

## Narratives of *Dansei Konenki*: The Indigenization of Male Menopause in Contemporary Japan

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### Introduction

*Dansei konenki*, a literal translation of the English term “male menopause,” may be a term that is unheard of for many readers. The phrase might invoke an obscure, eccentric illness that only exists in exotic, nonwestern countries. On the contrary, male menopause—a paradoxical term in itself—is a strictly biomedical illness category, originating in the West (first in Europe, and later in the U.S.). Although it has never become well known in America, the country where it was codified, it has become a very well-known disease in Japan. Intriguingly, the term has not successfully laid its roots in its place of origin, but has somehow found its appeal in contemporary Japan.

How does a particular biomedical condition that has not been broadly accepted as a legitimate illness elsewhere find a niche in a locale that is conventionally considered outside the core region of biomedical development? What are some defining features of contemporary Japan that might help us understand this paradoxical phenomenon? In this shortened summary of my thesis, I suggest that the adoption of *dansei konenki* embodies a particular sociohistorical moment in Japan—namely, that of the long-running economic decline over recent years.

The economic decline has proven to be a powerful force in reshaping important social values in the everyday lives of the Japanese—middle age men in particular—such as family values, work ethics, traditional corporate structures, and gender categories. As the illness narrative of one male informant (a patient diagnosed with *dansei konenki*) will show, the drastic effects of the dragging recession on middle to old-age men—such as large-scale layoffs and major transformations in the traditional structure of companies—all signify an increasingly hostile and insecure environment for this particular population.

More interestingly, this illness category has become largely divorced from its roots and taken on a distinctly different set of meanings and definitions—both in the medical community and the larger society—that reverberate within the specific context of contemporary Japan. A process frequently referred to as the “localization,” or “indigenization” of an illness category in recent anthropological literature is manifested in multiple layers in the Japanese society; the Western biomedical concept of *dansei konenki* is grafted onto local knowledge about health and the male body and is subsequently transformed. For example, leading Japanese physicians involved in the treatment of this condition contend (a) that a decrease in testosterone levels leads to an “autonomic imbalance,” triggering chronic fatigue, shortness of breath, and bad peripheral circulation and (b) that obesity, smoking, and a proclivity for trunks rather than briefs as underwear (because the latter type reduces the temperature of the testes) can negatively affect the circulating levels of the hormone. In contrast to the overwhelming emphasis placed on male sexuality (and its decline) in the Western discourse of male menopause, its “indigenized” counterpart in contemporary Japan embodies distinctly different theories of causation and physical manifestations.

On the more local level of indigenization, to borrow from Arthur Kleinman's popular quote, the illness "acts like a sponge, soaking up meaning from the life world of the sufferer and recasting it in terms of itself" (1989, p. 31). As I will illustrate through the narrative of one male informant, Yoshiharu Sakaguchi, the diagnosis of *dansei konenki* often soaks up meaning from both the patient and his wife and casts all suffering, effort, and experience in terms of a renegotiated spousal relationship—based on a new found acceptance and appreciation of each other.

### ***Data Collection***

In the summer of 2002, I conducted archival and ethnographic research on the scientific construction and lived experience of *dansei konenki* in Japan. During this period, I conducted archival research in the media and in the annals of Japanese medical literature. I interviewed several clinicians who specialize in treating *dansei konenki*, as well as patients afflicted with the disease. In addition, I conducted participant observation at one clinic in particular and in the homes and work environments of several patients—one of whom I document in this paper. The principal method of my investigation was notetaking during interviews—both formal and informal—and participant observations. All names, excluding those of prominent scholars whom I quote and professionals (such as Dr. Yokoyama) from whom I have permission to cite by their real names, are pseudonyms to protect their privacy. Through the analyses of these data, I argue that the indigenization of *dansei konenki* has been fueled by, and is contingent upon, two key factors: first, the unique sociopolitical background of contemporary Japan, primarily characterized by the long-running economic decline over the last decade and second, the major shifts they have instigated in the society, namely, those centered around traditional corporate structures, work ethics, family values, and gender roles.

### **Theoretical Relevance**

The medical anthropological literature has focused on instances where biomedical illness categories come in contact with nonwestern locales. Although some works have focused on biomedical illness categories that face substantial resistance for public acceptance in nonwestern contexts (such as one written by Lawrence Cohen, 1998), others document the acceptance and subsequent indigenization of biomedical illnesses (such as those done by Paul Farmer, 1993).

In *No Aging in India: Alzheimer's, the Bad Family, and Other Modern Things*, for example, Lawrence Cohen (1998) tackles the puzzling observation of how Alzheimer's in India is largely denied to exist. Although the author himself acknowledges the ambiguity in the Indian medical literature on senility and dementia, his overall impression of the Indian sentiment is captured in the opening global conference in Zagreb, where an American anthropologist asks an Indian speaker about the prevalence of senile dementia and Alzheimer's disease in India. The speaker does not recognize the meaning of those terms until someone shouts "crazy old people," whereby the speaker responds that there is no senility in India. For the speaker, it was only meaningful to speak of senile old bodies in the context of fragmented or nonexistent—and thus "Western"—families (Cohen).

Cohen comes to realize then, as he reiterates throughout the rest of the extensive ethnography, that although “for many Americans and Europeans, senile pathology was located in specific and isolatable disease processes, for many Indians, senile pathology was located in family dynamics and cultural crisis” (1998, pp. 15-17). Thus, in contrast to the U.S., where the pathologies of old age can be predominantly discussed as an unemotional and isolated medical issue, the discourse of senility and aging in India was intensely moral, emotional, and cultural. These discrepancies, Cohen argues, may explain the apparent difficulty that the Indians have in acknowledging Alzheimer’s and senile dementia as a disorder that afflicts their own people, where the elderly are well-cared for and very much part of the traditional Indian joint family.

Paul Farmer’s 1993 text, *AIDS and Accusation: Haiti and the Geography of Blame* is a historical ethnography of AIDS and its effects in a country ravaged by years of colonialism, poverty, and economic inequality. The ethnography written by Paul Farmer looks at instances where biomedical illness categories with a Western origin are taken up by nonwestern locales and are subsequently indigenized, similar to the case of male menopause in contemporary Japan. As the AIDS pandemic spread—most probably by the increased contacts between Haitian sex-workers and gay tourists under the American-supported dictator’s encouragement of tourism—local meanings as well as theories of causation and agency were grafted onto the biomedical definition of AIDS (Farmer). In spite of efforts by doctors and public health officials to educate the public about the scientific explanation and prevention methods of AIDS, Farmer’s extensive document shows how the destitute majority of the population attributed theories of voodoo curses, Haitian black magic, and white American racism in desperate attempts to find the blame and cure for this illness.

Like Farmer’s (1993) work, the study of *dansei konenki* (male menopause) in contemporary Japan addresses the same issues of the adoption, transformation, and subsequent indigenization of an illness category with its roots in the West. However, the uniqueness of this case study lies in the fact that male menopause has become much more rapidly and readily acknowledged as a sound, biomedical illness in Japan compared to the Western countries where it was initially codified. In other words, my work expands the analytic framework of Farmer by looking at the indigenization of a biomedical illness that has yet to be commonly recognized by the larger societies in the West. As stated earlier, I argue that the indigenization of *dansei konenki* has been fueled by and is contingent upon a particular sociohistoric moment in Japan, embodied by an extended economic recession, and the multitudinous shifts in family values, work ethics, and gender roles that the economic decline has induced in the Japanese society over the past decade.

### **Ethnography of Ishinkai Urology Clinic**

Starting with a description of how *dansei konenki* is defined and treated in a particular clinic in Tokyo, I attempt to highlight some themes often encountered in the illness narratives of *konenki* patients. Themes include the integral role that family support plays, the acknowledgement of vulnerability and loss of masculinity, and relief from personal burden and blame upon diagnosis (thus restoring the public functionality of the patient). Then I compare how *konenki* is perceived and treated quite discretely by two prominent practitioners in this field.

“Let’s begin. Can you start calling them in?” With the order of Dr. Yokoyama, a leading urologist and expert on prostate cancer treatment, male patients enter the *shinsatsushitsu* (diagnosis room). At around 11:30, a patient (42 years old) who had been suffering through a major depressive state triggered by the early onset of menopause, as well as stress factors in his work, is called in. A young woman, who is a psychotherapist in his company, accompanies him.

“Good morning. How are you feeling?” On first impression the patient looks enervated and morose. His voice is almost a whisper as he looks down to speak with an apologetic smile.

The young woman speaks first. “Good morning. I’m here today to assess his *utsu* (clinical depression), and get an official diagnosis from a doctor to better explain his situation to the company. Can we start by a brief history of medical diagnoses since he first came to see you?”

“Certainly. I believe the first visit was back in June, and it was obvious he was suffering from some form of *utsu*. But he’d shopped around among doctors—including psychiatry, who all told him he couldn’t be diagnosed with *utsu* (clinical depression)—only *yoku-utsu* (repressive, or nonclinical depression), for which you can’t receive proper medication. But obviously there was something wrong with him. So we measured his hormone levels, did some other rounds of tests, and I diagnosed him with male menopause, which is slightly early for his age.” Dr. Yokoyama follows with a detailed account of the patient’s improvement, treatment plans, and prognosis.

The female counselor reiterates the situation he faces at work. “He still can’t interact with clients the way he’s expected to, though. His peers and boss are losing confidence in him.” The patient is a sales representative for a large company selling automobiles. As a sales representative, social skills are of utmost importance, and it is easy to see how he might be mildly ostracized or stigmatized due to a lack of understanding about his medical condition.

Dr. Yokoyama replies, “I must emphasize, we’ve seen major improvements in his condition since he initially came to my office. He couldn’t get out of bed, then.”

The patient nods. “Now I can go to work everyday, although Mondays can be a little hard.”

Dr. Yokoyama hands the patient a questionnaire sheet, which doubles as a diagnostic chart he uses to keep a record of how patients are improving. “Why don’t you fill this out?” The patient gladly takes the questionnaire, which he completes for his monthly check-up.

The counselor asks, “Is he going to receive testosterone injections today?”

“Yes, the level seems to be stabilizing, so we’re gradually decreasing the dosage, carefully observing his symptoms. How much should we give you today?” The patient agrees on an amount that he received last month. Dr. Yokoyama wraps up his paperwork, complete with a diagnosis and explanation about the patient’s condition of depression related to menopause—stipulating that this was a physiological

consequence rather than an individual one—and the various treatment methods he was receiving (TRT,<sup>1</sup> *kanpo*,<sup>2</sup> and counseling). The female counselor thanks him, noting that it will help his boss, coworkers, and clients understand the patient's situation and help his reintegration into the company.<sup>3</sup> “It's important that people correctly understand what he is going through. He has a family (a wife and two young children) to support, and he's fortunate that they're so supportive. Time will cure him. *Gokurousama*.<sup>4</sup>”

The observation of one patient's clinical encounter in Ishinkai Urology Clinic gives a good example of how *dansei konenki*, as a new illness category, is diagnosed, represented, and treated in ways which are clearly not straight imports from the Western biomedical discourse of this disease, where its concept originated. For example, the questionnaire, which Dr. Yokoyama had the patient fill out, is his primary diagnostic tool, along with a thorough medical examination (such as circulating free testosterone levels). It is divided into three sections: (a) Psychological/autonomic nervous symptoms, (b) Masculinity check, and (c) Symptoms of the urinary organs. Category (a) enlists criteria such as anxiety, irritability, fatigue, depressive mood, insomnia, and hot flashes; category (b) lists the frequency of sex and sexual desires; and category (c) asks about the frequency and uncomfortable symptoms accompanying urination. The patient ranks each diagnostic criterion from 0-3, indicating the degree of severity he is experiencing.

Additionally, in contrast to defining *dansei konenki* as simply a consequence of declining testosterone levels (as customary in the United States), Japanese doctors have formulated their own diagnostic requirements for this illness category: a conspicuous example of an illness category that is reinvented in the local environment. Dr. Yokoyama notes that the myriad of symptoms (characteristic of autonomic imbalance) must follow a cycle of ebbs and flows—if any one symptom persists, then it is not caused by menopause. As for testosterone levels, his theory holds that the large difference between circulating free testosterone levels before and after a man enters his middle age<sup>5</sup> is what characterizes male menopause. Hence, rather than setting an absolute standard of hormone levels to distinguish normal from abnormal ranges—one of the principal tenets of biomedicine—diagnostic standards are set differently for each individual. Thus, there are no strict diagnostic cutoffs for what is considered to be physiologically normal or abnormal levels of testosterone. Most medical institutions set a “reference level,” which is typically around 13-15 pg free testosterone concentration in the blood.<sup>6</sup> Many times, as seen in the example above, Dr. Yokoyama will let the patient decide on the dosage of testosterone administration, according to his subjective discretion.

Another physician pioneering the treatment of *dansei konenki* in Japan has his own set of standards for diagnosing the illness. A well-known cardiovascular specialist, Dr. Fuminobu Ishikura of Osaka University Medical School, defines *dansei konenki* as a comprehensive term incorporating ED (erectile dysfunction), cardiovascular abnormalities, and clinical depression. Interestingly, these two physicians come from two

distinct backgrounds of medicine—Dr. Yokoyama from urology and prostate diseases and Dr. Ishikura from cardiovascular systems. Thus, both doctors accommodate specific knowledge about their specialties to construct an illness category that fits their own definition of male menopause.<sup>7</sup>

Treatment methods have also undergone significant indigenization and appropriation, formulated to reverberate within local contexts. The most prominent example is Dr. Yokoyama's three main methods of treatment which he almost always combines for any patient—TRT, *kanpo*, and counseling—in contrast to the standard Western treatment which is solely confined to hormone injections. Only in cases of severe clinical depression, he will refer his patients to a psychiatrist. Dr. Yokoyama also uses supplements such as *fukoidan*, a type of dietary fiber extracted from seaweed, as part of his treatment methods. Dr. Ishikura, on the other hand, asks the first-time patient to complete a comprehensive questionnaire used in diagnosing clinical depression and requires a session of relaxation methods, more commonly known as *jiritushinkei kunren hou* (training of the autonomic nervous system) in addition to drug prescription and psychological counseling.

Other means of the local indigenization of *dansei konenki* are manifested in Dr. Yokoyama's numerous articles and publications. In one article entitled “Male Menopause, Female Menopause” he wrote for *Anatani E-ru* (An Eire to You) (2002), a monthly subscription magazine targeted for reader audiences in their 50s, pages are devoted to discussing certain kinds of food that are effective in alleviating male and/or female menopausal symptoms, as well as certain personalities and professions in which there is a high (or low) incidence of patients with *konenki*. The idea of food as medicine and an emphasis on harmony, balance, and equilibrium promoting an optimal state of being are characteristic of traditionally East Asian concepts of health. In terms of daily diet, Dr. Yokoyama encourages readers to eat “sticky/slimy food,” such as fermented soybeans, a relative of the taro root, and okra—all of which supposedly have properties to “balance hormone levels and repair prostate and other male functions.” Beer is discouraged because one of its main ingredients, hop, contains estrogen-like compounds. Although beneficial for women, it will contribute to a “plump figure” in men (Yokoyama).

Personality-wise, men with “a strong sense of responsibility, a keen sense of competition, who are punctual, impatient, and always hungry for success” (Yokoyama, 2002) will have a stronger tendency to develop menopausal symptoms compared to those that are “stable in their mental states, and maintains his own pace of life, or *jibun-rashisa* (oneself, or one's uniqueness, unaffected by the environment).” These translate into vulnerable professions—those that use the brain more than the body—such as bankers, “corporate warriors,” company executives, and those who do a lot of deskwork. By contrast, gym teachers, military personnel (in the Self-Defense Force), and construction site workers have a lower incidence of *dansei konenki* (Yokoyama).

“Since around 1996, when the phrase *dansei konenki* began to be heard quite frequently in the general society, patients who come to me for treatment have skyrocketed. Interestingly, the average age is steadily

declining too. In 1999, it was about 49-50 years; whereas now I'd say the average age of my patients is around 46" (Yokoyama, 2002). It is not hard to imagine that the recent economic downfall, resulting in massive salary and job cuts among the middle-age workers, has probably contributed to this phenomenon. Consequently, his working hours are inundated with treating patients in the clinic as well as responding to requests from publishers and the general media who are eager to feature articles that address this emerging illness category.

"The initial research began in the United States in the 1940s. When I started introducing the idea to the medical community, I was really ridiculed. My colleagues called me 'Mr. Menopause' (Yokoyama, 2002). But now, patients come to my office from all over Japan and not just from around Tokyo. My efforts will have been all worth it if, through the numerous publications and public appearances I make trying to popularize this disorder, men suffering from it would finally take relief in the fact that it's a recognized disorder which can be treated. If I save one man from suffering [to the point that he is socially dysfunctional, or suicidal] I can save his family."

As exemplified by the sales representative diagnosed with male menopause accompanied by *utsu* (clinical depression), Dr. Yokoyama's narrative suggests to me that *dansei konenki*, as an indigenized illness category in contemporary Japan, has also taken on a socially significant function: the category serves to restore the social functionality of the patient, hence contributing to recovery of the function of his family, his company, and the dire economic climate of the society. Dr. Yokoyama's approach stands in stark contrast to the general representation of male menopause in America, where the discussion is heavily centered on issues of sexuality. Indeed, many physicians contend that male menopause in the United States is simply another way of describing sexual/erectile dysfunction in middle-age men.

The rapid rise in the number of *konenki* patients who visit Dr. Yokoyama's office, I suggest, reflects the collective need for such an illness category in the particular socioeconomic climate of contemporary Japan. The prolonged economic recession and decline starting from the early 90s signified the demise of old corporate rules, such as *shuushin-koyou* (guaranteed lifetime employment) and *nenko-joretsu*, a system closely following the ingrained ideas of East Asian filial piety, whereby one's position in the company directly reflects the years of service to the organization. Once the trademarks of Japanese corporations, *shuushin-koyou* and *nenko-joretsu* both contributed to creating an illusion of a man's company seem like his "second family."<sup>8</sup> The rapid demise of old corporate models have deprived men of their job security which was once guaranteed, inducing notions of fear, instability, and anxiety as the burden of supporting his family continues to fall on his shoulders. The driving force behind the indigenization of *dansei konenki*—the need to give a voice to and contribute to the restoration of the man's social functionality—becomes understandable under this particular socioeconomic context.

### **Yoshiharu Sakaguchi**

The following illness narrative, I believe, illustrates how the indigenized illness category of *dansei konenki*

has been fueled by, and is contingent upon a particular socioeconomic moment in Japan, and embodied by an extended economic recession and the paradigmatic shifts in family values, work ethics, and gender roles that it has induced over the past decade. Yoshiharu Sakaguchi is an executive of a multinational trading company and the head of the Toyama<sup>9</sup> branch office. He was diagnosed with *konenki* while preparing for his early retirement after the company decided to close the Toyama branch due to budget constraints. He had just received an order from the headquarters to return to Tokyo, where his wife and three children live. After this month, the Toyama branch was scheduled to close due to radical budget cuts, and he was being transferred to a small subsidiary of Mitsubishi. It was explained in terms of a euphemism for formal retirement or *risutora* (from the English word restructure)—a ubiquitous word for layoffs, especially of middle age men without the needed technological/computer skills nearing retirement.

Tales like his are heard everywhere in Japan for the last 10 years, ever since the real estate bubble burst in the beginning of the 90s and the economy quickly spiraled downward, heading toward an abyss. For 12 consecutive years, the country has not seen substantial economic growth. With inevitable budget cuts and the internal restructuring of companies, middle age men in mediocre administrative positions are the prime targets for layoffs. If they were not explicitly fired, they were put under intolerable pressure to retire with an added benefit sum to the standard retirement fee.

“This is totally not what our generation expected when we were working so hard for the country during the period of rapid economic growth in the 70s. Back then, it was all about growth—we worked harder each day believing that tomorrow’s standard of living would be better. And it was, until these recent years.” Mr. Sakaguchi’s somber tone goes on to explain the major structural changes that have marked a transition from the traditional to the new American economic models—where individual abilities are of utmost importance—ever since the long-term recession began.

“Back when I graduated from college, after admission to a good university, you’d be guaranteed a good job in an elite company and that would become your second family. They taught you everything from scratch, and so long as you were loyal to them, you secured *shuu-shin koyou* (lifetime employment). We worked in close-knit teams on projects, as opposed to individually allotted tasks—that’s why we would never have chunks of vacation time to spend with our families like all the American dads did. But now, in this age of insecurity, it’s all about the individual. The name of a prestigious university won’t get you that far; you have to have specific, marketable skills and knowledge, assets that’ll provide security even when your company’s doing badly. A general knowledge about politics or economics is no good anymore. (Mr. Sakaguchi holds an economics degree). That’s why I tell my youngest daughter (who is a high school senior, taking college entrance exams next winter) to apply to the department of engineering, or medicine, or anywhere you can get technical skills; things aren’t as easy as they used to be.”

Once the trademark characteristics of Japanese corporations, *shuushin-koyou* and *nenko-joretsu*<sup>10</sup> both contributed to creating an illusion of a man’s company seeming like what some sociologists call his second

family. The intense loyalty and commitment that companies demanded of Japanese men lay at the root of the notoriously absent father figure in many families.

Mr. Sakaguchi's account depicts the increasing difficulties that the creators of the current economic status confront today—and accordingly, how the diagnosis of *konenki* has added on to those distresses. For example, the diagnosis often signifies a loss of masculinity or the beginning of an old-age decline for patients.

As Mrs. Sakaguchi brewed *reishi*, a traditional Chinese mushroom for her husband, she began: “You must be nauseous with this strong smell. Two years ago in his annual check-ups, his numbers for prostate enlargement (which many practitioners regard as one measurement for diagnosing *konenki*) came out borderline. They tried to prescribe him some drugs to keep it under control, but I didn't want him taking Western medicine for the rest of his life. And I had heard about *reishi* mushrooms that they were good for the general health of aging men.”

“Have his numbers improved?” I ask.

“Not really. But it hasn't gotten worse either. I figure it mustn't be doing him harm.” Upon my inquiry of what kind of symptoms he experiences, Mr. Sakaguchi relayed a common set of symptoms said to accompany *dansei konenki*: a bad case of insomnia, night sweats and hot flashes during the day, mild depression, chronic fatigue, and prostate problems. He is currently seeing a specialist treating *dansei konenki*, after several months of going to various specialties (urology, endocrinology, psychiatry) a process Dr. Yokoyama calls “doctor shopping,” until the doctors finally discovered a major drop in his testosterone and other male hormone levels. Mr. Sakaguchi says he was primarily relieved when everything could be finally explained and treated, although the reaction contained inherent mixed emotions.

“Naturally, there is this feeling of doubt, because I've never known anyone with *dansei konenki*. Some people still laugh at the idea and say it's an oxymoron, but I had read quite a bit about it before seeing a specialist, and I didn't resist the idea too much, but . . . (sighs heavily) I felt sort of like a failure as a man. I guess it was a realization that I wasn't young anymore too, but more than that it's hard to explain. I thought to myself, *otoko rashiku naina* (you're not manly).”

Mr. Sakaguchi's initial reaction to his diagnosis of *dansei konenki* embodies a crucial consequence of the emergence of this new illness category in contemporary Japan: namely, that it has fixed the idea of vulnerability by signifying a rapid and irreversible degeneration of the masculine body to the patient. However, through the process of treating his condition, the Sakaguchis both acknowledge the reestablishment of a mutual understanding and new-found appreciation for each other: an instance of a favorable role that *konenki* has played in his life. Thus, as the following conversation reveals, the reverberations of this indigenized illness in the local life of Mr. Sakaguchi are pluralistic and exist in constant tension with one another—unlike many one-sided theories written on the effects of indigenized biomedical diseases.

As Mrs. Sakaguchi told me: “For us—ironic as it is, we've begun to talk more ever since he was diagnosed

with menopause. The major difference for me is that he can now understand what it's like to undergo menopause. Few men can really appreciate the fact that his wife is cooking and cleaning despite the hot flashes and moodiness!" Although the increased amount of conversation between the two meant more *guchi*,<sup>11</sup> or complaints on behalf of Mr. Sakaguchi on his symptoms of *konenki*, Mrs. Sakaguchi is still glad<sup>1</sup> that they have begun to talk more. The diagnosis of *dansei konenki* seemed to have enhanced both the quantity and quality of communication between the two compared to the earlier years of their marriage. On a societal level, this propitious consequence of the *konenki* experience probably contributes to the restoration of the patient's (and thus his family's) social functionality, as explicated above in the ethnography of Ishinkai Clinic.

"Even though he just complains more, it's increased our communication to one another—and also our awareness of how we feel about each other or deal with certain things. He used to be much more reticent and stoic-minded—I guess what you'd call the older model of masculine virtues. It's all so different now—just look at my daughter's fiancé! They go to karaoke together and talk incessantly on the phone. He talks more than she does!"

Mrs. Sakaguchi's ending remark points to another change, induced by the demise of the old economic paradigm that the current *konenki* generation is facing. Posters of a young male pop star holding his newborn son under the caption "We Don't Call Men Who Don't Participate in Child-Rearing Fathers," plastered throughout the subway stations around Tokyo, indicate the idealization of men as active participants in child rearing and household duties is another prominent feature of the recent shifts in social values. Concurrent with this change, there seems to be a mild social stigma for men of his generation, for having been a "workaholic salary-man" who has neglected fatherly duties. Thus, men like Mr. Sakaguchi are confronting changes in the modern ideals of younger men: whereas *otoko-rashisa* (manliness) traditionally embraced values such as stoicism, financial authority, and noncooperation in household chores, a modern young man is largely expected to be open and vocal in speaking his mind, view the opposite sex as equally competent players in the work force, and take an active role in domestic activities.

## **Conclusion**

Through the ethnographic account of a urology clinic and the illness narrative of one patient, I have tried to illustrate the process by which *dansei konenki* has become largely divorced from its Western roots and has taken on a distinct definition that reverberates within the specific context of contemporary Japan. This indigenization, I have argued, has been fueled by and is contingent upon two key social contexts: the extended economic recession and the major shifts in traditional corporate structure, work ethics, family values, and gender roles with which this social climate has dealt.

To be sure, male menopause is a relatively minor illness in terms of the degree to which it affects the physical and mental health of the patient and his/her family, when compared to diseases such as AIDS or Alzheimer's disease. Although illnesses that more ostensibly threaten the livelihood of patients have long

been the focus of medical anthropologists writing about biomedical indigenization, a disorder like male menopause is interesting in its own right. For example, studying the various meanings that it soaks up in the lives of individual patients fleshes out interesting gender issues, such as how this illness is associated with notions of vulnerability and the loss of “manliness.” In addition to its gender specific nature, the illness is also unique in that it is primarily limited to developed countries, where the majority of the population survives to old age, unaffected by infectious or contagious diseases. As Dr. Yokoyama notes, men who experience menopause are only those lucky enough to live that long (2002). In future studies, it would be of great interest and contribution to the field to further explore the indigenization of biomedical illness categories in traditionally nonwestern locales as well as the sociocultural forces that mediate and drive this process.

### References

- Cohen, L. (1998). *No Aging in India: Alzheimer's, the Bad Family, and Other Modern Things*. University of California Press: Berkeley, 15-17.
- Farmer, P. (1993). *AIDS and Accusation: Haiti and the Geography of Blame*. University of California Press: Berkeley.
- Kleinman, A. (1989). *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.
- Yokoyama, H. (2002, Sept.). “Female Menopause, Male Menopause.” *Anatani E-ru*. Benesse Corporation, 14-25

### Endnotes

<sup>1</sup> Testosterone replacement therapy.

<sup>2</sup> Traditional Chinese medicine. Even in treatment plans termed “biomedical,” many physicians combine *kanpo* and Western biomedical modes of treatment. For a more detailed discussion of the prevalence and integration of *kanpo* with biomedicine in modern Japan, see Margaret Lock’s *East Asian Medicine in Urban Japan* (1980, UC Press).

<sup>3</sup> The open discussion of clinical depression and menopause among the patient, the doctor, and his company’s hired counselor contrasts sharply with traditions in the U.S., where such disorders are more commonly “hidden” from the public view. I suggest that this may be attributable to a unique aspect of the Japanese perception on illness, discussed by Ohnuki-Tierny in her book *Illness and Culture in Japan* (Cambridge University Press, 1984). According to her theory, there is a general attitude of affirmation/acceptance to an illness that incapacitates an individual (or a “culturally tolerated sick body”). [Exceptions are ones that are incurable, such as AIDS and cancer, and mental illnesses whose cause cannot be sufficiently explained by biomedical mechanisms.] This allows for the expression of how important the patient is and the crucial interdependency among his circle of relationships—thus encouraging his/her recovery. By contrast, Western cultures hasten the recovery of a patient by admonishing the sick individual, and encouraging him/her to “fight” the illness, rather than affirming and accepting it.

<sup>4</sup> A phrase commonly used among co-workers at the end of the day. Literally translated, it means “good work for the day,” or “take it easy.”

<sup>5</sup> Here, I define “middle age” as the age range from the mid 40s to mid 50s.

<sup>6</sup> [www.nhk.or.jp/gatten/archive/2002q3/20020828.html](http://www.nhk.or.jp/gatten/archive/2002q3/20020828.html)

<sup>7</sup> Dr. Yokoyama and Dr. Ishikura are two prominent physicians involved in the treatment of male menopause. Their theories, as well as their clinic/hospital work, are completely independent from one another.

<sup>8</sup> The intense loyalty and commitment that companies demanded of Japanese men lie at the root of the notoriously absent father figure in many families of the post-war baby boomer generation.

<sup>9</sup> Toyama is a small city 90 miles west of Tokyo, facing the Sea of Japan.

<sup>10</sup> A system closely reflecting the ingrained ideas of East Asian filial piety, whereby one’s position in the company directly reflects the years of service to the organization.

<sup>11</sup> Idle complaints, grumbling in daily life.