

A brain hospital in Tokyo and its private and public patients, 1926-45

AKIHITO SUZUKI*

This paper examines patients' demography at Ohji Brain Hospital, a prosperous private psychiatric hospital in Tokyo, from 1926 to 1945. Increase and decrease in the number of resident patients, new admissions and deaths are discussed, based on a database compiled from the patients' admission register. Particular attention is paid to the length of stay. The changing pattern of the distribution of the length of stay is examined in the light of new therapeutics and different expectations held by the clients.

Keywords: *history; Japan; length of stay; mental hospital; patients; psychiatry; therapeutics*

Introduction

Although little known in the West, research into the history of psychiatry in Japan has been vigorously conducted in the last couple of decades. Biographies of eminent psychiatrists have been written, and their major works edited and published. A series of reprints called 'Classics in History of Psychiatry' includes sixteen titles, and their paperback editions are now appearing (Kure, 1982; Okada, 1982, 2000). *The Encyclopaedia of Psychiatry*, a remarkable publishing venture of 30 volumes, has devoted one special volume to the history of the discipline (Matsushita and Hiruta, 1999). Histories of psychiatric hospitals have also been getting increased attention: Yasuo Okada's *Matsuzawa Hospital: A Private History, 1879-1980* (1981), a *magnum opus* of 650 pages, will remain unsurpassed in its detailed description of the most important psychiatric hospital in Japan; Waichiro Omata's *Origins of the Mental Hospital* is an ambitious work, with two

* Address for correspondence: School of Economics, Keio University, 4-1-1 Hiyoshi, Yokohama 223-8521 Japan. E-mail: asuzuki@hc.keio.ac.jp

volumes covering 1000 years of Japanese institutional provision for the insane (Okada, 1981; Omata, 1998–2000). The long tradition of home confinement has been the subject of Genshiro Hiruta's fascinating monograph based on the study of small villages in the *longue durée* (Hiruta, 1985; Kuwahara and Itahara, 1998; Kuwahara and Itahara, 1999/2000). In order to collect together such individual studies, the Japanese Society of the History of Psychiatry was established in 1996 and its journal is now issued twice a year.

So far, many of the works have been written by practising psychiatrists, not by professional historians, and consequently some of them have the shortcomings familiar to history of psychiatry in the West three decades ago: they are anecdotal, judgemental and partisan. Argument based on rigorous analysis of systematically compiled data is rare. Many are also isolationist. In addition to the fact they are rarely published in languages other than Japanese, there has been no dialogue with the post-antipsychiatry and post-Foucault historiographical reflections developed in English-speaking countries in the last couple of decades. Paradoxically, this isolationist tendency leads to naïve, and perhaps unconscious, adoption of 'Westernization' as the basic framework around which the history of psychiatry in Japan is studied. The performance of Japanese psychiatry has been measured against the 'advanced' Western model; the smaller number of beds and the practice of home custody, in particular, have been major targets of angry criticism (Kure and Kashida, 1918; Okada, 2002). It is true that there is considerable historical truth in this type of narrative – psychiatrists and psychiatric policy-makers in the past *did* try to imitate psychiatry in the West. However, in this paper I avoid this semi-colonialist framework, because the narrative of Westernization *manqué* concentrates on the learned élite's drive towards the Western psychiatric model. Instead, I shall try to place Japanese psychiatry in a larger social context, far beyond the small circles of medical professors, psychiatrists or health officials, many of whom studied in European or North American countries. Comparisons between data in Japan and those in England will occasionally be made below, but I do so in order to explain the difference, rather than to criticize Japanese shortcomings. The second section of this paper will provide a brief account of some basic features of psychiatric provision in Japan before World War II (WWII), and will point out some of its differences from the models in Europe and North America.

The specific focus of this paper is Ohji Brain Hospital from the mid-1920s to the end of WWII in 1945. Although vastly overshadowed in its eminence and prestige by Matsuzawa Hospital – which had long been the only public hospital in Japan, and also the teaching hospital of the Medical School of University of Tokyo – Ohji Brain Hospital and its private annex (Komine Hospital) present key issues for understanding Japanese psychiatric practice in the period before WWII. It was a 'daiyo' (substitute) hospital, which played the role of a public asylum and accepted publicly-supported patients

but remained a privately-run institution. Thus it presents an interesting meeting of psychiatry for profit and psychiatry for public interest (Parry-Jones, 1972; Porter, 1987). This conjunction of private business and public authority was one of the most important driving forces in Japanese psychiatric provision before WWII, as I have discussed elsewhere (Suzuki, 2003). The third section of this paper will examine the patients of the hospital, after briefly sketching the life and works of its medical superintendent. In particular, I will emphasize the emergence of a new pattern of hospitalization in the late 1930s. Private patients started to stay for a fixed amount of time, determined by newly introduced therapeutic programmes. Public patients were, on the other hand, unaffected by new therapies and the disparity between private and public patients became even more manifest.

Psychiatric provision in pre-WWII Japan

The treatment of the insane in Japan has a long history (Suzuki, 2003). Some of the mentally disturbed were sent to a custodial institution with specialist medical or custodial facilities. Such institutions multiplied slowly during the Edo period (1603–1867). Omata's painstaking research has revealed that on the eve of the Meiji Restoration in 1868, when Japan started to throw itself into the whirlpool of Westernization and industrialization, at least 29 such institutions existed. Many were established in and close to Buddhist temples, which developed different therapeutic strategies according to their denominations (Omata, 1998–2000: 13). Whereas these religious-based institutions often had a therapeutic orientation, the 'tame', facilities where the insane were kept mixed with the destitute, were more custodial. Created in major cities from the seventeenth century, *tame* housed vagrants, the sick and lunatics, whose care was trusted to 'hinin', the lowest untouchable class in the Japanese caste system. Although somewhat similar to the *hôpitaux generales* in the Ancien Régime in France, recent research has revealed only a handful of lunacy cases in the records of the Japanese mixed institutions (Kuwahara and Itahara, 1999/2000). The most elusive but undoubtedly the most important locus of care had been the family, and this remained the case well into the mid-twentieth century. In the Edo period, the family provided care and security by confining the patient in a cage (*sashiko*) set up within the house, with the permission of the local authority. Hiruta's research into the archives of villages in Tohoku has shown the mechanism of the home custody in fascinating detail. Evidence of a similar administrative procedure has also been found in other places (Hiruta, 1985: 107–111; Kuwahara and Itahara, 1999/2000).

The implanting of the Western-style system for the care of the insane since the Meiji Restoration was made against this background of a diversified system of the provision for the insane. The building of 'modern' psychiatric

provision by the central government was carried out through two Acts of Parliament: the Mental Patients' Custody Act (1900) and the Mental Hospitals Act (1919), until their repeal by the Mental Health Act in 1950. The Custody Act was the first piece of national legislation for the regulation of psychiatric confinement (Japan, House of Lords, 1900). It demanded that if one wanted to have a lunatic confined, one should do so by appointing a 'custodian', who was responsible for his or her provision, care and confinement. Only the custodian was allowed to confine the lunatic, and he or she could do so only with the permission of the authority of the local government of a city, town or village. When a competent custodian could not be found, the administrative head of the local government would assume the status. The actual means of confinement was strikingly different from the practice in the West, where large asylums had already become a familiar part of the scene. In contrast, a majority of Japanese patients were confined in their own homes, rather than in asylums or mental hospitals. Obviously, this was a continuation of the tradition of *sashiko* which had been practised for at least several centuries. In 1905 about 12,000 patients were confined in their homes, while only about 5500 were put in institutions (Japan, Department of Hygiene, 1905; Suzuki, 2003). A cage with a heavy lock had to be set up in or close to the house according to a plan submitted to the local administrative office (Kure and Kashida, 1918). Perhaps both to allow light and air into the cage and to facilitate vigilance over the confined person, a latticework seems to have been the norm. This meant extremely high visibility of the patient in confinement, and people now in their sixties or seventies still retain vivid memories of chilling horror and dark fascination when they saw a furious patient through the lattice.

One should note that the Custody Act of 1900 was not meant to expand institutional provision, but this was exactly what the Mental Hospitals Act attempted to do in 1919. To achieve this, the Act empowered the central government to order the prefectures (a large local governmental unit, comparable to that of counties in England) to build public asylums. Half the cost for building the hospital and one-sixth of the cost for maintaining the patients would be covered by the central government, the rest being paid by the prefectures. This plan must have looked unrealistic, however. The only public asylum in existence was in Tokyo and housed about 450 patients in 1918. In contrast, in the same year there were already 57 private psychiatric hospitals with about 4000 patients (Kure and Kashida, 1918: 524). Most crucially, many of the private mental hospitals already admitted patients whose costs for staying at the hospital were paid by their local authority, either through the Mental Patients' Custody Act or otherwise (Okada and Sakai, 1995: 183–223). A large mixed sector in psychiatric provision had already been formed. The Mental Hospitals Act codified this practice of confining patients in privately-run asylums at public cost. Some private asylums were allotted a certain number of 'substitute' (*daiyo*) beds, and

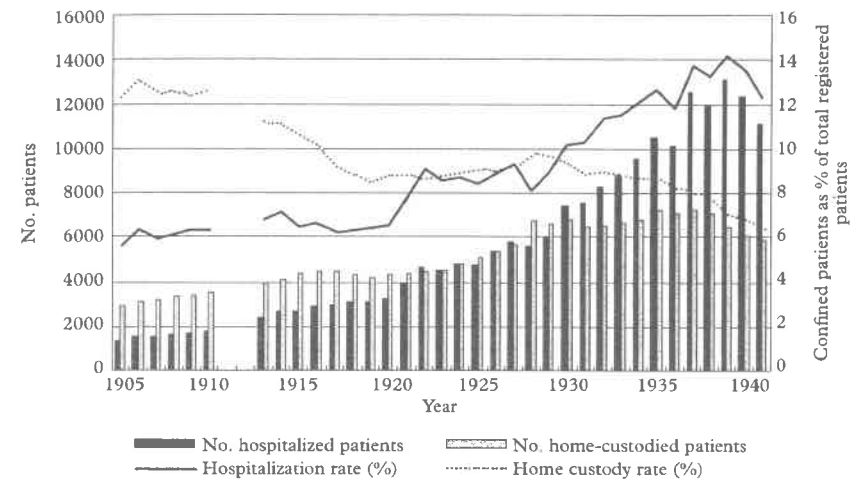


Fig. 1. Patients confined in hospitals and at home in Japan

accepted public patients up to that number. Private mental hospitals thus appointed were called 'substitute hospitals', which were to become the major provider of the care for the insane in the next couple of decades.

The provision for the insane in pre-war Japan was thus structured by the two Acts, which had different and somewhat contradictory aims, one centring on home custody, the other on hospitalization. In the following discussion, I refer to three categories of patients – hospitalized, custodied at home, and non-custodied at home ('at large') – which made up the total registered patients. The numbers of patients confined at home and in hospital, as well as their proportions to total registered patients are shown in Fig. 1. The overall pattern clearly shows the steady growth of psychiatric confinements. Psychiatric patients under confinement in officially sanctioned milieu grew both in number and in ratio to total population. From 1905 to 1940, the number of patients confined either at home or in hospital increased about four-fold. In terms of proportion to the total population, this is a 2.6-fold growth. It should be noted, however, that this growth appears modest if seen in terms of the ratio of confined patients against the entire number of registered patients, many of whom were allowed to stay at home under no officially regulated custodial means. For most of the period under review, about 80% of the registered patients were 'under no custody' and although

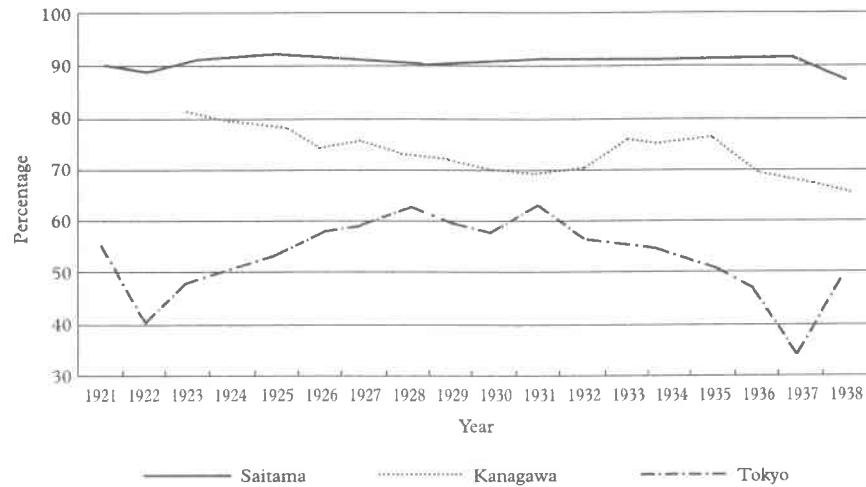


Fig. 2. Patients at large as a percentage of all registered patients in Tokyo, Kanagawa and Saitama

the figure started to decrease in the 1930s, in 1941 about 70% of registered mental patients were still at large. In other words, the growth of confinement of lunatics barely exceeded the pace of the growth of their registration. One hesitates to call this a 'great confinement', particularly when compared with Western countries (Bartlett and Wright, 1999).

One way to disentangle the manifold forces that kept Japanese patients out of confinement is by way of regional comparison. Three regions or prefectures were selected: Tokyo was the most urbanized, with one huge public hospital and by 1940 boasting 20 private hospitals, 10 of them being substitute hospitals; Kanagawa was in the process of urbanization during the period and saw the erection of a public hospital in 1929 and had 7 private hospitals (three of them were substitute hospitals) by 1940; Saitama was the most rural of the three, with no public hospital but six private hospitals (one being a substitute hospital). Figure 2 presents the proportion of patients not under custody (at large) compared with the total number of registered mental patients for those three prefectures between 1921 and 1938. In Tokyo the ratio of patients at large ranged between 40% and 60%. In Kanagawa, the ratio declined from about 80% to 65%, while the figure in Saitama remained stable around 90% throughout the period. Figure 2 suggests that the more

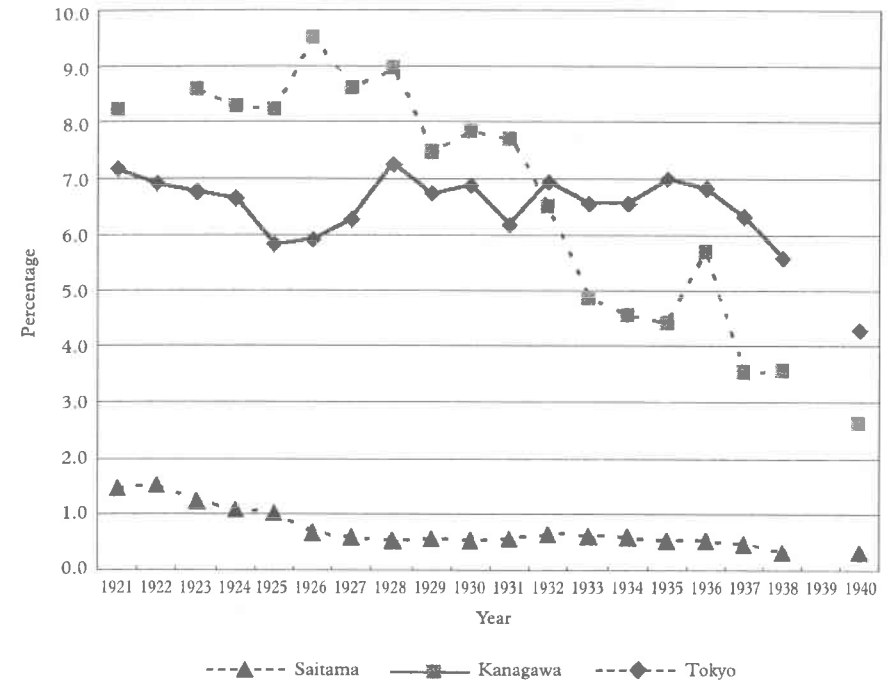


Fig. 3. Home-custodied patients as a percentage of registered patients in Tokyo, Kanagawa and Saitama (no figures for 1939)

urbanized a prefecture was, the lower the ratio of unconfined (either in hospital or at home). The three prefectures show marked differences also in the ratio of home custody (Fig. 3). In Tokyo, only 1.4% of the patients were under home custody in 1921 and this declined to 0.3% by 1938. Moreover, these very few home-custodied Tokyoites were situated in its rural and island parts (Japan, Metropolitan Police). As seen in Fig. 3, the proportions were higher in Kanagawa and Saitama, and these figures suggest that urbanization had something to do with the decline of home as the locus of care.

Figure 1 also clearly establishes a shift in the locus of confinement from the home to the hospital. The hospital, the cornerstone institution of the Mental Hospitals Act, was on its way to success, presenting the familiar picture of medicalization and institutionalization of the care for the insane.

On closer examination, however, some points need to be emphasized. The first is the pattern of the decline of home custody. The decline started around 1910, before the Mental Hospitals Act and before the significant rise in the number of the hospitalized patients. This shows that, proportionally speaking, home-custody was already becoming less common, even *before* the passing of the Mental Hospitals Act. In other words, increasingly fewer patients were put under home custody than those registered by the police as insane but in no need of confinement. Despite the image promoted of mental hospitals as the modernizing institution against the evil of home custody, the latter had declined by itself, rather than being overwhelmed by the former. Another ambiguity surrounds the Mental Hospitals Act. The Act must undoubtedly have contributed to the dramatic rise of the hospitalized patients after 1920: the number of public hospitals and substitute hospitals grew from eight (one public hospital and seven substitute hospitals) in 1919 to 84 (seven public hospitals and 77 substitute ones) in 1940. It turns out, however, that those public or semi-public institutions did not bear the major burden of the care for the insane. Figure 4 shows the proportion of public and private patients in public and commercial (both substitute and purely private) hospitals. Three observations can be made: the contributions of the public hospitals remained low and stable; the proportion of publicly supported patients staying at a commercial institution declined; and the purely private type of hospitalization, namely patients who paid for their stay at privately-run hospitals, grew. The numerical and proportional growth of privately-funded hospitalizations reveals a hitherto little-noticed aspect of the rise of mental hospitals in pre-war Japan, i.e., the emergence of a large number of people who were ready to pay significant sums of money to be treated there. In other words, the growth of the *demand* for psychiatric service contributed significantly to the making of a society that segregated a large number of the insane. The Mental Hospitals Act seems to have both stimulated the demand and answered it through its public and substitute hospitals. During the period under consideration, the effect of stimulation exceeded the capacity of the public authorities to cope with the demand and the gap was filled by purely private institutions.

Thus, the interaction of public authority and patient demand, or that of social policy and the economy of psychiatry, was the major key in understanding the expansion of psychiatric provision in pre-war Japan. As a flourishing substitute hospital, Ohji Brain Hospital and Komine Hospital, its purely private annex, are ideal for studying aspects of Japanese psychiatry from the social historical viewpoint.

Ohji Brain and Komine Hospitals, and their patients

Ohji Brain Hospital (OBH) was established in 1901. It was a product of entrepreneurial speculation stimulated by the Mental Patients' Custody Act,

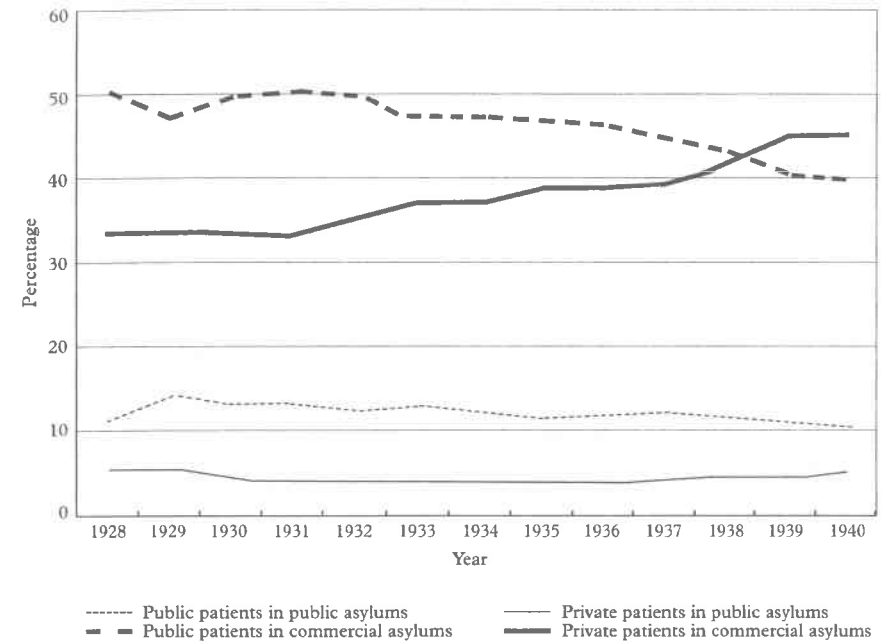


Fig. 4. Public and private patients in public and commercial asylums as a percentage of hospitalized patients

and was one of five private mental hospitals started in Tokyo around the turn of the century, all counting on a large demand for psychiatric beds necessitated by the Custody Act (Okada and Sakai, 1995: 183-223). Its founder, Zenjiro Komine, had no medical qualification. He had kept an inn at Hongo in Tokyo, where the Medical School of University of Tokyo was (and still is) situated, and the inn catered for those patients who travelled to and stayed in the area to be treated at the university clinic. His venture of starting a new psychiatric hospital was thus a move into a somewhat similar business, a combination of accommodation and medical facility. Indeed, the early OBH might have looked more like an inn than a hospital, for Zenjiro failed to secure any resident medical man for the first few years of his business. The earliest surviving patients' record of OBH looks less like a medical record than a hotel guest-book: it consisted of a record of the arrival

and departure dates and the fees paid, with minimum information about the diseases of the boarders.

Shigeyuki Komine (née Ohshima), Zenjiro's adopted son, transformed this struggling institution (Komine, 1985: 259–65). Komine junior attended Tokyo Medical College and qualified to practise in 1905. He had had some clinical experience at the University of Tokyo and Tokyo Metropolitan Asylum at Sugamo, which served as the teaching hospital of the University, before he became the superintendent of OBH in 1908. He further upgraded his medical qualification by obtaining an M.D. from the Department of Biology of Tohoku University in 1923. When later that year the old building of OBH was seriously damaged by fire, he reacted boldly by expanding the hospital facility and having a new hospital (a fire-proof one), with a capacity for 145 private patients, built close to the old hospital. Completed in 1925, Komine Hospital (KH) must have been the pride of its medical superintendent. It was a three-storey state-of-the-art hospital with an impressive archivolt. Now Komine ran two hospitals, whose management seems to have been merged and overlapped, judging from the state of their records. The new hospital also housed Komine Research Institute, which was the founder's tribute to the Wistar Institute at Philadelphia, where he had studied under Henry Donaldson in 1918–19. From then on until his sudden death in 1942, Komine's life was dazzling. He held numerous offices in important medical associations, sat on the boards of directors of the Japanese Association of Public and Substitute Mental Hospitals from 1932, and of the Japanese Medical Association from 1937. In 1940 the Ministry of Health awarded him a medal for his numerous contributions. Without doubt Shigeyuki Komine fulfilled the expectation of his father. He took a path familiar in English psychiatry in the late eighteenth and early nineteenth century, when gentrification of second-generation madhouse owners progressed as the trade of mad-doctoring was transformed into the medicine of mental diseases (Andrews and Scull, 2001; Porter, 1987).

Komine was thus a medical scientist with an up-to-date knowledge of laboratory biology, an owner of two flourishing hospitals, and at the same time an eminent medical man engaged with questions of socio-medical issues. As such, the list of his publications shows wide-ranging concerns. During his lifetime, Komine published about 80 articles, some of which appeared in *No [Brain]*, a journal on psychiatric hygiene which he started in 1926 and edited until his death. In his early years, his articles were mainly on biological medical science. The chemical study of the blood of psychiatric patients and the metabolism of the nervous system of the mouse seem to have been the major foci of his research (Komine, 1919, 1920; Kure, 1925). The clinical sides of psychiatry such as its aetiology, diagnostics and therapeutics were not neglected, however (Komine, 1933). In his later years, articles written in the field of social psychiatry and social medicine in general became a prominent part of his output. The topics he addressed include degeneration and abnormal

psychology, medico-social study of morbidity of city dwellers, history of medicine and insanity, regulation of medical practice, and psychiatric analysis of folklore. Suicide was given particular attention, and he published major works on parent-child suicide and lovers' suicide (Komine, 1938a, 1985). Eugenics was an inevitable issue in inter-war psychiatry, in Japan as well as in Europe and North and South America, and Komine published two papers on sterilization, sounding a cautious note on the thorny question which divided the Japanese medical world in the 1920s and 1930s (Komine, 1938b, 1939).

I now turn from the doctor to the patients of the complex of Ohji Brain Hospital and Komine Hospital (OBKH.). The earliest surviving admission register I have found in the archive is that of 1926. From then on, it runs continuously until 1945, with the exception of 1943. Most of my figures below are drawn from the database that I compiled from the admission registers. I have supplemented this database with examination of the casebooks of discharged patients in selected years. One can also determine the numbers of admissions, discharges, deaths and resident patients from published statistics.

Figure 5 shows the number of resident public and private patients at OBKH. Being a substitute hospital, OBH took both public and private patients, and KH took only private ones. The numbers of patients suggest that KH acted as a buffer to OBH. The relatively large number of patients housed at KH during 1925–27 was, no doubt, due to the shortage of beds and space at OBH, after the 1923 fire seriously reduced its capacity. When the new wards were built for the OBH in 1928–29, the number of patients housed at KH diminished. The number of total resident patients of OBKH grew about 1.8 times, from 163 in 1926 to about 280–300 in the late 1930s. The figure is roughly parallel with the number of beds of the two hospitals, which is also shown in Fig. 5. While the number of beds of KH remained stable at 145 throughout the period, that of OBH increased continuously. Roughly speaking, the first large increase in the capacity in 1929 was filled mainly by public patients, while the second increase in 1937 prompted the resurgence of the number of private patients. This pattern suggests that those enlargements were perhaps planned, respectively, as public and private wards.

Taken together, OBKH does not represent the problem of serious overcrowding which was common in psychiatric hospitals in pre-war Tokyo. This was largely because of the existence of KH with its under-used capacity. When one looks at the two hospitals separately, however, the picture is somewhat different. Although OBH was, generally speaking, less crowded than other substitute hospitals in Tokyo, it was around 90% full until the second major expansion in 1937, while KH never accommodated more than about one-third of its capacity. The picture of crowded public wards and spacious wings for paying patients, so common in the mixed asylum in nineteenth-century Europe and North America, largely applied to KH and OBH. One might even speculate that in OBH itself, which had both public

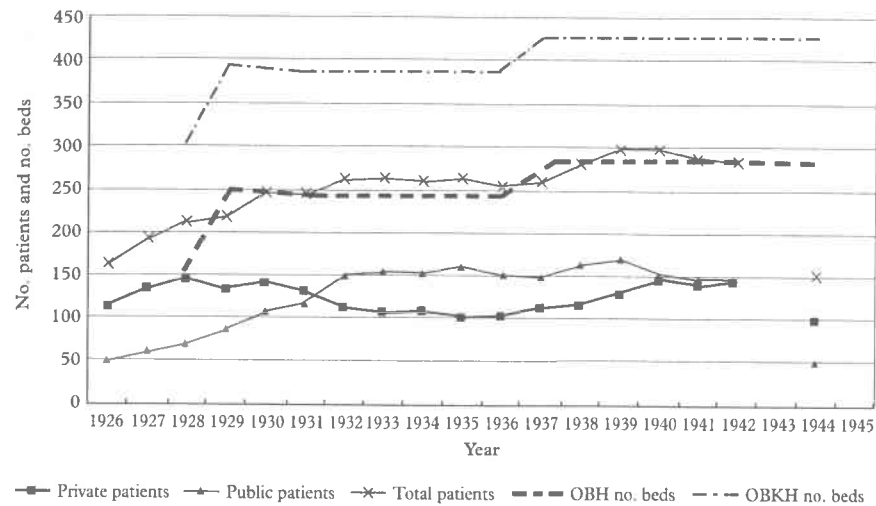


Fig. 5. Numbers of patients and beds at Ohji Brain and Komine Hospitals (no figures for 1943 patients)

and private wards, the patient density might have differed between the two types.

Figure 5 shows that there was a sharp drop in the number of resident patients at the end of the period, and between 1942 and 1944 the number of public patients was reduced by 61% and private patients decreased by about 20%. The major factor was the soaring death rate in the hospitals (see Table 1). Devastation came in 1944, when 19% of private patients resident at the beginning of the year died during the course of the year, and a staggering 47% of public patients died. Other psychiatric institutions suffered as badly. The annual death rate of public patients at Matsuzawa Hospital reached 35.8% in 1944 and 41.4% in 1945. At Inokashira Hospital, another substitute hospital, death rates were 38.6% and 52.7%, respectively (Okada, 1981: 553). The deaths of the patients at Matsuzawa Hospital were largely due to diseases related to severe malnutrition and deficiency, caused by the worsening of the wartime economy and the tightening of rationing, which undoubtedly also took a heavy toll on the public patients in other hospitals. Judging from the death-rate, which by far exceeded those recorded in

TABLE 1. Death of resident patients at OBKH, 1927-1945

	Private patients (resident)			Public patients (resident)		
	No. at start of year	No. deaths	Deaths as % of total	No. at start of year	No. deaths	Deaths as % of total
1927	119	1	0.8	52	3	5.8
1929	142	9	6.3	69	15	21.7
1931	139	12	8.6	107	7	6.5
1933	107	12	11.2	161	18	11.2
1935	104	11	10.6	156	19	12.2
1937	101	7	6.9	149	16	10.7
1939	114	12	10.5	167	20	12.0
1941	150	10	6.7	153	23	15.0
1942	141	12	8.5	149	25	16.8
1943	-	-	-	-	-	-
1944	126	24	19.1	109	51	46.8
1945	93	16	17.2	56	4	7.1

German asylums during World War I, the end of WWII was arguably a dreadful time for OBH and other Japanese psychiatric hospitals (Vanja *et al.*, 1999: 136-9).

There was, however, a more subtle but important change, hitherto not remarked on by historians of Japanese psychiatry. The change was more structural than drastic, was manifest more for private patients than for public patients, and was concerned more with discharge than death. From 1936 to 1940, the number of new private patient admissions rose consistently (Fig. 6), and the annual new admissions doubled from 264 to 519. The rapid growth in the admissions is observed for both males and females. During the same period, the resident private patients at the end of each year increased by only 50.

This leads to the question of the patterns of stay at the hospital. Table 2 gives the average and median figures for male and female private patients; three cohorts, according to the year of admission (1930, 1935, 1940), were selected. To equalize the condition, those staying more than five years are excluded from the cohorts of 1930 and 1935. Both for men and women, the median figure remains roughly stable around 40-45 days throughout the period, but the average length of stay became somewhat shorter from 1930 to 1940, reduced by about 25% (26% for men and 23% for women). This slight decrease in average length of stay was not accompanied by an overall shortening of the length of stay, which would have lowered the median.

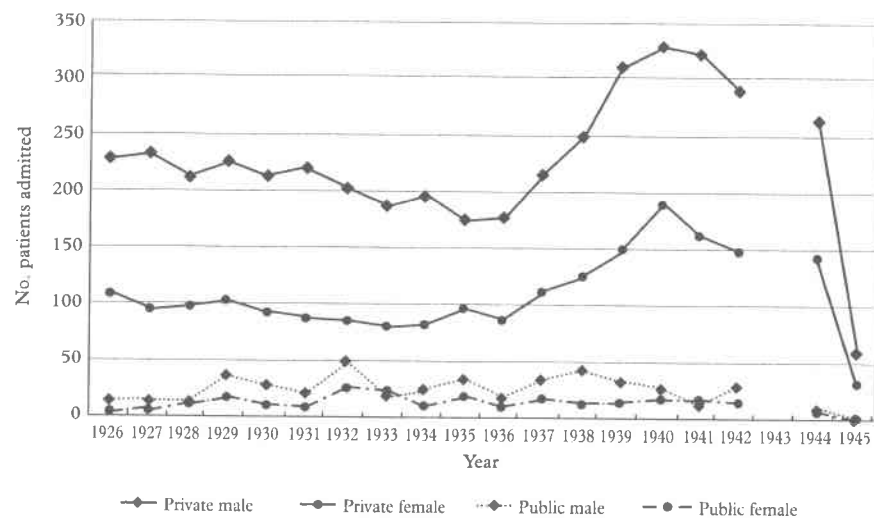


Fig. 6. New admissions at OBKH

TABLE 2. Average and median length of stay for private patients, 1930, 1935 and 1940

	1930		1935		1940	
	Male	Female	Male	Female	Male	Female
Average (days)	114.3	94.9	84.6	79.0	84.4	73.2
Median (days)	42.5	44.0	35.5	46.0	40.0	43.0
No. staying >5 years	2	1	1	2	-	-
No. patients	216	93	186	102	333	189

Figure 7 represents the distribution of the length of stay of the 1930 and 1940 cohorts of admissions. The shape of the 'bell' of the 1940 cohort has a narrower base and a more pointed peak than that of 1930 cohort. In other words, the 1940 cohort had a more marked concentration in the period 1-3 months. The standard deviation for the two cohorts are 214.8 days for 1930 and 152.5 days for 1940.

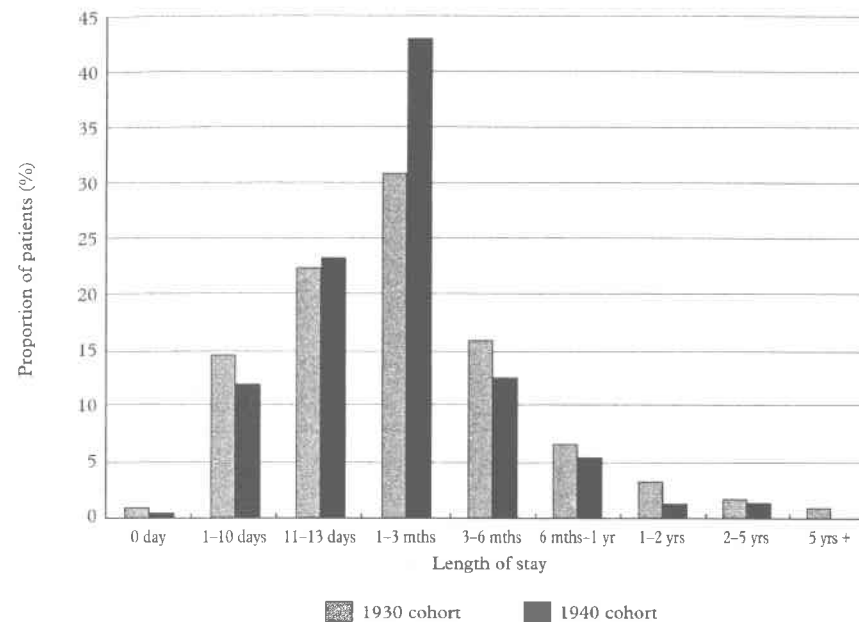


Fig. 7. Distribution of length of stay

There exists another marked difference between the 1930 and 1940 patients. Table 3 presents the outcome of the stay for the private patient admissions and residents for the years 1930, 1935 and 1940. The relative stability in the proportion of deaths (3-10%) suggests that OBKH did not become a graveyard to which dying patients were sent *en masse*. The rate of cure for new admissions rose from 2.5% to 8.6%, but that for the resident patients did not increase markedly. The clearest and most sustained trend was the increase in patients who left OBKH 'relieved' and the decrease in those who left 'uncured'. Roughly speaking, in a single decade the ratio of those relieved and those uncured was reversed from 1:2 to 2:1.

The increase in the 'relief' rate might be due to the changing diagnostic profile of the admitted patients, i.e., people were entering OBKH for complaints which were easier to relieve (but not to cure). One piece of evidence may support this interpretation, namely the decline of dementia praecox. From 1930 to 1940, the proportion of the patients who were

TABLE 3. Outcome of treatment, private patients, 1930, 1935 and 1940

	1930		1935		1940	
	No.	%	No.	%	No.	%
<i>New admissions</i>						
Cured	8	2.5	14	4.9	45	8.6
Dead	32	9.9	24	8.4	30	5.7
Relieved	63	19.4	109	38.1	211	40.3
Uncured	141	43.5	86	30.1	126	24.0
Remained	71	21.9	49	17.1	100	19.1
Others	10	3.1	4	1.4	12	2.3
Total	324	100.0	286	100.0	524	100.0
<i>Residents</i>						
Cured	2	1.5	5	4.8	3	3.0
Dead	5	3.6	11	10.6	6	5.9
Relieved	12	8.8	20	19.2	30	29.7
Uncured	48	35.0	19	18.3	16	15.8
Remained	68	49.6	49	47.1	45	44.6
Others	2	1.5			1	1.0
Total	137	100.0	104	100.0	101	100.0

diagnosed as suffering from dementia praecox decreased from 43.9% of the new admissions (both public and private patients) to 36.6% (Table 4). This decrease in schizophrenia was counterbalanced not by an increase in any major diagnostic category, but by small increases in various minor categories. There was some increase in diseases which are more neurological than psychiatric, such as epilepsy and hysteria. It does not seem, however, that these shifts were sufficient to explain the great change in the relief rate. A more convincing explanation lies elsewhere, namely, in the introduction of new therapeutics at OBKH, which matches the magnitude of the changes in the patterns of the admission and discharge in the late 1930s.

The period of the 1920s and 1930s was exciting for psychiatric therapeutics worldwide. A whole array of new 'therapies', with at least some effect in alleviating symptoms, were reported one after another (Pressman, 1998; Shorter, 1997: 190-238). Malarial therapy, insulin coma therapy, electroconvulsive therapy (ECT) and various other physical means brought a resurgence of therapeutic optimism in a medical discipline dominated by pessimism. Judging from the publications of the doctors based at OBKH and

TABLE 4. Diagnoses for patients admitted in 1930 and 1940: numbers and proportions

	1930		1940	
	No.	%	No.	%
Dementia praecox	155	43.9	203	36.6
GPI	99	28.0	136	24.5
Manic-depressive illness	20	5.7	54	9.7
Hysteria	4	1.1	21	3.8
Neurosis	7	2.0	13	2.3
Others	55	15.6	110	19.9
Unknown	13	3.7	17	3.1
Total	353	100.0	554	100.0

from the patients' records, OBKH was in the forefront of new therapeutics in Japan. The doctors at OBKH were the first in Tokyo to report their success in malarial therapy in 1926, nine years after the discovery was publicized by Julius Wagner-Jauregg in 1917 (Matsuki, 1933; Miura and Kobayashi, 1930; Nishikawa, 1930; Sugiyama, 1931). Insulin coma therapy and ECT were added to the armament of OBKH in the 1930s. Although the details of the introduction and use of these two therapies at OBKH remain to be investigated, casual browsing of patients' records confirms that these new therapies were extensively used from early on. The casebooks of about 20 patients who received insulin shock therapy during 1937 were bundled together, suggesting the results were compared and studied perhaps for publication. This was three years after Manfred Sakel at Vienna broadcast the successful treatment of schizophrenia through insulin coma. In 1940, two years after the famous experiment of ECT in Rome by Ugo Cerletti, the therapy was already used extensively at OBKH. Sampling of one box of casebooks of the 77 patients discharged in the year shows that 22 patients (28.6%) received ECT, 6 were treated by insulin coma therapy, and 4 patients received both ECT and insulin coma.

Although the surviving admission registers start just after the malarial therapy was introduced and thus do not allow assessment of its impact, its early circumstances can be elucidated through a paper written by two doctors then working at OBKH (Miura and Kobayashi, 1930). Since syphilis was a very widespread disease at that time, patients diagnosed as suffering from GPI constituted 20-40% of the admissions. The market for the new therapy was quite large. Moreover, the business of running malarial therapy was a

self-propelling one, so to speak (Miura and Kobayashi, 1930). Since the plasmodium of malaria could not survive outside the body of the mosquito or in human blood, the only way to have it available was to keep patients infected with malaria. To avoid the plasmodium from being wasted, it should be passed on from one patient to another. This also meant that, once started, the therapy cost nothing: the patient receiving the therapy provided the raw material for the next treatment. In fact, it is almost certain that the therapy was charged for in addition to fees for bed and board, perhaps according to the number of shots, although the exact charge for the therapy is unknown (Okada, 1981: 509).

It is thus no surprise to learn that malarial therapy was extensively used at OBKH. During the four years after the first experiment at the hospitals, the therapy was tried on about 250 patients, about two-thirds of all the newly admitted patients diagnosed as suffering from GPI (Miura and Kobayashi, 1930). Since GPI was a malignant and largely fatal condition when untreated, malarial therapy was attractive, with very little to lose and a good prospect of definite gain. The doctors must have found that the therapy was easy to justify to the family – and to themselves. Comments such as ‘doctors should not lose a single day to start the therapy’ or ‘some risk should be put aside and one should be brave’ reveal their optimistic and cavalier attitude (Miura and Kobayashi, 1930). Indeed, the articles betray that the doctors infected at least one patient whose symptoms definitely contraindicated the therapy for the fear of exacerbation or death which might follow the fever (Matsuki, 1933; Sugiyama, 1931). Moreover, it was also an attractive therapy for the patients. It is reported that it soon became very popular and familiar to the families (Matsuki, 1933). The very short interval between the date of admission and the date on which the therapeutic course started might suggest that many families came to the hospital with the express purpose of trying out the therapy on the patient (Miura and Kobayashi, 1930).

Although details differed significantly, it might be possible to infer some parallels in insulin coma therapy and ECT, introduced in the late 1930s; this may be justified in view of the increase in admissions, more rapid turnover, higher concentration of discharge around 1–3 months, and increase in relief rate. I should like to argue that, taken together, these major statistical findings suggest a hypothesis that a new pattern of hospitalization emerged. The new paradigm of the use of the psychiatric hospital was centred around the therapeutic course. Instead of waiting for an indefinite period for the natural disappearance of the disease, or staying at the hospital until their money ran out or until arrangements were made for care and control at home, the patients at OBKH stayed for a definite length of time, during which they received a certain course of treatment. At the end of the course of around 1–3 months, they left the asylum. Since the treatment had certain effects in alleviating symptoms, many of them were discharged ‘relieved’. Trying the treatment for a definite period, rather than staying until

TABLE 5. *Length of stay for public patients, 1930, 1935 and 1940*

Length of stay (days)	1930		1935		1940		Total	
	No.	%	No.	%	No.	%	No.	%
0	0	0.0	0	0.0	0	0.0	0	0.0
1–10	0	0.0	0	0.0	1	2.4	1	0.7
11–31	1	2.6	2	3.7	0	0.0	3	2.2
32–90	1	2.6	6	11.1	2	4.8	9	6.7
91–180	0	0.0	3	5.6	9	21.4	12	8.9
181–365	2	5.1	5	9.3	3	7.1	10	7.4
366–731	8	20.5	7	13.0	11	26.2	26	19.3
732–1826	13	33.3	22	40.7	13	31.0	48	35.6
1826 +	10	25.6	8	14.8	3	7.1	21	15.6
Unknown	4	10.3	1	1.9	0	0.0	5	3.7
Total	39	100.0	54	100.0	42	100.0	135	100.0
Average	788		683		558			
Median	959		770		499			

hospitalization was no longer possible or necessary, became the model of psychiatric institutionalization for private patients.

It should be emphasized, however, that all these exciting new developments took place strictly on the private side. On the public side, there was little sign of as great a change. Tables 5 and 6 present the length of stay and the outcome of hospitalization for the public patients in selected years. Although there were some improvements in cure rate and some shortening of the average and median length of stay, there was little sign of changes as large-scale as those on the private side. Table 7 gives the length of stay of all public patients admitted between 1926 and 1942 combined. One interesting point is the similarity between the length of stay for cured, uncured and relieved patients, for both median and average values. For private patients, the comparable figures vary considerably. This may suggest that, for the public patients, discharge was not dependent on medical conditions in a significant way. This may be one reason why the new therapeutics in the 1930s, which were actually used on at least some public patients, did not have a great impact on their patterns of stay in hospital.

Another interesting insight is gained through international comparison. If we compare the OBKH data with those from Buckinghamshire County Asylum in late nineteenth-century England, it becomes clear that Japanese public patients were discharged less frequently than their English counter-

TABLE 6. *Outcome of treatment for all public patients, 1930, 1935 and 1940*

	1930		1935		1940	
	No.	%	No.	%	No.	%
<i>New admissions</i>						
Cured	0	0.0	1	2.0	2	4.8
Dead	3	7.5	10	19.6	3	7.1
Relieved	0	0	0	0	3	7.1
Uncured	1	2.5	0	0	1	2.4
Remained	36	90.0	40	78.4	33	78.6
Total	40	100.0	51	100.0	42	100.0
<i>Residents</i>						
Cured	2	2.3	7	4.5	7	4.0
Dead	11	12.6	19	12.2	44	25.0
Relieved	0	0	0	0	3	1.7
Uncured	3	3.4	9	5.8	3	1.7
Remained	71	81.6	121	77.6	115	65.3
Others	0	0.0	0	0.0	4	2.3
Total	87	100.0	156	100.0	176	100.0

TABLE 7. *Outcome of treatment for all public patients, 1926-42*

	Number	Median length of stay (days)	Average length of stay (days)
Cured	129	491	795
Relieved	34	473	761
Uncured	39	517	822
Total discharged alive	201	500	794
Discharged dead	364	567	1132
Remaining	118	1735	2271
Transfer	11	-	-
Escape	1	-	-
Unknown	23	-	-
Total	718	698	1221

parts (Wright, 1999). While about half of English patients were discharged, the proportion of discharged patients at OBKH during 1926-42 was 28% (201 out of 718 patients). At OBKH 51% of public patients died in hospital, and for the 118 patients remaining at the hospital at the end of 1942, the malnutrition of 1944 followed. Japanese public patients also stayed longer in the hospital, with the median figure about 700 days, while the comparable figure for the Bucks patients in the mid- to late-nineteenth century was around 500 days. Among the patients discharged from the Bucks asylum, two-thirds left within a year, while at OBKH only about one-third of discharges took place within a year. It is somewhat surprising to learn that the Japanese public patients were discharged less frequently from and stayed longer in a psychiatric hospital, for, as mentioned above, the home rather than the hospital was still the normal place of care for mental patients in Japan, while in England in the late nineteenth century asylum care was much more established. This might be due to the difference in the profile of those admitted to the public asylum. It is now becoming clear that English asylums were not filled by 'pauper' lunatics: the patients were lunatics, but not always pauper. A significant proportion of them came from the respectable working class, labour aristocracy, or even from lower middle classes. In contrast, the existence of fewer beds for public patients in Japan might have forced psychiatric welfare officers to use these for the really destitute mental patients, whose poor families (if there were any) could not take the patients when discharged (Kitahara, 1995: 314). In contrast, the English asylum inmates referred to above came from relatively better-off families, who were more likely to be able to cope with their difficult and unproductive member at home. This, however, is a pure speculation and much further work is needed to substantiate these hypotheses.

Conclusion

This paper has attempted to examine the complexity of Japanese psychiatry in the two decades before WWII, through information for the Ohji Brain and Komine Hospital. For many aspects, including death rate, discharge rate and length of stay, the contrast between the public and private patients was very marked. Moreover, in the 1930s, the gap seems to have widened in terms of the length of stay and the rate of relief, due to the new paradigm of psychiatric hospitalization as a result of the new therapeutics, whose impact should merit closer and fuller examination.

I will conclude this paper with one historiographical reflection on the role of new therapeutics in the 1930s. Edward Shorter has characterized the therapies as giving asylum psychiatrists a new hope and therapeutic optimism (Shorter, 1997: 190-238). This is only partially true in the context of OBKH. Calling insulin coma and ECT an engine of therapeutic optimism does not capture the complexity surrounding their impact on the pattern of admission

and discharge. Nor does it explain the fact that the cure rate recorded by the doctors at OBKH rose by only 4% after the introduction of the two therapies. Quite understandably, the Japanese hospital doctors were not euphoric about the curative power of the new therapies.

So, is there a better way to characterize the impact of the new therapeutics? Here, the insight of the late Jack Pressman about the history of lobotomy in the USA provides an important hint (Pressman, 1998). Pressman has pointed out that the introduction of lobotomy radically changed the standard and meaning of cure and recovery within the state asylums. The large-scale changes in patients' demography which took place in the 1930s suggest the therapies' power to transform radically the meaning of hospitalization itself, both for the doctor and the patients. From the doctor's point of view, they gained a new control over the time and space of the hospital. The doctor could now assign a certain definite length of time to a patient, instead of waiting for some change to happen that was beyond medical control, whether it was cure, death, or discharge into the care of his or her family. Planning the schedule of the hospital and making effective use of the limited number of beds became possible. Doctors could now enjoy the sense (or illusion?) that they did something for the patients, instead of feeling powerless *vis-à-vis* the unstoppable long-term decay of the mind. They could also plan forward, make more efficient use of the beds, and make more profit from the larger number of patients attracted. For the family of the patient, therapy certainly offered a new hope, and this was undoubtedly a factor contributing to the large influx of private patients in the late 1930s. At the same time, I would like to suggest, the families sent the patients not merely into a new therapeutic environment – and, indeed, cure rate remained quite low even though it increased during the period under consideration; but the major merit, and perhaps the attraction, of the new paradigm was relief from uncertainty. After a relatively fixed period of time spent in the hospital and a definite fee paid, the patients would be discharged, perhaps becoming somewhat easier to cope with at home at least for a short while. In other words, staying at a psychiatric hospital became a service commodity which became psychologically easier to purchase and economically feasible to provide. The new psychiatric therapeutics of the early- and mid-twentieth century, I should like to suggest, changed not only the parameters of the psychiatric bedside, explored in depth by Pressman. They also started to transform the dynamics of the interaction between the inside of the psychiatric hospital and the outside, by somewhat lowering the hurdle of crossing the threshold of institutionalization. One should also remember that the public patients were largely excluded from the new development, even though at least some of them received the treatment, too. This discrepancy drives home the observation that psychiatric therapeutics never took place in a social vacuum. Their success, or failure, should be understood in a complex network of medical, administrative, economic, social and cultural issues.

REFERENCES

- Andrews, Jonathan and Scull, Andrew (2001) *Undertaker of the Mind: John Monro and Mad-Doctoring in Eighteenth-Century England* (Berkeley: University of California Press).
- Bartlett, Peter and Wright, David (1999) Introduction. In Peter Bartlett and David Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community 1750–2000* (London: Athlone Press), 6.
- Hiruta, Genshiro (1985) *Hayari-yamail To Kitsune-Tsuki* [Epidemics and Fox-Possession] (Tokyo: Misuzu-Shobo).
- [Japan, Department of Hygiene] (1905) *Eiseikyoku Nenpou* [Annual Report of the Department of Hygiene].
- [Japan, House of Lords] (1979–1985) *Teikoku Gikai Kizoku-In Giji Sokkiroku* [Parliamentary Debates in the House of Lords], No.12, 1900 20 Jan., and No. 21, 1900 10 Feb. (Tokyo: University of Tokyo Press).
- [Japan, Metropolitan Police] (1881–1945) *Keishi-cho Toukeisho* [Book of Statistics of the Metropolitan Police].
- Kitahara, Itoko (1995) *Toshi to Hinkon no Shakai-shi* [A Social History of the City and Poverty] (Tokyo: Yoshikawa-Kohbun-Kan).
- Komine, Shigeyuki (1919) Metabolic activities of the nervous system. *Journal of Comparative Neurology*, 30, 69–82.
- Komine, Shigeyuki (1920) Shinkei kei no shinchin-taishya kiten [Metabolic activities of the nervous system] *Shinkeigaku Zasshi* [Journal of Neurology], 19, 161–71.
- Komine, Shigeyuki (1933) Diagnostics of early mental diseases and recent therapies. *Nihon Iji Shinbun* [Newsletter of Japanese Medicine], 4(4–8).
- Komine, Shigeyuki (1938a) Johshi ni tairu igakuteki kousatsu [Medical study of lovers' suicide]. *Bulletin of the Komine Institute*, 6.
- Komine, Shigeyuki (1938b) Some thought on sterilization. *No [Brain]*, 12(9), 13–27.
- Komine, Shigeyuki (1939) Considerations on sterilization. *Osaka Iji Shinshi* [Osaka Medical News], (July), 408–14.
- Komine, Shigeyuki (1985) *Dousei-ai to Dousei-shinju no Kenkyu* [Homosexuality and Homosexual Lovers' Suicide] (Tokyo: Komine Institute, privately published).
- Kure, Shuzo (1925) *Kure Kyoju Zaishoku Niju-go Nen Kinen Bunshu* [Festschrift for the 25th Anniversary of Kure Shuzo's Professorship] (unpublished).
- Kure, Shuzo (1982) *Kure Shuzo Chosaku-shu* [Works of Kure Shuzo], 2 vols., edited by Yasuo Okada (Kyoto: Shibunkaku Publication).
- Kure, Shuzo and Kashida, Goro (1918) *Seishin Byosha Sitaku Kanchi: Jikkyo Oyobi Sono Toukei-Teki Kansatsu* [Home custody of mental patients: its situations and its statistical observations]. *Tokyo Igaku-kai Zasshi* [Journal of the Medical Society of Tokyo], 32, 521–56, 609–49, 693–720, 762–806.
- Kuwahara, Haruo and Itahara, Kazuko (1998) *Edo-Jidai Kouki ni Okeru Seishi-Shougaiha no Shogu* [The confinement of mentally disabled in Late Edo Era]. *Shakai Mondai Kenkyu*, 48, 41–59.
- Kuwahara, Haruo and Itahara, Kazuko (1999/2000) *Edo-Jidai Kouki ni Okeru Seishi-Shougaiha no Shogu* [The confinement of mentally disabled in Late Edo Era]. *Shakai Mondai Kenkyu*, 49, 93–111, 183–200.
- Matsuki, Shigehisa (1933) *Io ryoho* [Sulphur therapy]. *BKRI*, 3, 130–148.
- Matsushita, Masa-aki and Hiruta, Genshiro (eds) (1999) *Seishin-iryō No Rekishi* [History of Psychiatric Practice], Supplement No. 1 of *The Encyclopaedia of Psychiatry* (Tokyo: Nakayama Press).
- Miura and Kobayashi (1930) *Mahi-sei chihou no marariya ryoho* [Malaria therapy of the general paralysis of insanity]. *BKRI*, 1, 88–145.
- Nishikawa, Taneo (1930) *Mahi-sei Chihou Kanja no marariya ryoho* [Malaria therapy for GPI patients]. *BKRI*, 1.
- Okada, Yasuo (1981) *Shisetsu Matsuzawa Byoin-shi: 1879–1980* [Matsuzawa Hospital: A Private History, 1879–1980] (Tokyo: Iwasaki Academic Press).
- Okada, Yasuo (1982) *Kure Shuzo: Sono Shougai To Gyouseki* [The Life and Works of Kure Shuzo] (Kyoto: Shibunkaku Press).
- Okada, Yasuo (2000) *Saito Mokichi No Shougai* [The Life of Saito Mokichi as a Psychiatrist] (Kyoto: Shibunkaku Press).

- Okada, Yasuo (2002) *Nihon Seishin-ka Iryo-shi* [History of Japanese Psychiatry] (Tokyo: Igaku Shoin).
- Okada, Yasuo and Sakai, Shizu (eds) (1995) *Kindai Shomin Seikatsu-Shi, vol. 20, Byoki / Eisei* [Social History of the Lives of Populace in the Modern Age, Vol. 20, Disease and Hygiene] (Tokyo: San-ichi Press).
- Omata, Waichiro (1998–2000) *Seishin-byoin No Kigen* [Origins of the Mental Hospital], 2 vols. (Tokyo: Ora Publication).
- Parry-Jones, William L. (1972) *The Trade in Lunacy* (London: Routledge and Kegan Paul).
- Porter, Roy (1987) *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: The Athlone Press).
- Pressman, Jack (1998) *The Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press).
- Shorter, Edward (1997) *History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley and Sons).
- Sugiyama, Yohei (1931) Sesshu marariya netsu-kei to ketsueki gunkei tonon chiken [Some observations on infected malarial types and blood types]. *BKRI*, 2, 76–87.
- Suzuki, Akihito (2003) The state, family, and the insane in Japan 1900–1945. In Roy Porter and David Wright (eds), *The Confinement of the Insane, 1800–1965: International Perspectives* (Cambridge: Cambridge University Press).
- Vanja, Christina *et al.* (1999) *Wissen und Irren: Psychiatriegeschichte aus zwei Jahrhunderten – Eberbach und Eichberg* (Kassel: Eigenverlag des LWV Hessen).
- Wright, David (1999) The discharge of pauper lunatics from county asylums in Mid-Victorian England: the case of Buckinghamshire, 1855–1872. In Joseph Melling, Joseph Forsythe and Bill Forsythe (eds), *Insanity, Institutions, and Society, 1800–1914* (London: Routledge), 93–112.