Chapter 1 | ALCOHOLISM AND CODEPENDENCY

New Vocabularies for Unspeakable Problems

COPING WITH ALCOHOL

Fukuda-san's husband began to drink heavily when he was working as a long-distance truck driver delivering coal. At the end of a long day of hard labor, the workers regularly went out drinking to relax and enjoy some camaraderie. In 1970, when Japan cut back on its use of coal, he switched jobs and went to work for a painting business. The paint thinner weakened the effect of the alcohol, and he steadily increased his consumption. As Fukuda-san tells the story, "By 1980, he was completely addicted to alcohol, but at that time I didn't know anything about the disease of alcoholism. I just thought that, more than anything else, he really liked his alcohol *[Nani yori mo osake]*." Although by 1980 his drinking was causing major problems in both his work and his family life, three more years passed before he was diagnosed with alcoholism; throughout this period he continued to work. After nine more years, Fukuda-san was encouraged to visit the Center and seek support for her own difficulties. She described the events to me once over tea:

> In 1980 he started getting bad hangovers, and he'd take days off work. On Sundays he'd start drinking in the morning, and on Mondays he wouldn't be able to get up. So other people would have to cover his work for him, and they stopped being able to depend on him. The problem got worse and

worse. And I was always the one who had to call up and say he wouldn't be coming in that day. I couldn't say he had a hangover, so I'd say, "He isn't feeling quite well today. . . ." At first they understood that *[sore de tsūjita],* but after a while they didn't. "He's hungover, no doubt!" they said to me once.

One time he had to drive down to Kyoto, leaving in the evening. When he arrived, he passed out in the car—unconscious. He was taken to a hospital in Kyoto and they diagnosed it as a "liver problem." It was the first time he had ever been to a doctor. They told him he was basically healthy, and he stayed there for ten days while they treated his liver. I stayed with him, sleeping next to his bed. Then we came back to Tokyo. Not one single person told him to stop drinking! The doctor said, "If it's just a little, it shouldn't be a problem." I myself thought the cause was that he worked too hard. Anyway, he was drinking beer on the way home.

He started drinking heavily again. In 1983, I went to the local public health center *[hokenjo]* and for the first time I was told that the problem was an alcohol problem *[arukōru no mondai].* They gave me an introduction to a hospital and I went for a consultation in secret. If I suggested to him directly that he had an alcohol problem, it would have been a terrible scene. But I knew something was wrong; he was a different person. If I said one thing he didn't like he'd turn over the plates, throw things, say crazy things—I thought he'd gone insane *[nō miso ga okashikunatta].*

I brought him home a pamphlet and tried to talk to him about it calmly. If I said, "Now Dad, your drinking habits are not normal anymore," he would start throwing things. Once he threw a fruit knife that stuck in the wall behind me. "What is this hospital?! Some kind of hospital for lunatics?! Are you trying to call me a lunatic?!" he'd yell. "I'm no drunkard!" *[Nani kono byōin?! Kichigai no byōin janai ka?! Ore o kichigai ni suru ka?! Ore aruchū janai!]*

He's a hectoring husband *[teishu kanpaku]*, which meant that if I said "Don't drink," he would. And if he said, "Go buy me some sake" *[Osake o katte koi],* I did. I thought to myself, "So this is what living hell is like" *[Ikijigoku wa kō iu koto da na to omoimashita].* I was the perfect "service wife" *[sewa nyōbō],* picking up after him, changing his clothes, pulling up his pants when he came out of the toilet half-dressed.

One month after my visit to the health-care center, he himself suggested going to the hospital. They diagnosed it as cirrhosis of the liver and told him he needed to check in. But my husband resisted being admitted because he had delivered coal to mental hospitals before, so he had seen people behind bars. And the doctor said he *would* be put behind bars while he went through

withdrawal. He argued with the doctor for an hour but refused to be admitted. I sat next to him saying over and over, "Doctor, please admit him, please make him check in," until finally the doctor got mad and threw me out of the room. My husband decided to commute as an outpatient. They prescribed antabuse and that was how he eventually stopped drinking.[1]

Fukuda-san's story reveals several common themes that appear in women's histories of coping with their husbands' alcoholism: the many years they endured before even seeking help or finding appropriate care; the way in which men's heavy drinking is tolerated and even normalized in the Japanese workplace; and the fact that a relatively small (though growing) number of doctors are educated about alcoholism and prepared to make a distinction between healthy drinking and alcoholism as a disease requiring special forms of treatment. Her story also reveals the widespread public ignorance about the nature of alcoholism and addiction itself, and the association (which her husband shared) of alcoholism with insanity—rooted in part in the fact that historically alcoholics were confined to lock-down wards in mental hospitals and treatment was largely limited to behavioral management. The case histories of the women who arrived at the Center showed how women were often pushed to extremes before they even considered asking for help. Patience *(gaman)* and endurance *(nintai)* were considered necessary virtues of married life. As Koike-san put it, "When my husband would return home after drinking, I'd feel disgusted, but in my case, he wasn't violent or verbally abusive when drunk, so I didn't have a strong sense of victimization. I felt that it was something that I simply had to endure *[gaman shinakya ikenai na to]*."

In my private conversations with women attending meetings at the Center, they shared stories of husbands' repeated hospitalizations and their years, even decades, of struggling single-handedly to hold the family together until their husbands' drinking was finally identified as the predominant problem. In Fukuda-san's case (and her case was unusual in that her husband eventually did stop drinking), her husband recovered without ever receiving outside professional care; Fukuda-san herself, with help from her son, facilitated the turbulent withdrawal process at home.

ALCOHOL AND ALCOHOLISM IN DAILY LIFE

Drinking and alcohol are woven into the fabric of everyday life in Japan. Businessmen convene at bars and nightclubs after a day's work to conduct business more casually or simply to socialize. Students gather for *nomikai* (literally, "drinking gatherings") after sports events and club activities; college students drink with their professor after evening or afternoon seminars as part of the seminar experience. There is little enforced government regulation of alcohol consumption, advertising for alcohol, or age limits in Japan, with the exception of strict punishment for drunk driving. According to some estimates, one in every eleven minutes of television advertising is devoted to promoting alcohol. While the legal drinking age is twenty, the law does not require liquor stores or drinking establishments to check identification before serving or selling alcohol. The state benefits from taxes on alcohol consumption. Until quite recently, vending machines selling beer and sake were ubiquitous in public spaces such as train stations and in local neighborhoods. Alcohol consumption, including heavy drinking, is commonplace.

Consumption levels of alcohol have been gradually increasing in Japan over the past decade, while in the United States and Europe levels have steadily decreased. A World Health Organization survey of alcoholics per capita in fifty nations conducted in 1995 placed Japan roughly in the middle; however, most health-care workers in the field agree that due to the limited awareness of alcoholism as a chronic, addictive disease, the number of alcoholics is always underestimated. A government survey reported that there are 2.2 million alcoholics (Japan's total population is 123 million), but volunteer groups have argued that there are in fact as many as ten million (one in six adults) who drink to excess (*Japan Times,* Feb. 12, 1993). Both the number of heavy drinkers (defined by the World Health Organization as people who drink 150 milliliters of alcohol or more a day) and the cumulative amount of alcohol consumed more than doubled in Japan between 1965 and 1985, rising from 364,640 kiloliters to roughly 870,000 (National Cancer Center, *Cancer Statistics on Japan 2001*). In the United States and most Western European countries, it decreased by 15–30 percent between the years 1970 to 1972 and 1994 to 1996 (Global Status Report on Alcohol 1999: 13–15).

Beyond amounts consumed, Japan stands out for its surprising toler-

ance of drinking and public drunkenness. It is not unusual to see men in suits passed out on train platforms or street corners in after-hours commercial districts of Tokyo, or to see pools of vomit on train platforms and street corners, sights that strike many visitors as incongruous with the general level of safety and decorum in public spaces in Japan. A general level of public safety enables a businessman to sleep on a train platform without fear of being beaten up or robbed. In addition, the helplessness, infantilism, and loss of control associated with drinking do not seem to carry the same negative implications as they do elsewhere (Steven Smith 1988). High school and college nurses report that students often innocently come to the infirmary seeking sympathy and remedies for hangovers after a night of drinking (Hashimoto 1995).

Alcohol is an integral part of working life in most Japanese companies, both large and small. Though white-collar organizations have historically been more extravagant in their drinking customs, truck drivers and construction workers also often drink together after a day's work, even if this means crouching on the sidewalk near the work site for an evening bottle of beer or *shōchū* (a harsher liquor than sake, made from potatoes). Large companies allocate funds for employees' drinking after work, and the kind of intimacy and relaxation that occur in these after-hours contexts is considered integral to work. In her analysis of a Japanese after-hours hostess club, Anne Allison has shown how businessmen are "taken care of" by young female hostesses, who tease, flatter, and flirt with them as they pour drinks and entertain them (Allison 1994). In this context, drinking facilitates the "humanization" of work through spiritual refurbishment, self-affirmation, nurturance, and social approval (101, 200). It is also an opportunity for men to "let their hair down" after a hard day's work, do business more informally, and engage in a more playful way with colleagues, often across hierarchical ranks. Through after-hours drinking, the meaning of work is broadened to include playfulness, relaxation, intimacy with colleagues and superiors, and even sensuality and sexuality. The after-hours space, Allison points out, works very much in the interests of the company. It draws workers away from life at home, fusing their identity as men not to their role as husbands and fathers but to their role as workers and masculinized consumers of leisure. Because the workplace comes to include not only work but also collegiality and play, it allows male workers to identify with their com-

panies in a more total way, imagining themselves as "workers twenty-four hours a day" (198–200).

In popular culture, drinking is constructed as a vehicle for the expression of individuality and, particularly, masculinity. In a Tokyo Broadcasting Service television series investigating hidden facets of Japanese society (*Soko mo Shiritai* [1993]), a cameraman followed various characters on their late-night drinking routes. The show emphasized the personalized nature of men's drinking rituals. Clients frequent the same establishments, where bar owners (often women, who are referred to as "Mama" or "Mama-san") indulge their clients in a personal, even intimate way (Allison 1994). In one case, the customer of a small bar routinely slept in the bar after a night of drinking, meticulously sweeping a small spot on the floor at closing time and, with the help of the proprietor, carefully spreading a tarp, sheet, and sleeping bag, and then climbing in. The owner and bartender, who consented to the practice, quietly locked the door behind him. At the close of this scene, the TBS cameraman pokes his camera down into the man's sleeping bag. "How often do you do this?" the narrator asks.

"About four times a week."

"What does your wife think?"

"Well, we've agreed upon this system."

"What?"

"It's just a burden to her if I go home anyway *[Kaeru to nyōbō ni meiwaku kakeru].* So she likes this better."

At the end of the episode, the male narrator concludes, "My impression is that a man is most manly *[otoko rashii]* when he's drinking. It's not that he doesn't love his wife, but he's truly *himself [jibun rashii]* when he is drinking among his friends" (TBS Broadcast, "Let's Find Out About" *[Soko mo Shiritai],* 1993).

Although many men become adept at modulating their drinking so that they can be social but remain in control of themselves, others cannot. In one of many personal experiences that involved men's drunkenness, my husband, my son, and I were invited over to a friend's house to celebrate the New Year. New Year's is one of the most widely celebrated holidays in Japan, and many take a holiday from work for several days, relaxing at home, watching television, and enjoying special New Year's foods. We arrived at noon and were immediately offered special New Year's sake and a beautifully baked fish. As we sat on the tatami under a *kotatsu,* a low

table with a heater under it, we made conversation with our friend's husband, a businessman in his late fifties, as she busied herself with meal preparations and work around the house.

He was a reserved man, but as he drank more and more cups of sake, he gradually began asking us about what we thought of Japan and expressing his opinion on matters of the world, the Japanese economy, foreign relations, and so forth. At each juncture, he poured himself another cup of sake, and after a while he stopped bothering to place the sake bottle back on the table in front of us, leaving it cozily within arm's reach on the tatami. Eventually his two daughters returned home from shopping, and we all moved to the bigger family table near the kitchen for the next course, a pot of sukiyaki. The father sat at the head of the table and dutifully manned the sukiyaki pot (traditionally a man's job), while we sat at the other end of the table chatting with the daughters. Shortly afterward, when I glanced at the other end of the table, I noticed that he had quietly gone to sleep, his head completely collapsed onto his chest with an arm still outstretched to the sukiyaki pot. I asked if he was all right, and the daughters giggled and gestured to ignore him. His wife delicately approached him and asked in a quiet voice if he would like to retire to his bedroom. Each time she asked, he abruptly revived himself, reaching out to add something else to the sukiyaki pot or take another bite, only to fall asleep again in mid-mouthful. Soon he was snoring and muttering to himself at the head of the table, and it grew increasingly difficult to ignore him and continue to make polite conversation, but this is precisely what the situation required us to do. Eventually, after much cajoling, he agreed to retire to his bedroom. At that point, he stood up, thanked us each formally for coming, and disappeared downstairs for the rest of the afternoon.

What struck me about this episode was the way a husband and father's drinking to the point of passing out could be normalized within the context of daily family life. The fact that the husband had consumed enough alcohol to pass out was not seen as worrisome or unusual. Nor did it seem to create a major disruption. Without growing violent or obnoxious, he quietly drank himself into a stupor, while all the while we were encouraged to ignore him and make light of the situation. Eventually the problem was managed by his wife, who deftly escorted him from the scene. The event also highlighted the husband's marginalization in the goings-

on of the household. He appeared as a somewhat buffoonish presence to be tolerated and indulged.

THE INVISIBLE LABOR OF MANAGING ALCOHOL

Alcoholism in the United States calls attention to itself and attracts resources for treatment because of the destruction and waste of resources it causes: traffic accidents, violence, homelessness, public disruption, crime, and family break-ups. Yet these effects have been largely contained or concealed in Japan. It is noteworthy that in the Japanese context, although heavy drinking is an almost obligatory aspect of working life for men (Steven Smith 1988) and alcohol consumption has increased over the past ten years, Japan continues to be a highly productive society with high levels of social stability and low divorce rates. Heavy drinkers are relatively protected in Japan. Although driving under the influence of alcohol is a problem in Japan, the fact that most workers commute by train, rather than car, protects the heavy drinker and allows him to drink on his way home from work. Because the streets are relatively safe, falling asleep or even passing out on the train or the train platform does not pose the same danger of theft or injury as in other urban environments.

But beyond the issue of safety, the story betrays an underground economy of labor by wives and mothers, police, train conductors, bar hostesses, and other blue-collar and "pink-collar" workers who work to mitigate, mediate, or conceal the otherwise destructive effects of alcoholism. Train conductors regularly wake sleeping men to alert them to their stop; they also pick up drunken businessmen from the train platform and wake them. Bar hostesses, too, graciously put drunken men into taxis. And wives undress their drunken husbands, put them to bed, and then wake them up the next morning, feeding them and sending them off to work again. The fact that alcohol consumption rose dramatically in Japan between 1965 and 1985, the period of Japan's dramatic economic growth and a period marked by widespread social stability, testifies to the way in which the social system mediates and contains the destruction typically associated with alcohol addiction. It also suggests that numerous problems associated with alcohol abuse are kept hidden in Japan, including child abuse and domestic violence. Although child abuse is widely recognized as a problem in Japan, 20 percent of child abuse cases were attributed to

alcohol-dependent parents in 1983. The figure may represent just the "tip of the iceberg."

In Steven Smith's 1988 study of drinking and alcoholism in Japan, he remarks that because the amount or frequency of alcohol consumed is not in itself considered a symptom of alcoholism, men's drinking is often diagnosed as a problem only when drunken behavior erupts into public conflict or disruption. According to Smith, "Most patients who are diagnosed as alcoholics have come to that situation because of disturbances in their social relations. They eventually exceed the ability or desire of families to make excuses for them" (185). Thus, as long as women (and others) continue to prevent this disruption, alcoholism goes unrecognized as a clinical and social problem. The educational program at the Center, too, while directed at families of alcoholics, emphasized posing a "burden" *(meiwaku)* to society as an important marker of alcoholism, and included films of police rescuing alcoholics and other dramatic situations. The films sent the message that posing a burden to society was one of the chief liabilities of being a heavy drinker.

Thus, men drinking heavily, even to the point of their being frequently incapacitated, was often not seen—in and of itself—as a major health problem requiring treatment. Women saw it as their job to keep their husbands' drinking from spilling over into public disruption, and physicians reinforced the message that women should simply "manage" their husbands better in response to their drinking. (In Fukuda-san's story above, one physician who had recognized the problem of alcoholism suggested that it was within a wife's power to persuade her husband to seek treatment.) Women were frequently told that their husbands would "get better" if they received good care from their wives. For example, Koike-san told me: "When he'd go to the hospital, come home, drink again, and return to the hospital, the doctor would just say, 'Take care of his general health and make good food so that he gets better.' I didn't realize that it was the drinking itself that was the first fundamental problem. Finally now I see that."

It is interesting to note that because women were committed to helping their husbands function despite their drinking and because heavy drinking alone was not recognized as a problem unless it created broader social disruption, it was often a husband's inability to continue working that finally marked a departure from normal social functioning and suggested a deeper problem. Koike-san, whose husband had not worked for several

years and who had been supporting her family single-handedly, told me that during that time it had never occurred to her that alcoholism might be the problem.[2] Her husband's inability to work stood out as the most problematic of his actions:

> "How did my husband come to such a state?"—I didn't ask myself. I suppose I just wasn't thoughtful enough about it. All I knew was that he couldn't work like usual people. I figured he must have some defect in that regard. . . . All I could think was that he didn't have the power to face adversity *[Tada konnan ni tachimukau kiryoku ga nai shika omowanakatta].* All I knew was that I couldn't expect him to work normally. If only he could find a job that suited him, I kept thinking. He couldn't last at any of his jobs. Two or three years and he'd want to quit. Three times the company he worked for went bankrupt. Then he tried to start his own business, but that didn't go well. Whatever he did didn't end up well. I thought maybe he was unlucky. And that he wasn't the kind of person who can surmount trying situations.

The gendered division of labor surrounding alcoholism explains why so little attention is paid to female alcoholics and male codependency. Codependency by definition seems a women's problem, and social workers reported that men rarely if ever entered into support groups for families of substance abusers. Although the problem of female alcoholism of course exists (there are a very small number of hospital wards that admit female alcoholics), as does male codependency, the problems are less likely to be "named" or diagnosed. Women's alcoholism is more easily hidden, since women can cover up for their drinking in the privacy of their own home and are not expected to earn a living wage.[3] Similarly, men are less likely to fall into the role of dependent caregiver. The caregiver role is unfamiliar to them, and in the case of extreme dysfunctionality, a husband can always consider separation or divorce without losing the capacity to support himself.

ALCOHOLISM AS A DISEASE AND CODEPENDENCY AS A PROBLEM

The disease model of alcoholism, which broke ground in the United States in the 1950s, claims that alcoholism should be considered a disease, a bio-

chemical transformation, of which the chief symptom is a loss of control with respect to drinking. Heavy drinking alters the brain's chemistry, so that it comes to depend on alcohol to maintain its new homeostasis. Hence drinkers can no longer control their desire for alcohol, and alcoholism should not be considered a weakness of will. In the United States, the disease model redefined alcoholism as a disease rather than a moral failure, as it had previously been characterized, and prescribed specific kinds of treatment, such as attendance at AA meetings, predicated on the desire to stop drinking entirely.

The notion of alcoholism as an addictive disease that requires specific forms of intervention is gradually gaining recognition among physicians in Japan; however, many physicians who treat alcoholics in nonspecialized hospitals still treat patients' liver problems and, after a brief detoxification period, dismiss them with the advice that "a little" alcohol should not be a problem. In common parlance, the term describing the state of being severely drunk (*arukōru chūdoku,* literally, "alcohol poisoning") is often conflated with the condition of alcoholism, or chronic drinking.

In recent years there has been a growing movement among physicians to educate the public and the medical world about the notion of alcoholism as an addictive disease. These physicians use the term *arukōru izonshō* (alcohol dependency syndrome) to describe alcoholism, rather than *arukōru chūdoku.*[4] The Center was centrally involved with attempting to institute this shift in consciousness. The notion of alcohol addiction constitutes a radically different construction of the problem of heavy drinking and its management. Under the old paradigm, women were encouraged to manage their husbands' drinking privately and often attempted to stop their husbands' drinking single-handedly by resorting to all kinds of covert means—pouring out their husbands' alcohol, consulting doctors secretly (as Fukuda-san did), or, an age-old tactic, pouring antabuse in their husbands' miso soup. Alcoholism was treated very much like a mental illness: families were encouraged to cope with the matter privately until this was no longer feasible, at which point the patient was likely to be forcibly committed to a mental hospital, where conditions were typically grim (Munakata 1986; Steven Smith 1988). Women who could no longer take care of their husbands privately were forced to relinquish them to the care of a hospital, where they were often involuntarily incarcerated.

The disease model changed these dynamics. This model of alcoholism,

which grew up in tandem with Alcoholics Anonymous spiritual support groups in the United States, emphasizes that no one can "make" the alcoholic stop drinking. Because alcoholism is characterized by a loss of control, stopping drinking requires a major commitment on the part of the drinker himself (or herself), and a profound psychological, even spiritual, transformation. Women who attempted to "put" their husbands into treatment found that they were turned away. A key concept in the AA construction of alcoholism is that an alcoholic must "want" to stop drinking, and must undergo an almost spiritual process of transformation in order to recover. In turn, a wife cannot "manage" her husband's recovery or "solve" the problem. A key element in the husband's recovery is that the wife withdraws from the role she has taken on, by necessity, of effectively managing the household and shutting her husband out.[5] She focuses on her own "recovery," which involves carving out her own world independent of her husband, even if he continues to drink, and finding ways to live her life, supporting a husband without attempting to "cure" him. A caretaker is also encouraged to examine her own tendency (or "need") to care for her husband and the validation she may derive from that caregiving.

Through the management of their husbands' drinking and the encounter with the discourse of alcoholism as an addiction, women embark on new regimes of self-exploration and self-expression as they encounter new vocabularies for describing social relationships. For most of the forty or so women whom I came to know over my year of participation, this process, as much as their husbands' struggle to obtain sobriety, became the focus of their recovery. In fact, few men were successful in becoming sober, and most never entered long-term treatment. The women were left to come to meetings and, along with other women, draw on new narratives, rooted in U.S. pop psychology, of marriage, self, and identity, to try to better their situation. For women who had become accustomed to entirely managing their husbands' problems, the diagnosis of alcoholism revealed new vistas, allowing them to stop feeling that they weren't being "good enough" wives and mothers and to start asking whether they had been "too good."

Before the meetings, few women would have considered their husbands' alcoholism an impetus to self-discovery. (In fact, most were referred to the Center not because they sought out help for themselves, but because they were referred by their husbands' physicians.)[6] Most women accepted their

referral to the Center reluctantly, assuming it was merely one more thing that they were being asked to do for their husbands—that coming to the Center would help cure their husbands. A central turning point for the women took place when they gave up the idea that they could "cure" their husbands and began coming to the Center "for themselves." The idea of women coming together to talk and share stories, speaking frankly about family problems, particularly with strangers, is somewhat unusual in Japan. The fact that the unfortunate situation of a husband's alcoholism was one of the few possible provocations for these women to convene and reflect on problems of Japanese marriage attests to the conservatism of Japanese society.

THE CENTER AS A SPACE FOR SOCIAL CRITICISM

The Tokyo Metropolitan Mental Health Care Center, where the meetings were held, was an institutional-looking building, a two-story, box-like white cement structure with large dark rectangles of glass. It was the largest of three city-funded outpatient mental health care services in Tokyo—part of a network of community health care facilities that provided telephone and outpatient counseling, as well as the weekly group meetings I attended. It seemed an unlikely place for women's consciousness-raising, but women often spoke about it as the only place where they could "really talk" about central issues in their lives. One of the older women, Fukuda-san, once told me that she considered it her "second home town" *(furusato):* a place of rebirth.

The fact of the matter is that there are few spaces to talk openly about family or personal problems in daily social life in Japan, particularly for women. In general, family issues are not divulged to neighbors or even to extended family. In village life, women often used to hold "meetings around the well" *(idobata kaigi)* where they exchanged gossip and information; in the urbanized living spaces of the postwar period, however, neighbors have grown increasingly anonymous, and women's worlds have increasingly become confined to the home and activities around the children. Whereas men gather over golf games and after-hours drinking to "vent" and talk over personal matters with friends and colleagues, there are few such opportunities for women. Middle- or upper-middle-class women may gather to do volunteer work, participate in child-rearing sem-

inars or the PTA, or take cooking classes, but these gatherings often emphasize social betterment and community service, and are not conducive to confession or venting.

Margaret Lock has shown that in modern times Japanese women often vent their frustrations to physicians. The expansion of the medical sphere through the system of national health insurance, combined with the fact that there are few acceptable spaces for addressing social tension and conflict, has made the sphere of medicine one of the few sanctioned spaces for expression of social grievances (Lock 1987; Ohnuki-Tierney 1984). In a series of provocative articles exploring the phenomenon known in the Japanese mass media as the "housewife syndrome," Lock showed how women's social complaints were medicalized, given names such as "child-rearing neurosis," "high-rise neurosis," "marital overdose," and "kitchen sickness" (Lock 1986, 1987, 1988, 1990; see also Madoka 1982; Katsura 1983). She pointed to the conservative approach taken by many physicians, who viewed women's complaints as weaknesses to be surmounted and encouraged women to reintegrate themselves into their housewife roles.

The network of public centers, which included the Center (founded in 1985), was part of a broader city-government effort, begun in the 1960s, to change public attitudes toward mental health and to provide a space for consultation. The agenda was to promote the "rehabilitation of the mentally ill" and to promote "acceptance of those who have psychological problems." A key strategy was better outpatient and consultation services. (Report on Local Community Mental Health Committee of Tokyo 1981). Although the Center was not initially involved in alcoholism treatment, in the mid-1980s, as it became clear that alcohol was increasingly becoming a social problem, the Center implemented an alcohol treatment program. The categories in operation at such publicly funded institutions as the Center play a key role in Japanese social life, because such centers serve as a triage site: a place where people come when they don't know where else to go or even how to define the problem. For this reason, they shape the way people define and manage problems that arise in daily life.

The chief psychiatrist at the Center, Dr. Saitō Satoru, saw his promotion of the ideas of alcoholism and codependency as part of a broader mission of social criticism. He was particularly concerned with Japan's program of rapid economic growth and the toll it had taken on the people. In

his widely read books on addiction and codependency, *Kazoku Izon Shō* (Family Addiction, 1989) and *Kazoku no Yami* (The Dark Side of Families, 1998), Saitō describes alcoholism and substance abuse as centrally intertwined with the broader social system in Japan, especially the needs of the enterprise society, the demands placed on women as caregivers, and the importance placed on academic success in children's lives. He often uses the language of addiction as a metaphor for the Japanese system of middle-class advancement through education and productivity, describing Japanese parents as "addicted" to the school system or "workaholism" as Japan's biggest addiction. According to Saitō, society "makes" people into addicts in its relentless pressure for "social alignment" *(shakai teki dōchō).*

In an early conversation, he told me, "It's women who are enabling workaholism. Women prepare food for men, wait up for them, ask them if they want a bath before they go to bed. This enables men to become pathologically dependent. We have to look at them as a pair—not just the husband. Overdevotion goes along with overwork. Most Japanese men don't even know where their own socks are kept!" (personal communication, October 30, 1992).

In an essay entitled "Two Types of Troubled Fathers," Saitō points out that alcoholism exists not only among day laborers in the slums, but also among the Japanese elite. These elite alcoholics epitomize for Saitō the hard worker and good husband:

> A typical man graduated from a top-tier university and works at a top-level bank. He has attained a high social status. When he gets drunk he gets violent. His wife contemplates divorce. At work people think of him as someone who does his job. But this kind of alcoholic hurts his family and hurts the next generation. The office only values efficiency and productivity. This kind of alcoholic actually thinks he has fulfilled his role. . . . He goes out drinking after work with his coworkers, his "pseudo-family," and relives his childhood, referring to the proprietor of the bar as "Mama. . . ." Gradually he gets pushed to the margins of family emotions. (Saitō 1989: 46)

Saitō's metaphorical use of *addiction* and his claims that "any family" could be an alcoholic family and that being a "good wife" itself is a form of addiction are overblown and serve the rhetorical purpose of making his work appeal to a broader audience. He pathologizes the work of the wife

and mother in a way that makes many social workers and clients uncomfortable. And yet, through the language of pathology, Saitō has called attention to latent patterns in Japanese society that had not previously been described as problems.

Whereas most Japanese health-care practitioners were not interested in the problem of addiction in the 1970s, Saitō, influenced by the American recovery movement, took his ideas to nurses and social workers who worked in the trenches of public health care, many at local ward-funded health-care centers *(hokenjo).* Focusing on one of the largest and most central wards in Tokyo, with a population of some 800,000 people and four public health centers, Saitō trained the local public health nurses to deal with addiction themselves rather than referring patients to nonspecialized hospitals. He initiated the first family meetings at these local centers. The ward in central Tokyo where the Center is located became a model for other districts. In 1983, he started one of the first alcohol treatment programs at a large public hospital in Tokyo, Matsuzawa Hospital, training the psychiatrist who managed it. By the early 1990s, he had trained the psychiatrists who managed several major alcohol treatment centers in Tokyo.

The success of Saitō's worldview shows the resistance of Japanese society and the women themselves to politicizing women's issues, and the tendency to talk about these issues as medical or psychological problems. Saitō viewed the reinterpretation of addiction as a means to social change and the medicalization of women's family problems as a step toward feminism. In explaining his rationale for starting the support groups, he once told me, "Why did the idea of codependency take off in Japan? I think it had to do with the fact that these problems had been around for a long time. People had some consciousness of it *[jikkan]* but there was just no word. Just as women were starting to feel discontented with the ethic of self-sacrifice for the sake of the family, the theory of codependency came along to medically validate their feelings" (personal communication, April 30, 1993). "I want to interpret so-called medical problems more broadly," he continued. "Serving one's husband to the point of losing one's own sense of self is not a medical problem—it's a way of life! That's why it should not be handled by doctors!" He viewed the meetings at the Center as a kind of grassroots feminism. Although Center and Al-Anon meetings are currently reserved for wives of alcoholics, he hoped eventually to establish a group that would be open to all women—a group he imagined would be called "Ladies

Anonymous." The idea struck me as noble but mildly absurd. The very notion of "Ladies Anonymous" illustrates the dearth of vocabulary available to women to describe their discontent; alcoholism and codependency provided a language for them to talk about life problems.[7]

The way the clinic functioned as a triage facility, and at times as a catchall for a variety of social problems, illustrated the shortage of spaces where women's problems could be addressed. In the absence of facilities to deal with this social problem, medical facilities stepped in. I observed this process in the context of the weekly case conferences, in which the clinic staff met with a psychologist and psychiatrist in order to triage new cases or assess the progress of ongoing cases. A central issue in new cases was domestic violence—a key problem in the context of alcoholism. Public discourse on domestic violence (increasingly known as "dv" in clinical circles) is limited in Japan, though growing, and there are as yet few publicly funded shelters for abused women, and little educational material available.[8]

Interestingly, alcohol treatment facilities in hospitals often seemed to function as a quasi-shelter for women battered by their husbands. Alcohol treatment units often have "family inpatient units" *(kazoku nyūin)*—something rarely found in the United States—where family members of alcoholics can check themselves in to rest and recover. In one case presented at the case conference, a mother came in for counseling; her son was a habitual gambler who was violent at home and possibly schizophrenic. The father was an abusive alcoholic. The mother (the client) described herself as "mentally exhausted" *(seishin teki ni maite iru).* The psychologist decided that the first step should be to admit the mother (seemingly the only sane member of the family) to the hospital. In this way, the hospital stepped in to provide shelter for the woman, while the more difficult task of luring the husband and son into treatment remained to be negotiated.

THE FAMILY MEETING

Though the tenor of the meetings was at times somber, as I described earlier, the meetings were a radical departure from many other alcoholism groups available to women: specifically, they aspired to be nonhierarchical (like the American AA model) and they encouraged women to speak freely about their feelings and thoughts. In contrast, the Japanese adaptation of Alcoholics Anonymous, Danshukai, one of the largest organiza-

tions for families recovering from alcoholism (it has forty-seven thousand members, in contrast with AA's five thousand in Japan), is a self-help group where families of alcoholics attend the same meetings as the alcoholics themselves. Danshukai has been self-consciously adapted to suit the needs of "Japanese culture."[9] In contrast with the meetings at the Center, which were seen as a chance for women to help themselves, men played the leading role at the Danshukai meetings and women were considered "auxiliary members," there to support their husbands (Steven Smith 1988). While Danshukai shares the AA notion of social support and sobriety as means of recovery, it departs from the Al-Anon notion (which was taken very seriously at the Center) that family members cannot heal their families' illness, that alcoholism is the abuser's problem and not the family members', and that family members should attend meetings to learn to manage and to look after themselves rather than to "fix" the abuser. Instead Danshukai adheres more closely to conventional Japanese gender role constructions. At the end of the meeting, after men recite a "Sincerity Pledge" of sobriety, women recite a "Family Pledge" that includes these affirmations:

> My husband/son joined Danshukai. Stopping drinking is truly hard.
>
> My husband/son, who made the decision to abstain, is wonderful.
>
> My husband's/son's drinking is an illness. Because it is an illness it must be cured. Furthermore, it can be cured.
>
> My husband's/son's affliction is my affliction.
>
> In order that my husband/son stops drinking I will suffer, too; I will be cured, too. (Steven Smith 1988)

Many women who eventually came to the Center had been to Danshukai meetings. Several stopped going because their husbands refused to participate and they found little reason to continue attending on their own. Others reported that it was difficult to speak freely there. Koike-san, a regular member of the weekly meeting at the Center, complained that Danshukai replicated the subordinate role of women. She told me that at the end of Danshukai meetings, it was the women's responsibility to serve tea to everyone. Since they served two or three cups per person, this involved a considerable amount of work. "Doesn't this go against the philosophy of codependency?" she asked. When she suggested a system of "self-service," one of the members rejected the idea because other branches of Danshukai served tea the conventional way. Eventually she stopped attending these meetings.

The emphasis at the weekly meetings was on women learning to "talk about themselves" rather than focusing on their husbands' or their children's recovery. The very definition of recovery for caretakers entailed learning to disentangle their own lives from the lives of the substance abusers—letting the substance abusers make their own mistakes and allowing themselves to relinquish the caretaking role.

And yet the reality is that there are few precedents for women to publicly discuss their own feelings and private experiences, or for the idea that public sharing could have a therapeutic effect. Because of the stigma of mental illness and the view that families should take responsibility for managing it, outpatient treatment has been markedly limited in Japan and largely conducted in hospitals, where administering medication is the central aspect of treatment. Counseling clinics and private therapists' offices are notably few. In general, "talking therapies"—the notion of healing someone through conversation with a therapist—have not taken root in Japanese medical practice, and neither psychoanalysis nor any other psychodynamic psychotherapy has gained a broad following in Japan. The "indigenous" therapeutic practices in Japan, notably Morita and Naikan therapy, draw on Zen practices and other pursuits of self-cultivation to emphasize quiet self-reflection *(hansei)* and physical labor as means to spiritual healing. In particular, they emphasize reintegration into the social whole through appreciation of one's privileges and expressions of gratitude toward others. Even at the Center, the word *counseling* was used infrequently. Individual consultations were referred to as "interviews" *(mensetsu)* and support groups were called "meetings."

In the late 1980s, when Saitō began experimenting with group meetings for women married to alcoholics, there were few support groups in the context of Japanese psychiatry. "Group meetings" usually meant a collective case interview led by a physician, in which the doctor consults with each family sequentially, asking for information and then offering advice (see Steven Smith 1988; Takemura Misao, personal communication, October 23, 1993). The patients hardly engage with one another. Saitō was fond of telling the story of how, in the early years of experimenting with the group therapy format at the local public health center, one of the social workers persisted in talking about her cat for over a year. Yet eventu-

ally the meetings at the Center achieved a reputation as a successful experiment; nurses and social workers from hospitals all over Japan came to train and observe. In particular, there was much excitement about the family meeting.

The women who had been coming to the meetings the longest often constructed their stories as a narrative: a dilemma posed by their family and then an insight they received from that dilemma—a strategy or a way of coping that they learned. The new arrivals at the group often talked in a rather desultory way about the scenes and antics of their husbands or teenage children, their own health problems, and their struggles to manage these problems. They focused on the details of their families' illnesses or incidents related to the problem rather than how they felt about it. Their distress often seemed to manifest itself in stress-related psychosomatic symptoms, such as fatigue or dizziness; they rarely talked about anger or sadness. At the first meeting Aoki-san attended, she described how her anger first emerged as physical disorientation, though finally she sought help:

> I'm Aoki. In my life I'd never experienced anger until the time my husband and I went in for a consultation at the hospital. On the way home I was so distracted that I was running red lights and so forth. When I got home my daughter noticed something was wrong and pulled out my futon. I got in but couldn't sleep. Suddenly I remembered there was the community healthcare center *[hokenjo].* So I got up and went. I talked to someone there for two hours, pouring out my soul, until the place closed. I finally felt I had cleared my head *[Kimochi ga sukkiri shita].*

The staff considered an expressive narrative voice and "power of articulation" *(hatsugen ryoku)* important elements of women's "recovery." The most salient feature of narratives of recovery was the women's ability to speak about *themselves (jibun o hanasu).* Women who began their sentences with "my husband" or "my son" were regarded as not yet recovered. Japanese housewives frequently are known in their communities as "X's wife" or "Y's mother," identifying and introducing themselves that way. These women said that it took them a while to understand the concept of "talking about themselves" *(jibun o hanasu).*

Clinicians put particular emphasis on women's clarity in marking the subject of the sentence. Wives of alcoholics were known among clinicians

to "leave out" the subjects of their sentences and to talk about their husbands as if they were talking about themselves *(otto no koto o jibun no koto no yō ni kataru).* While omitting the subject of a sentence is not uncommon in Japanese grammar, clinicians interpreted the phenomenon as women forfeiting their identities to care for their husbands. The head of the alcohol treatment program at a large public hospital in Tokyo was quoted as saying, "As they take care of their husbands, they are overtaken by a sense of duty, believing that their husbands simply could not get by without them. They lose a sense of the boundary between themselves and their husbands and start to leave out the subjects of their sentences" *(Otto no mendō o mite iru uchi, watashi ga inakereba to iu gimu kan ni shihai sare, otto to jibun to no ryōkai ga nakunari, shugo ga nukeru)* (*Yomiuri Shinbun,* June 12, 1993).

In one meeting, for example, Ōta-san, an elderly participant whose adult son lived at home with her, said: "Ōta *desu* [I'm Ōta]. I'm here for my son's drug addiction. [He was] admitted to the hospital two times this year. [If he] didn't like it then he would just leave; [he has] no appreciation for money. [He] comes home and doesn't do a thing. Doesn't talk with my husband. I have to really hold myself together or else."

At another meeting, this same woman (Ōta-san) introduced herself in a way that caught the social workers' attention. Instead of repeating the conventional introduction, "I'm Ōta. I'm here because of my son's drug addiction," she elided the two sentences saying, "I'm drug addiction Ōta" *(Yakubutsu no Ōta desu),* transforming her son's sickness into an adjectival phrase modifying herself, a grammatically correct construction in Japanese. The staff commented on the elision after the meeting, citing it as symbolic of how "attached and identified" she was with her son.

Wetzel (1994) remarks that Japanese sentence structure deemphasizes the speaking subject as the fixed reference point of the sentence and that verbs are conjugated contextually, according to the relationship of the speaker to the interlocutor, rather than according to the personal pronoun itself, independent of its context. Bachnik and Quinn (1994) and Wetzel (1994) go further to argue that the construction of language is intertwined with cultural constructions of self. This sentiment is reflected in the importance placed on grammatical constructions by the Center's clinicians. The idea is a rather heavy-handed application of English grammatical structures as "normal" and "healthy"; one does not need to fully accept that language conditions notions of self in such a literal way to see that

language may naturalize a slippage in boundaries, making this slippage difficult to problematize explicitly. In explicitly placing themselves at the center of their narratives, and in clearly distinguishing the "I" of the sentence, women attempted to overwrite implicit cultural assumptions coded into daily life through language. Nonetheless, the social workers' equation of Japanese grammatical forms with the deletion of self and their positioning of self-expression and self-assertion as antidotes left women to negotiate between two rather reductionistic discourses, neither offering a nuanced model of how to articulate one's own desires within the context of social expectations.

JAPAN'S RECEPTION OF THE CODEPENDENCY PERSPECTIVE

In my early meetings at the Center, it became clear that while the codependency concept held considerable allure for women (particularly, the idea that it is possible to go too far with being "helpful" and that one can love while also drawing boundaries between self and other), the women had not embraced the wholesale pathologization of the concept of caregiving that was prevalent in the 1980s United States. Women often talked about their codependency in affectionate, almost proud, terms (particularly with respect to their children), telling stories of how they couldn't resist spoiling their children or lending them money, even when this occurred in the context of destructive behavior.

Nor did social workers view Japanese codependent women as deviating from rational behavior, succumbing to psychodynamic compulsions, or lacking self-control. In contrast with the American pop psychology language of self-loathing, there was little sense that the situation in which the women found themselves betrayed a self-destructiveness on their part. From the standpoint of social dictates, most Japanese codependent women have made all the "right" decisions and are, in fact, supremely in control of themselves and their surroundings. As one social worker explained it to me, In Japan, "the wives with the problems are seen as being the 'good wives' *[Mondai no tsuma wa 'ii tsuma' to sarete imasu].*" While the notion that some people are more codependent than others exists on the periphery, neither group discussions nor educational materials focused on members' upbringing or family environment as causal explanations for code-

pendence. Nor was there a sense that the women had actively chosen alcoholic or otherwise troubled husbands out of self-loathing or individual maladjustment. Although women were encouraged to talk about their feelings at each weekly meeting, they rarely discussed their upbringing or childhood environment as a causal explanation for their situation. Instead their conversations focused on the way in which society expects women to behave in codependent ways, the social expectations and belief systems that produce and even require codependent behavior. Codependency was read as being produced socially rather than psychodynamically.

In fact, most women arrived at the Center with a strong sense that they had been doing the best they could, and yet, despite this, they remained unable to remedy the situation. Many women told me that it took them a very long time to accept the concept of enabling and the idea that their own behavior could be counterproductive. For example, Fukuda-san, a client at the Center, told me over tea:

> His relatives used to blame his drinking on me. "Just don't buy him sake! Don't give it to him! Just take it away!" they'd tell me. But frankly I could never imagine that *I* had done anything wrong. I had put myself out for my husband's every wish. I kept telling myself that at the time. I thought I was doing exactly what I was supposed to do: "serve" my husband *[otto ni tsukusu],* buy the sake, protect the family. But over the years of coming to the Center I've begun to see that I too had some responsibility. I helped create the kind of relationship environment where he could drink *[nomu kankei o tsukutta].*

Social workers at the Center often remarked that Japanese women had learned to see self-sacrifice as a virtue (jibun o gisei ni suru no ga bitoku to sarete iru). Yet in truth, the social and economic practices that crystallized in the postwar period supported and sustained this belief system. In many ways, women were expected to quietly support their husbands. But in truth, particularly beginning in the postwar decades of the 1950s and 1960s, as men began to work away from the home, women have largely been in charge of managing the home—and managing the husband. Women's efforts to cover up for their husbands' drinking and to continue to maintain appearances to the neighbors, the husband's boss, or the extended family was, to them, merely an extension of what they had been

doing previously. The notion of women as the manager of the home has coexisted with the symbolic notion of men as "the boss." This situation became extreme in the families of alcoholic men. A wonderful example of the explicit sanctioning of women's cover-ups—and the fine line between women's "quiet" support and actual management of the family, is revealed in the following advice from a Japanese psychiatrist that appeared in the "Life Guidance" advice column of the Yomiuri Daily News in 1985–86:

HUSBAND SOAKS IN DRINK EVERY NIGHT

I am a housewife in my thirties. I want to discuss a problem concerning my husband.

My husband is in his late forties. He has his own business, and I take care of the bookwork for him and help him run the company. The problem is with his drinking. He drinks about seven *go* [about three quarts] of sake each night. . . . After having observed him carefully over the sixteen years of our marriage, I can summarize my husband's strange behavior through the following description: (1) He soaks in alcohol every night, literally drinking until he passes out. (2) While drinking he forces me to sit down in front of him while he complains to me for two or three hours about all kinds of things around the house. (3) He makes decisions for the company and for the family without discussing them with anyone. (4) He is so jealous that I can't go anywhere without being questioned in a humiliating manner. (5) I can't remember him being at home without a drink in his hand.

I have never disobeyed him. When he criticizes me, he gradually starts screaming so the neighbors can hear every word he says. Sometimes he even throws things around. My daughter says that he doesn't possess a single fatherly trait. Do you think he can ever change?

The psychiatrist replied:

It would be somewhat hasty for me to make a judgment about your husband based merely on your letter. . . . One thing seems certain: . . . drinking has gotten the better of [your husband] and this should be tended to, through professional treatment if necessary.

. . . I don't know what kind of business you have, but why don't you quietly take steps to run more of the business yourself, while establishing

him more as a figurehead. Judging from what you write, I have the feeling that you could do this.

A person like your husband may seem arrogant and demanding on the outside, but his basic nature is probably very dependent. Your daughter says that he doesn't act like a father. This is another reason for assuming more of the responsibilities of the business and enduring more of the hardships for him.

Compared to the adversity you suffer now, this source of action may actually lead to fulfillment. If you follow this advice, even though you say your husband doesn't listen to others, he can be influenced by virtue of his dependency to seek treatment for his drinking.

I offer this advice for the benefit of your family. (McKinstry and McKinstry 1991: 61–62)

This advice makes clear why women would have felt that sustaining their husbands in any way possible and hiding their transgressions, no matter how extreme, was the right thing to do. The management of the family business is seen as a natural step from the usual "quiet support" (naijo no ko) a wife gives a husband. The advice strikes me as quite reasoned and helpful, reflecting contemporary constructions of marriage and family. Yet it is this advice that the clinicians at the Center and those involved more broadly with alcohol care seek to overturn.

In what follows, I suggest that, ironically, to the extent that codependency is seen as being surprisingly close to "the normal" in Japanese social life (and therefore less easy to pathologize), it may carry the potential to produce a somewhat more useful conversation in Japan than it has in the United States (in its popular rendition), allowing women to explore the often subtle distinctions between "healthy" and "destructive" interdependence.