs, alcohol manufacturers, and 'Big Tobacco'—the multinational corporations that dominate the production, supply, and marketing of cigarettes—contribute to the maintenance of the existing unequal structure of society. Singer's critical analysis echoes that provided by Mark Nichter and Mimi Nichter, who, in the final case study of this chapter, show how Indonesia's tobacco industry advertises specifically to men, encouraging them to smoke a cigarette together as a way to maintain emotional balance, free of "excessive worry and negative thinking." The authors emphasize that these advertisements are effective because losing control is not only a loss of dignity in Indonesian society, it is also dangerous: the loss of control makes one susceptible to malevolent spirits. Advertisements feed into these cultural notions about stress and emotional balance by promoting smoking to deal with emotionally charged issues, such as losing a job or having to manage a girlfriend's nagging. Mark and Mimi Nichter write: "The tag line is usually on the same theme: 'Don't give in, just enjoy a cigarette and it will pass.'"

5.3 Promoting Smoking in Indonesia

Mark Nichter and Mimi Nichter

Smoking is pervasive in Indonesia: over 60 percent of men and approximately 3 percent of women smoke. The tobacco industry in Indonesia utilizes aggressive marketing strategies. The industry conducts extensive market research to identify what themes are most effective for selling cigarettes to different market sectors. Many themes in tobacco advertisements are transnational—themes of sophistication and success, masculinity, friendship, independence, sexiness, and having fun. But as we illustrate below, more subtle themes link smoking in Indonesia to cultural values and collective anxieties, the control of negative emotions, protection from malevolent forces, stress management as a form of self-medication, and enhancement. In these many ways, advertisements have established smoking as a normative practice with social utility (Nichter et al. 2009).

One of the most basic of Indonesian concepts—that influences what clothes people wear, the shampoo they purchase, how they judge the efficacy of medication, and their choice of cigarettes—is *cocok*. This Bahasa Indonesia concept has been translated as compatibility, but it means far more. The term is used in many contexts and does not just designate what is compatible, but what is suitable. To say something is cocok is also a statement that something is 'befitting' and 'healthy' in the original sense of the term, something that contributes to one's own sense of wellbeing. In Dutch, the term *gezondheid* does not index what is healthy for all people because what is healthy for you may not be what is healthy for me. In Indonesia, a medicine that is cocok for me is not just efficacious, but a medicine that has few side effects when taken. Cocok designates a medicine as beneficial to one's person, not just useful for treating a particular pathogen. If the medicine is given to someone else for the same complaint and if does not prove effective, it may not be cocok for them. Following this reasoning, when a medicine does not work, one does not conclude it is necessarily the wrong medicine for a specific disease or that it does not work because of drug resistance. Rather, it may simply not be cocok for them. One finds a similar concept termed *hiyang* in the Philippines (Hardon 1991). In the case of shampoo, a product that is cocok enhances the luster of one's hair; in the case of clothes it brings out one's best features. By way of a compliment, someone else may say, "yes, that is cocok for you."

So what does this have to do with cigarettes? A lot. It is thought that there is a brand of cigarette that is cocok for each type of person. One person's brand may be a heavy, strong, clove cigarette (*kretek*) that matches their persona; another person, who has a mild personality, may find a light, filtered cigarette cocok. Cigarettes are cleverly marketed to index subtle sets of associations and not just appeal to social significations such as social class. One's brand may be very personal, leading that person to refuse offers of other brands of cigarettes from friends. While researching smoking cessation in Indonesia, one of the only culturally appropriate ways of turning down the offer of a cigarette was to say, "Sorry, it is not cocok for me, I smoke my own brand or hand-rolled cigarettes."

The concept of cocok is exploited in what is a very sophisticated marketing strategy that juxtaposes the quest for a cigarette that is cocok with the importance of being brand loyal as a social value, once one finds the right cigarette. One respondent jokingly described this to us as the difference between searching for a girlfriend and finding a woman who was cocok with him, marrying her, and remaining loyal—even if one was tempted to try new brands.

Smokers search for a suitable brand of cigarette with the idea that one exists for everyone; you just have to find it. If you smoke and cough, or feel some irritation when you are smoking, it's a sign that it is the wrong brand—that brand is not cocok for you. If you are not a heavy smoker and become ill, and you are told that the reason for your illness is your smoking, you may be smoking the wrong brand. If, on the other hand, you smoke a cigarette that has long been cocok for you and experience symptoms like fast breathing after smoking, this may be a sign of ill health. Thus smokers interpret doctor's advice not to smoke as "You are too sick to smoke now. Don't smoke until you get healthy enough to start up again." Indeed, when a smoker gives up smoking, others may consider this a sign of ill health. Resuming smoking signals that things are now okay; the person has recovered from his illness and is strong enough to smoke again.

As people age, their cigarette brand may change. Young men may smoke light cigarettes (e.g. the popular youth brand, Mild A) and graduate to stronger ones later. But, once a person finds his cigarette brand, the one cocok for him, the tobacco industry encourages him to be loyal as it defines him as much as he defines the brand. Loyalty to the brand is linked to loyalty as a cultural value.

As anthropologists working in the field of tobacco control in Indonesia for 12 years, two of our biggest challenges were the idea that 'smoking was cultural' and that a brand of cigarette that is cocok will not harm the smoker if he smokes in moderation (10–12 cigarettes a day). A third was the dedication that smokers often showed for their brand. Their brand became a part of their self-identity.

An article and editorial in the journal *Tobacco Control* focused attention on one particular cigarette advertisement in which someone extends a hand to a person trying to board a moving bus with the tag line, "It is better to die than to leave an old friend behind." An analysis of the advertisement ties it to the timing of its appearance (during Ramadan), and suggests that the advertisement reminded people not to forget about smoking during the month of ritual fasting (Sebayang et al. 2012). Whether this was the intent—given that most Muslim smokers continue to smoke each evening when they break their fast—the core message spoke to loyalty.

Smoking in Indonesia is also tied to the core value of togetherness—*ramai*. Cigarettes are marketed as a primary way of sharing a collective experience—enjoying a family gathering, a party, hanging out with friends, or breaking the fast during Ramadan. Refusing a cigarette (or any consumable product) offered out of friendship is deemed impolite and is socially awkward. Smoking is a way of passing time with others and sharing silence, and when smokers try to quit, they often speak of feeling isolated or left out. Smoking is advertised as a means of enhancing people's inherent sociability and providing them with self-confidence to interact and speak. Those attempting to quit smoking often say that they feel insecure and socially awkward; they no longer fit into their familiar flow of social interaction. A non-smoker may be encouraged to smoke by other family members to fit in. One of our key informants, for example, was challenged by his father for being a non-smoker. How could he not smoke when all of the men in his family for the past three generations were smokers? How could he feel part of his family when everyone else smoked? He was advised to at least smoke a mild cigarette.

This may seem vaguely familiar to the Western reader—cigarettes are readily recognized as having social utility (Nichter 2015). Even those who do not consider themselves smokers in the US may smoke at parties to interact with others while drinking, to look like they are doing something. There is, however, a deeper cultural dimension of smoking that speaks to an entirely different type of social utility.

In Indonesia, smoking is promoted as an aid to assist a person to be emotionally balanced. In Central Javanese culture, in particular, considerable attention is placed on men staying in emotional control, ideally free of excessive worry and negative thinking, and calm at all times. To lose control is not only a loss of dignity, but is dangerous. When a man loses control, malevolent spirits may impose their will on him. Control is admired as a virtue, and young men test their ability to control bodily functions like sleep and appetite. Daydreaming while bored is also dangerous, as one's thoughts wander and one's mind is easily swayed by forces beyond one's control (Ferzacca 2002). Smoking can assist a person to be calm and not daydream or dwell on life's problems.

Cigarette advertisements tap into this network of associations. Advertisements use the yin-yang symbol and offer a tag line promising balance in one's life and smooth relationships. They promote smoking to deal with emotionally charged issues like a girlfriend's nagging or continuous disagreements. The tag line is usually on the same theme: "Don't give in, just enjoy a cigarette and it will all pass"; smoking will help these relational worries go in one ear and out the other.

The same is true for stress. Smoking is promoted as a way of coping with a wide range of everyday stressors. Unemployment among the young is high in Indonesia. "Don't stress," cigarette ads tell young men, "there is nothing you can do, so just enjoy" with a cigarette. If you feel you are being manipulated and not appreciated in your job, ads suggest that a man should laugh it off, have a cigarette, and just wait, because one day you will be the puppet master. If you encounter obstructions in life, rise above them by smoking—a cigarette break will help you find a way through or around your problem.

Cigarettes are marketed as a 'drug food' that will help one think more clearly and creatively and be an antidote for over-thinking and feelings of anxiety when the solution to a problem is not apparent.[1] We were repeatedly told by informants that when they could not concentrate or experienced inertia, they smoked so creative new ideas would come. "Having a cigarette makes me feel refreshed," stated one respondent, "much like taking a bath." In ads, successful professionals are shown, with copy that asserts that smoking inspires their thinking.

Coffee shops with Wi-Fi are commonplace in urban Indonesia and are frequented by creative people who are seen at the forefront of change. Smoking is ubiquitous in coffee shops and one of the

most likely places one encounters women smokers. As in the US decades ago, smoking is a symbol of women's empowerment in Indonesia. While cigarette ads do not yet feature women smoking, they do present fashionable, modern, upscale women in environments where men are smoking, where they are shown to be approving of the behavior.

Indonesians who are compelled to quit smoking, often because they are very ill, find it difficult. One reason people offer for not being able to quit is their reliance on smoking to cope with *stres*, a term which in Indonesia indexes an ambiguous state that includes worries, concerns, and anxieties about one's future. Smoking is commonly depicted as a means of controlling stress in movies and late-night TV advertisements for cigarettes. Smoking is associated with gaining control, not of becoming dependent, and the tobacco industry has gone to great lengths to distinguish cigarettes from drugs that represent uncontrolled dangerous states. Cigarettes are not spoken about as addictive, and terms referring to addiction, *ketagihan* and *kecanduan* in Bahasa Indonesia, were reserved for alcohol and illegal drug use. The association of smoking with control is so strong that mental institutions hand out cigarettes to patients to help keep them under control.

Cigarettes are not just thought of as a drug food good for the qualities of enhancing and controlling; they are also associated with the unique taste of Indonesia (cloves) and, by extension, cultural identity. Many brands of cigarettes are marketed as good enough for the global market yet having a distinctively local taste. They are as Indonesian as the blends of spices used in food. Smokers are encouraged to remain loyal to their brand, but are also enticed to "just try" what appears to be an endless flow of new brands. Travelers encounter new brands in the same way as they encounter new foods, as one informant remarked: "Well, you want to just try it and see what the taste is, like a dessert. You do not want to eat or smoke too much of it, just a taste for the experience. For the smoker, it is like a hobby."

But there is more to smoking than being a hobby. The same informant described his smoking as like eating rice, the staple food in Central Java. "I can eat many things and have a full belly," he said, "but I do not feel satisfied if I do not eat rice. Rice has to be there. It is the same with smoking. If I do not smoke, I feel there is something missing. I am not satisfied." His statement is revealing on many levels. Not only is smoking normative for him as a habit (and no doubt an addiction, given that he smokes 20 cigarettes a day), but he is deeply influenced by the physiology of smoking. It affects how and when he eats, how foods taste, his thirst and liquid consumption, and feelings of satisfaction. From other men, we heard more extreme comments: "I think I can live without food for some days, but never without cigarettes."

Later, the same informant called attention to a bodily state mentioned commonly by people trying to quit smoking. The informant spoke of *mulut kecut*, a sour taste in the mouth that occurs both when one feels hungry and after eating a rice meal. "I always smoke when I'm hungry and I get this taste in my mouth . . . and I smoke after every meal to avoid *mulut kecut* as well as to feel satisfied (*puas*)." Medical anthropologists pay close attention to cultural experiences of bodily sensation, as it reveals a lot about the embodied states that people seek and avoid. What is notable about *mulut kecut* is that rice, the very staple of life, is not enough to feel satisfied. Without a cigarette, even the experience of a good meal is soured. This feeling of lack that smokers experience is a bonanza for the tobacco industry.

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In the Maluku Islands, Indonesia's 'spice islands' with the highest cigarette consumption in the country (over 70 percent of men), while writing this discussion, we watched a fisherman light a cigarette after his lunch of rice, fish, and *sambal*. This is the same meal we have had twice a day now for weeks. At this moment, we can well appreciate the appeal of a "refreshing" taste after lunch. Yet it all seems rather paradoxical, the way things have turned out. From the fifteenth through the eighteenth centuries, all of maritime Europe was in competition to find faster routes for reaching these very islands. Whoever reached the Malukus first could make a fortune by bringing back spices to preserve and add flavor to Europe's bland diet, to disguise food of dubious quality, and to be used as medicines for ailments ranging from flatulence to the plague. Today, tobacco companies have reached these same remote islands and successfully sell a variety of brands of cigarettes as drug foods that add a little spice to life and the local diet. Kretek and menthol cigarettes are imported and nutmeg, cloves, and mace are exported—mace for use in the manufacture of Coca-Cola. And so, the flow of global trade continues as it has for centuries, and with it the exchange of one drug food for another.

Note

1. We use the term 'drug food' to denote any addictive substance consumed as part of one's daily regime and taken with the intent of enabling one to work, think, or interact with others in a desirable fashion (Quintero and Nichter 2011).

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The focus in Indonesian marketing suggests the relevance of a gendered approach to managing stress. While it remains the case that men are more likely than women to binge drink and smoke, particularly in low-income settings, and that these behaviors are common especially among unskilled, unemployed, and underemployed men and service workers. In Australia in the 1950s and 1960s, pharmaceutical companies marketed A.P.C. powders—a combination of aspirin, phenacetin and caffeine—to women with the slogan "Stressful Day? What you need is a cup of tea, a Bex, and a good lie down." Over-the-counter sales of A.P.C. combination drugs with phenacetin were banned in Australia in 1979 and in the US in 1983 because of the association of phenacetin with kidney disease and various cancers. In the 1970s, Virginia Slim cigarettes were marketed to women as a symbol of liberation, with the slogan "You've come a long way, baby." Today, women in low- and middle-income countries are subject to similar strategies, and tobacco smoking and alcohol are increasingly being marketed to women (Kaufman and Nichter 2010).

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What can anthropologists contribute? We have described how linguistics can help us unpack the semantic networks involved in cultural notions of stress, and by focusing on the social use of the term, we can gain a better understanding of the socioeconomic and political dimensions of what's at stake in everyday life. Beginning with the concept of idioms of distress, we start by listening to people describe their feelings of stress in their own terms, while making sense of their often fragmentary, tentative, and sometimes even contradictory meanings (Nichter 2010), rather than trying to translate their symptoms into *DSM* categories. Applied anthropologists who simply draw on such biomedical categories risk contributing to a medicalization of the problem at hand. Instead, anthropologists might work with alternative community-based approaches, and come to a different understanding of people's emotional responses to relational, financial, and other social problems. At the same time, we should not shy away from the biological stress reactions. Some anthropologists are engaging in interdisciplinary studies which incorporate biomarkers for stress (elevated cortisol levels measured in saliva) in their study designs, generating novel insights on the

complex biocultural mechanisms through which household tensions and societal conflicts affect body and mind (Kohrt et al. 2014).

Cultures have developed ways to deal with these stresses, and there may be positive benefits to the existing methods of handling stress: addressing bewitchment can bring about resolution to tensions in social relationships, and expressions of *nervios* or *susto* can draw attention to inequalities. Of course, societies find ways to distinguish between stress and madness, but if we better understand idioms of distress, we can see that even the most severe mental health problems might be approached differently. While not idealizing or glamorizing non-biomedical approaches, given that people are highly stigmatized and ostracized in some cases, anthropologists can bring a greater contextual understanding, one that takes seriously local ways of knowing and expressing stress and illness.

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