The Confinement of the Insane

International Perspectives, 1800–1965

Edited by
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of cure was unable to provide even basic custodial care to patients increasingly marginalized by chronic disease, poverty and race. The history of the South Carolina Lunatic Asylum and State Hospital illustrates how the broader political, economic, social and racial context could profoundly influence the internal workings of mental institutions, and effectively undermine the aims of their founders.

8 The state, family, and the insane in Japan, 1900–1945

Akihito Suzuki

A brief look at the history of psychiatric confinement in Japan from the Meiji Restoration (1868) to the Japanese experience of the Second World War (1941–5) must give a sense of déjà-vu to those familiar with its European counterparts in the nineteenth century. A *cause célèbre* of wrongful confinement led modern Japan to the Mental Patients' Custody Act (1900), its first national legislation for regulating the confinement of lunatics. In 1919, the effort of a few eminent psychiatrists, as well as the initiative of health officials at the central government, led to the Mental Hospitals Act (1919), which promoted hospital-based provision for the insane. Under these two acts, psychiatric provision in pre-war Japan expanded rapidly in the first four decades of the twentieth century, just like its empire in the Far East. Especially when compared with the situation in England in the late eighteenth and early nineteenth century, one is struck by the similarities. When the two countries started to confine the insane on a large scale, with an interval of about one century, they were both in the turmoil of industrialization, which perhaps acted as a kind of predisposing condition to the rise of asylum. Moreover, England and Japan shared three important factors in their creation of asylum-based psychiatric provision: the impetus given by exposé of the abuse of psychiatric confinement, the initiative taken by the central government, and the establishment of a psychiatric profession.[1] The rise of journalism and 'public opinion', the re-definition of the relationship between the central and local governments, and the arrival of a professional society, all left their stamp on the making of asylumdom both in

I would like to thank Dr Kazushige Komine, who has kindly allowed me to consult the archive of Oji Brain Hospital, and Ms Kaoriko Yokozawa, whose efficient assistance has been vital to the conduct of this research. I should also like to thank Professor Ken'ichi Tomobe and Dr Takeshi Nagashima at Keio University, whose encouragement and comments have been invaluable. Parts of this chapter were read at a Seminar for the Research Group of History of Psychiatry and the International Workshop for the History of Psychiatric Hospitals, held at Keio University in December 2000. I should like to extend my thanks to those who attended the seminar and the workshop, particularly to Dr Yasuo Okada. The research for this chapter has been generously funded by the School of Economics of Keio University.

[1] For the situation of psychiatric provision in England in the nineteenth century, A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700–1900* (New Haven, Conn., 1993) remains the most comprehensive work.

Japan and England. Such similarities, obvious at a most cursory glance at two randomly selected countries, entice historians to seriously engage in in-depth and comparative socio-cultural studies in the history of psychiatry, one of the principal aims of this volume.

One can as easily spot major disparities between psychiatric provision in pre-war Japan and other European and North American countries. One of the most important differences is the sheer size of institutionalized population. Pre-war Japan confined only a fraction of the mentally disordered within the walls of asylums. In 1919, on the eve of the Mental Hospitals Act, there were only about 3,000 patients confined in mental hospitals, which is a remarkably small number for a nation of the population of about 55 million. England and Wales in the same year had about 35 million population and more than 100,000 asylum inmates.[2] The 1919 Act rapidly increased the number of those confined, but in 1940 the figure reached just around 22,000, still 'lagging far behind' countries in the West. The Second World War and post-war upheavals subsequently paralysed Japanese mental health care. The National Institute of Mental Hygiene reported in 1953 that at that time there were in Japan 18,527 psychiatric beds or 22.6 per 100,000; the corresponding figures for England was 313 beds per 100,000, 278 for USA, and 497 for New Zealand. Even Italy, another defeated power, had 134 psychiatric beds per 100,000.[3] Pre-war Japan thus did not witness the full-bloom 'great confinement', which was a common feature in many western countries discussed in this volume.

The restricted growth of asylum accommodation has been mainly explained by Japan being a 'latecomer'. From the early twentieth century through to the present, there have been abundant discourses that criticize the 'inadequacy' of Japanese psychiatric provision and relate it to the hidden 'backwardness' of a state with impressive military or economic prowess. There is considerable historical truth and moral wisdom in this line of interpretation. This view, however, masks some crucial issues, which have been the subject of intense debate in the recent historiography of psychiatry. Most importantly, criticizing psychiatric provision in pre-war Japan for 'backwardness' tacitly assumes that hospitalization of the insane was an *inevitable* or *natural* step at a certain stage of the evolution of psychiatric social policy. One of the major achievements in the history of psychiatry in the last twenty or thirty years is to have demonstrated that the 'great confinement' was a product of intense conflict, political manoeuvres, and specific historical forces, being far from a pre-destined social phenomenon.[4]

[2] Scull, *The Most Solitary of Afflictions*, 334–74.

[3] National Institute of Mental Hygiene, *Seishin Eisei Shiryo* [Sources for Research in Mental Hygiene], 1 (1953), 21.

[4] Literature on this subject is now too vast to be listed here. For a useful and insightful overview of the latest scholarship, see J. Melling, 'Introduction', in B. Forsythe and J. Melling (eds.), *Insanity, Institutions and Society: A Social History of Madness in Comparative Perspective* (London, 1999).

Without either reducing pre-war Japanese psychiatric provision to a botched attempt at mimicking western practice nor romanticizing it as an 'alternative' to western-style modernity, this chapter will try to analyse its pattern, content and shortcomings within its own context and parameters.

Particular emphasis will be laid on the role of the family. As has been emphasized by Patricia Prestwich in the French context and David Wright in the English one, the major actor in decision-making in psychiatric committals was normally the family.[5] In many cases, the family decided what should be done to control the troublesome and troubled family member; whether he or she should remain at home and under family management, or whether he or she should be sent to an institution to become its inmate, and if so, which type of institution should be utilized. The history of the family and its internal dynamics, its solidarity, and its codes of behaviour for its members, are thus a crucial part of the history of psychiatric institution in many countries in Europe. Moreover, many recent studies in the social history of psychiatry have revealed that the role of the family in psychiatric committal and institutionalization is best understood in the context of the family's interaction with its neighbours, its relationship with the local and the central governments, and its negotiation with the asylum doctors it consulted.[6] This chapter attempts to bring this family-centred contexualist model into the relatively uncharted landscape of Japanese psychiatric provision in the earlier half of the twentieth century.

The major sources this chapter uses are twofold. The first is a series of *Annual Reports of the Department of Hygiene* (*ARH*) which was issued annually by the Central Sanitary Bureau (CSB) in the Ministry of Home Affairs and, after 1938, by the newly created Ministry of Health and Welfare. Although the data published in *ARH* constitute the most basic material for any historian interested in medicine, disease and hygiene in modern Japan, this indispensable set of sources has not been used extensively by historians of Japanese psychiatry.[7] From 1905, *ARH* included detailed statistical tables of mental patients, and from 1928, a list of all mental hospitals and the numbers of patients kept in each hospital, with annual admissions, discharges and deaths. My statistical account below is drawn mainly from compiling the tables published in *ARH*.

[5] D. Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine* 10 (1997), 137–55; P. Prestwich, 'Family Strategies and Medical Power: "Voluntary" Committal in a Parisian Asylum, 1876–1914', *Journal of Social History* 27 (1994), 799–818. See also chapters by Wright, Moran and Gouglas, and Prestwich, in this volume.

[6] Two recent collections of essays that emphasize this direction are: Forsythe and Melling (eds.), *Insanity, Institutions and Society*; P. Bartlett and D. Wright (eds.), *Outside the Walls of the Asylum: The History of Care in Community 1750–2000* (London, 1999).

[7] *Annual Reports of the Department of Hygiene* for the period 1877–1926 have been reprinted as *Meiji-ki Eisei-kyoku Nenpou* [Annual Report of the Department of Hygiene in Meiji Era] (Tokyo, 1992) and *Taisho-ki Eisei-kyoku Nenpou* [Annual Report of the Department of Hygiene in Taisho Era] (Tokyo, 1993).

These aggregate data are supplemented by statistical analysis of admission registers and individual patients' case records at Oji Brain Hospital (OBH). Established in 1901 in Takinogawa in the northeast suburb of Tokyo, OBH was one of the first private psychiatric hospitals in Tokyo. Its extremely detailed, voluminous and uncatalogued case records from around 1920 to 1945 have survived intact, with other archival materials, which are now held by Komine Research Institute for History of Psychiatry run by Dr Kazushige Komine, a practising psychiatrist and historian of psychiatry based in Tokyo. From this formidable archive, I have been able to examine systematically admission registers between 1925 and 1945 and about ninety case records of the patients discharged in 1935.

As well as these hitherto unexamined materials, this chapter relies heavily on works of two outstanding Japanese scholars. The first is Yasuo Okada, whose voluminous works based on painstaking research into the history of psychiatry in Japan from the late nineteenth century onwards, deserve to be known beyond the small circle of Japanese historians of psychiatry. His history of Matsuzawa Hospital is a 650-page *magnum opus*, that (literally) chronicles the most important psychiatric institution in Japan. It will perhaps remain unsurpassed in its exemplary care about historical details and firm grasp of day-to-day activities within the hospital, where Okada himself worked in his youth as a medical doctor.[8] Okada has also excavated numerous important medical articles, newspaper reports and archival materials and has made them available through reprints with invaluable comments.[9] Less voluminous but historiographically more sophisticated are works by Genshiro Hiruta (who is also a practising psychiatrist) whose *Hayari-yamai To Kitsune-tsuki* [Epidemics and Fox-Possession] is an in-depth study of medical and psychiatric history in small villages in northern Japan in the *longue-durée* from 1703 to 1867.[10] Although Hiruta's work examined a very different area and a much earlier age than my own, his insightful arguments turned out to be a constant source of inspiration for this chapter.

The account below is divided into three parts. The first section will briefly examine the two laws which structured psychiatric provision in Japan before the Second World War, namely the Mental Patients' Custody Act (1900) and Mental Hospitals Act (1919). Emphasis will be laid on both the continuity

[8] Y. Okada, *Shisetsu Matsuzawa Byoin-shi: 1879–1980* [Matsuzawa Hospital: A Private History, 1879–1980] (Tokyo, 1981). Other major works of Okada include two biographies of pioneering psychiatrists in Japan: *Kure Shuzo: Sono Shougai To Gyouseki* [The Life and Works of Kure Shuzo] (Kyoto, 1982); *Saito Mokichi No Shougai* [The Life of Saito Mokichi as a Psychiatrist] (Kyoto, 2000).

[9] The most important collection of materials is Y. Okada and S. Sakai (eds.), *Kindai Shomin Seikatsu-shi*, vol. XX, *Byoki / Eisei* [Social History of the Lives of Populace in the Modern Age, vol. XX, Disease and Hygiene] (Tokyo, 1995). Hereafter this work is referred to as *SHDH*.

[10] G. Hiruta, *Hayari-yamai To Kitsune-tsuki* [Epidemics and Fox-Possession] (Tokyo, 1985).

from earlier times and the innovative nature of this legislation. The second part will investigate the statistical profiles of mental patients and hospitals during 1905 to 1941, and examine the rise and fall of various styles of care of the insane. Particular attention will be paid to care and confinement at home, both because official sanctioning of confinement at the patient's own home is a highly idiosyncratic practice if seen from the viewpoint of modern European practice, and because this home custody provided an important prototype for management of the insane practised in other *loci* of care. The third section will cast a brief look at the early history of OBH and its patients, in order to examine some issues discussed in the previous two sections in the context of one specific institution. The limit of the space only allows me to address a few points from this rich archive, and I will be very selective in my choice of the insights drawn from the intimate life stories of madness at mental hospitals in Japan in the early twentieth century.

Home or hospital?: Mental Patients' Custody Act (1900) and Mental Hospitals Act (1919)

Like early modern European countries, the apparently sole concern of public authorities over lunatics in Japan in earlier times was to prevent the harm done by the insane in the administrative context and to regulate penalties for crimes done under reduced mental capacity in the forensic context.[11] Particularly prominent was the fear of lunatics at large, wandering on the city street and the country field, committing or threatening violence on the person and property of others, setting fire to buildings, and so on. Hiruta's study has revealed that lunatics (who were sometimes, but not very often, regarded as possessed by a fox or other animal) in small northern villages in the Edo period (1603–1867) were put in *sashiko*, or a makeshift cage set up next to their own house. Especially furious ones were further handcuffed or chained in their cages.[12] In Edo, recourse was taken to the prisons and poorhouses for keeping vagrants and the sick poor, as well as putting the patient in the cage at his or her own house.[13] Lunatics were seen and treated in the framework of their threat of violence against themselves and others, and confinement and bodily restraint were the order of the day. In short, they posed a problem to the police, which is a familiar background to understanding insanity in many societies.

[11] For an overview of the concept of medical and legal insanity in earlier Japan, see G. Hiruta, 'Nihon No Seishin-iryo-shi' [History of Japanese Psychiatry], in M. Matsushita and G. Hiruta (eds.), *Seishin-iryo No Rekishi* [History of Psychiatric Practice] (Tokyo, 1999), 35–64.

[12] Hiruta, *Hayari-yamai To Kitsune-tsuki*, 56–126.

[13] H. Kuwahara and K. Itahara, 'Edo-jidai Kouki Ni Okeru Seishin Shougaisha No Shogu, [Management of the Mentally Handicapped in Late Edo Period], parts I–V, *Shakai Mondai Kenkyu* [Studies in Social Problems], 48 (1998–9), 41–59; 49 (1999–2000), 93–111 and 183–200; 50 (2000–1), 79–94 and no. 2, 1–45.

The Meiji Restoration in 1868 put an end to the semi-feudal rule of the Tokugawa Shogunate (1603–1867) and restored the emperor as the head of the centralized state modelled after western countries (particularly Germany). The restoration did not immediately change policies towards the insane. The emphasis on the necessity of controlling the violence of lunatics persisted, with strong associations of insanity with ferocity of animals on the loose. Early police rules of the city of Tokyo soon after the Meiji Restoration put the rules for the regulation of lunatics next to those about unrestrained and dangerous animals on the street, such as oxen, horses and mad dogs.[14] Through successive legislation between 1878 and 1884, the basic pattern for administrative control over dangerous lunatics was completed in Tokyo. When necessary, lunatics were ordered to be kept in custody either in their own house or a hospital, and the local police visited the place of their abode once a month. Although details remain to be investigated, evidence suggests that similar rules were established by local governments in other areas.[15]

Perhaps the most important element in this concern of the policing of the lunatics at large was that of the responsibility of the family for the management of its disorderly member. Although the evidence is patchy, Hiruta's examples from small villages in the Edo period and Okada's evidence from the already highly modernized and then rapidly westernized metropolis concurred on this point of the family's duty to be vigilant over their dangerous insane member. In one of the villages studied by Hiruta, when a lunatic son escaped from his father's house and killed two villagers and himself, the father was punished severely for the neglect of his duty. Half of the father's property was confiscated and he was expelled from the village.[16] The 1882 Old Criminal Code fined between 50 sen and 1 yen 50 sen 'those who failed to perform the duty of the custody of the mad and let them wander on the street'. As Okada has rightly pointed out, the lunacy problem in late nineteenth-century Japan was thus characterized by the convergence of two elements – the police and the family.[17] Perhaps the most striking element is the ease with which a prison-like facility was created in a private house with the sanction, and at the instigation, of public authority.

Predictably enough, the tradition of incarceration at home made the situation open to a type of abuse familiar in the history of psychiatry, namely wrongful confinement, or shutting up a person on the false pretence that he or she was

[14] Y. Okada, 'Seishin Eisei Hou' [Mental Hygiene Act] in *Gendai Seishin Igaku Taikei* [An Outline of Modern Psychiatry], vol. v-c (Tokyo, 1977), 351–97, 353–4.

[15] See the speech of Toshio Saito in the House of Commons in the Imperial Diet, *Teikoku Gikai Shugi-in Giji Sokkiroku* [Parliamentary Debates in the House of Commons] (Tokyo, 1979–85), 19 February 1900.

[16] Hiruta, *Hayari-yamai To Kitsune-tsuki*, 112–13.

[17] Okada, 'Seishin Eisei Hou', 353–5.

insane.[18] In 1885, the nation was shocked by the Soma case, in which a former feudal lord ('*Daimyo*') was confined under dubious pretence. The Soma case revealed the glaring defect of the system and exemplified how easily one could be confined illegally. A call for new legislation quickly gained momentum. In 1898 a governmental committee was appointed to study psychiatric laws in western countries, particularly those of England, and one high government official with a medical background agitated for a major reframing of the regulations of the insane in the light of trends in western medicine.[19] Another motive for the new legislation was to demonstrate legal maturity of Japan towards the western countries, which had still maintained a colonialist tariff policy and allowed only semi-independent status to Japan on the justification that the Japanese legal system was not modern enough for it to be granted an autonomous status in the international community. These concerns culminated in the Mental Patients' Custody Act in 1900.

This first piece of national legislation regulating the confinement of the insane aimed both at the prevention of wrongful confinement and the secure custody of lunatics. For the former purpose, the Act took a straightforward but fresh approach, by newly criminalizing unjust or improper confinement, and set heavy fines and penalties on those who detained a sane person or improperly confined an insane person, and on those doctors who issued an improper certificate of lunacy.[20] In contrast, in order to achieve the second aim, the Act not so much created something new as codified the old practice. In essence, the Act demanded that if one wanted to have a lunatic confined, one should do so by appointing a 'custodian', who was responsible for the provision, care and confinement of the patient. 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 city, town or village. When a competent custodian could not be found, the administrative head of the city, town or village in which the patient lived, would assume the status of the custodian. The place of confinement should be licensed by the administrative head and should meet special requirements for the safe custody of the patients: normally, the place was either the custodian's house or a mental hospital or mental ward of a general

[18] From the numerous studies of wrongful confinement in England, see particularly R. Porter, *The Social History of Madness* (London, 1987); M. Clark, 'Law, Liberty and Psychiatry in Victorian Britain; an Historical Survey and Commentary, c. 1840 – c. 1890', in L. de Goei and J. Vijselaar (eds.), *Proceedings of the First European Congress on the History of Psychiatry and Mental Health Care* (Rotterdam, 1993), 187–93; P. McCandless, 'Liberty and Lunacy: The Victorians and Wrongful Confinement', in A. Scull (ed.), *Madhouses, Mad-Doctors, and Madmen: the Social History of Psychiatry in the Victorian Era* (London, 1981), 339–62.

[19] Okada, 'Seishin Eisei Hou', 354–5.

[20] *Teikoku Gikai Kizoku-in Giji Sokkiroku* [Parliamentary Debates in the House of Lords] (Tokyo, 1979–1985), no.12, 20 January 1900 and no. 21, 10 February 1900.

hospital. If the custodian wanted to confine the patient at his or her own house, he should do so first by seeking permission from the local administrative head and making a petition which included a detailed plan of the place and cage. Local police and/or doctors were ordered to inspect the place of confinement 'as often as necessity arises' (how often varied from place to place). To ensure that the patient should not escape and do harm to others, he or she kept under custody at the custodian's house was put in a cage set up there. Perhaps both to allow light and air to the place and to facilitate vigilance over the confined, a latticework, with a window to serve food for the patient, seems to have been a norm. This meant extremely high visibility of the patient in confinement, and those now in their sixties or seventies still retain vivid memories of chilling horror and dark fascination when they saw a furious patient through a lattice cage.

Despite the rhetoric of modernization and protection of human rights surrounding this piece of legislation, a core part of the Mental Patients' Custody Act was a national and legal confirmation of a long-standing local semi-customary practice. First, the custody was done in a small social and administrative unit, exclusively the business of the family and/or the local authority (city, town and village). It determined who should pay the cost for confining the patient, and whether in a hospital or at a private house. In contrast, the involvement of the central or intermediate local government ('*fuken*' or prefecture) in the implementation of the Act was nil. Secondly, the pattern of the family asking the local authority for permission to confine the patient in their own house had a long tradition. As Hiruta's work has demonstrated, since the Edo period, putting a lunatic in a *sashiko* was by no means a purely private business, and there existed a fairly strict procedure: those who wanted to set up a *sashiko* had to first ask the permission of the village authority who, at the petition, examined the patient and the place of confinement and referred the case to the legal court of the *han* (a semi-independent feudal state) for the final approval.[21] *Mutatis mutandis*, this procedure was exactly what the Mental Patients' Custody Act decreed. Particularly important here is the question over who should be a custodian of the patient. Although the 'legal guardian' was named at the top of the list of possible custodians, Earl Ogimachi's explanation to the House of Lords in 1900 reveals that this was made merely for legal cosmetic purposes, in order to make this law consistent with other civil codes. The government conceived of the business of custody primarily as the private discretion of the head of the household over matters within the household, rather than that of a guardian, who could hail from outside the household and whose power was

[21] Hiruta, *Hayari-yamai To Kitsune-tsuki*, 107–11. Cases of procedure in a similar spirit are to be found also in Edo. See Yasuo Okada, 'Edo-ki No Seishin-ka-iryo' [Psychiatry in the Edo Period], in Masa-aki Matsushita and Genshoiro Hiruta (eds.) *Rinsho Seishin Igaku Kouza* [*Encyclopedia of Clinical Psychiatry*] Supplement 1 (Tokyo, 1999), 232–3; Kuwahara and Itahara, 'Edo-jidai Kouki Ni Okeru Seishin Shougaisha No Shogu'.

based upon contract.[22] The Custody Act thus officially sanctioned the 'natural' power and responsibility of the head of household over his family members, as well as nationally codifying the long-standing local and customary rules of the domestic confinement of lunatics under public control. An important aspect of the Mental Patients' Custody Act is that it did not aim for the encouragement or enforcement of psychiatric confinement. Actually, the Act made confinement more difficult, both by penalizing improper detention and by setting a standard for home custody, the cost for which (alteration to the building to meet the standard, latticework, lock and so on) was to be met by the custodian. The goal of the Act was the *regulation* of confinement, and to make it both legal and strict. The promotion or numerical increase of confinement was neither the stated aim nor the likely effect of the Act, as I shall discuss in detail below.

The expansion of confinement in hospital was exactly what the Mental Hospitals Act attempted. Again, several factors seem to have converged to effect its creation. The most prominent was the glaring fact that psychiatric provision was badly in short supply. In the House of Commons, Takejirou Tokonami, then Minister of Home Affairs, repeatedly cited the figure that only 4,000 out of 60,000 mental patients were confined in hospitals, and emphasized that this rate of confinement was far below the western standard and a 'national shame'. Another reason frequently raised at the parliament was the wretched situation of some of the patients under home custody, revealed by a massive four-part report written by the team of Shuzo Kure and Goro Kashida, the former being the leading figure in psychiatry in Japan: Professor of Psychiatry at Tokyo Imperial University and the head of the Tokyo Metropolitan Hospital at Matsuzawa (hereafter Matsuzawa Hospital), then the only public asylum in Japan. The report was far from a work of sensationalistic journalism, but was published in a leading medical journal at that time, based on a painstaking, detailed and rigorous survey of about 400 cases of home custody, conducted intermittently from 1910 to 1914.[23] I shall come back to this enormous piece of work below, but suffice it to say that Kure's condemnation of cases of home custody was no doubt a part of the almost universal strategy of psychiatrists to medicalize the realm of the care of the insane and exclude non-medical, lay or unqualified practitioners. The fact that the report included a critical and condemnatory survey of the practice of religious and folk healing of insanity betrays the ultimate motive of the authors of the report. Although their condemnation of the

[22] *Teikoku Gikai Kizoku-in Giji Sokkiroku*, 10 February 1900.

[23] S. Kure and G. Kashida, '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 (1918), cases 521–56, 609–49, 693–720, 762–806. A work in a similar vein is S. Ishikawa, 'Seishin-byousha No Kanchi Ni Tsuite' [On the Custody of Mental Patients], *Kokka Igaku-kai Zasshi* [Journal of State Medicine] 236 (1906), 779–90. Kure and Kashida's work has been reprinted and published by Seishin-igaku Shinkeigaku Koten Kankou-kai in 1973 and re-issued in 2000.

practice of confining the patient in a private house was sincere, and almost certainly motivated by genuine concern over the plight of the patients confined in a cage and exposed to the gaze of neighbours, emphasizing the horror of home custody was, at the same time, a convenient lever towards creating hospitals, which meant stable and prestigious jobs for psychiatrists and the enhancement of their role in the medical machinery of the state.[24]

Another push towards hospitalization came from a renewed and revitalized fear of the danger posed by unconfined patients. This time, however, the image of the dangerous lunatic was not the traditional one of the wild animal, but rather that of criminal monomaniacs. The fear became more intense, because these monomaniacs were apparently normal except for one single issue and thus difficult to spot, unlike the all-too-obvious savageries of classic maniacs. At the House of Commons in 1918, Kiichi Saito, an MP and the founder of Aoyama Brain Hospital, delivered a long speech accusing the government of leaving numerous dangerous lunatics at large.[25] Amid the jeering of 'Shorter! Shorter!' and 'Can't see what you mean!', Saito conjured up the dark threat posed by homicidal monomaniacs, arson-monomaniacs, theft-monomaniacs and rape-monomaniacs, the number of which were all allegedly increasing. Although the government's explanation of the purpose of the new Bill was less hysterical than Saito's panic-mongering, it nevertheless frequently referred to a handful of criminal lunatics (estimated at about 150) and talked about a plan of erecting a national hospital for confining dangerous monomaniacs.[26] The scare raised by the supposedly rapid increase of dangerous monomaniacs who lurked on the street played perhaps an important role in passing the Bill in 1919.

With these concerns as the major driving forces, the Mental Hospitals Act (1919) was conceived in a very different spirit from the Custody Act. While the earlier Custody Act was centred around the prevention of wrongful confinement and the regulation of psychiatric custody, the major aim of the new Act was the *expansion* of hospital-based public provision for mental patients. To achieve this goal, the Act empowered the Minister of Home Affairs to order the prefectures to build public asylums in which poor patients were to be kept, and that half of the cost for building the hospital and one-sixth of the cost for maintaining the patients would be covered by the central government. From the viewpoint of both central and prefectural governments, however, it must have been deemed unrealistic to expect speedy completion of a nationwide system of hospital-based provision based only on purely public resources, for there existed only

[24] The classic studies of the history of psychiatry from this perspective in nineteenth-century Britain and France are, respectively, Scull, *The Most Solitary of Afflictions* and J. Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Cambridge, 1987).

[25] *Teikoku Gikai Shugi-in Giji Sokkiroku*, 6 March 1918, a question entitled 'Why Does the Government Leave Numerous Mental Patients at Large When They Disturb the Public Order?'

[26] *Ibid.*, 23 February 1919.

one public asylum, which was in Tokyo and housed about 450 patients in 1918. In contrast, in the same year there already existed fifty-seven private psychiatric hospitals, with total capacity for about 4,000 patients.[27] Most crucially, many of the private mental hospitals admitted patients whose cost for staying at the hospital was paid by their local authority, either through the Mental Patients' Custody Act or otherwise. From the viewpoint of private psychiatric hospitals, keeping public patients brought the benefit of stable income from long-term stay, while from that of public authority, they provided a place to confine dangerously insane patients whose family could not take sufficient care of them.[28] In short, there already existed a large mixed sector in psychiatric provision. 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 were arranged to accept 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 manifest goal of all these procedures was to *expand* hospitalization, an aim which was virtually absent in the Mental Patients' Custody Act.

Another important departure from the previous Act was the role of the state, prefectures and the asylum doctor. As noted above, the Custody Act conceptualized the control of lunatics on a small social scale. The business was done by the family, relatives, neighbours and city, town or village. The Mental Hospitals Act put the care in a larger social frame, namely that of the central state and the prefecture. The cost of the provision for lunatics now would be met from the budget of the prefecture, with help from the central government as noted above. The head of prefecture now possessed enhanced powers to admit or discharge a patient to public and substitute mental hospitals.[29]

Yet another beneficiary of the new Act was the asylum doctor. Before, doctors had little power over committal and discharge, which were at the discretion of the custodian of the patient. Under the new Act, medical power increased considerably. The doctor was now able to admit or discharge the patient only with the sanction of the head of the prefecture. Having fended off the suggestion of a system of external inspection by members of the city council, the Act granted the asylum doctor tremendously increased power.[30] Likewise, the Japanese Association of Psychiatrists, a group established by Kure, acted as a

[27] Kure and Kashida, 'Seishin Byosha Sitaku Kanchi', case 524.

[28] The mutual dependence and benefit of the public and private asylums in Tokyo is satirically described in the serialized articles in *Yomiuri Shinbun* [Yomiuri News]. See *SHDH*, 183–223.

[29] For an account of the fierce debate at the Diet over this enormous discretion given to the head of prefecture, see M. Yuasa, 'Lectures on the Mental Hospitals Act', *Shinkei-gaku Zasshi* [Journal of Neurology] 19 (1920), 488–94 and 543–50.

[30] *Ibid.*

kind of professional consultant group for the law makers at the Central Sanitary Bureau and executor of the policy at the Metropolitan Police, and had a certain say both in legislation and administration of the Act.[31] Although the archive of the association reveals more humiliation and bitter compromise of the doctors vis-à-vis the high-ranked civil servants at CSB and the Metropolitan Police, the chance to negotiate with those who virtually ran Japan and Tokyo was obviously greeted by its members aspiring for a secure place in the machinery of the state.[32] The role and the power of psychiatrists in the new Act thus grew to a considerable extent, when compared with those defined in the Custody Act, which referred to doctors mainly in the context of punishing their misconduct. The new Act thus signalled the rise of the state, the prefecture, and the psychiatrist vis-à-vis the family and the local government.

Progress of confinement or persistence of domestic care? Statistical analysis of psychiatric patients

In order both to assess the impact of the two Acts and to detect the trends which prompted the legislation, as well as to describe the general picture of psychiatric patients in early twentieth-century Japan, I should like to turn to the presentation of statistical data and their analysis, compiled from tables in the *ARH*.

Any discussion of psychiatric provision should start with a basic question, namely, the number of patients. Figure 8.1 represents the numbers and rate (per 10,000) of the known mental patients from 1905 to 1941, published in *ARH*. The figures were calculated by health officials by adding up the numbers of three categories of patients, namely: (1) those who were found by a visiting police officer as insane but regarded as 'unnecessary to be confined'; (2) those who were confined (either at home or in institution) under the Mental Patients' Custody Act; and (3) from 1919, those who were put into mental hospitals under the Mental Hospitals Act.[33] During the period under consideration, both the actual number of the patients and the rate per population sharply increased, the former having more than trebled and the latter having doubled. This growth is rather difficult to interpret, like so many data in psychiatric epidemiology. Did the increase in figures or rates represent real increase in disease occurrence, lowered tolerance towards the behaviour of the insane, or more effective detection? Although many early twentieth-century Japanese commentators on

[31] K. Komine (ed.), *Nihon Seishin Byou-i Kyoukai Kiji* [Archives of the Japanese Association of Psychiatrists], (Tokyo, 1974).

[32] *Ibid.*, 1–45.

[33] In addition, a small number of patients (about 100–200) who were 'temporarily confined' were added to the figure. Also note that the figures in the tables published in *ARH* did not include those who were put in a place of confinement through a procedure based neither on the Mental Patients' Custody Act nor the Mental Hospitals Act. For a further discussion on this omission, see note 51 below.

psychiatric issues maintained that the occurrence of mental disease was growing in accordance with the modernization of Japan, the Central Sanitary Bureau was well aware that this type of argument did not hold true, even with a most cursory look at the evidence. In its first report on mental patients in 1905, the CSB pointed out that although major urban areas such as Tokyo or Kyoto showed relatively higher rates, the correlation between mental disease rate and the extent of modernization ended just there. Osaka, with the second largest city in Japan, had the second *lowest* rate, while rural areas such as Iwate, Saga and Okinawa had higher rates.[34] The pattern of regional variations in mental disease rate continued to baffle the simple scenario of the link between civilization and madness until the end of my period.

More promising is the line of argument that sees the growth in rate as a result of increased awareness of those troubled in mind. Without adhering to the simple scenario of linking civilization with intolerance toward madness, there exist several reasons to suppose that some part of the increase of mental disease during this period resulted from more effective detection of lunatics. Among the factors which might have contributed to making the insane more visible, the most powerful one is the public cult of emperor. The colossal ceremonies for the burial of the old emperor and the accession of a new one involved a massive policing of the entire population all over the nation and colonies.[35] In order to prevent any disruption of the sacrosanct sobriety of the ceremonies, an enormous number of local and special policemen were deployed to remove the slightest possibility of disorder. At the accession of Emperor Hirohito, according to a study by Yutaka Fujino, the particular target of scrutiny was the 'Other' in the Japanese society at that time – Koreans, socialists, the urban poor, those suffering from communicable diseases and the insane. To take an example of Hyogo, a round-up survey of *all* households for mental patients and other undesirable members of society was completed in ten days. Wandering madmen were sought during three days from 7.00 a.m. to 4.00 p.m., which led to the discovery of 229 new patients.[36] Also imperial rituals of a more modest size were accompanied by intensive search for mental patients. Indeed, in 1939 a doctor in Hiroshima tried to interpret the high patients' rate of the prefecture (twice as much as the national average) to frequent visits of the royal family to important shrines in the area.[37] The erection of the mausoleum of Emperor

[34] *ARH* (1905), 59–60.

[35] Central Sanitary Bureau, *Showa Tairei Eisei Kiroku* [The Hygienic Report at the Showa Grand Ceremony of Accession], (1929), reprinted in *Showa Tairei Kiroku Shiryo* [The Records of the Showa Grand Ceremony of Accession], introduction by H. Nishi, F. Ogino, and Y. Fujino (Tokyo, 1990).

[36] Y. Fujino, 'Showa Tairei To Minshu No Seikatsu To Kenko' [The Showa Grand Accession Ceremony and People's Health]', in *Showa Tairei Kiroku Shiryo*, 65–86.

[37] 'A Round Table for Mental Patients' Protection Day', *Wako* [Harmonious Light] 6 (1939), 91–108, 97. One police officer at the round table, however, refuted this argument by citing the low rate of Mie, another prefecture visited frequently by the royal family.

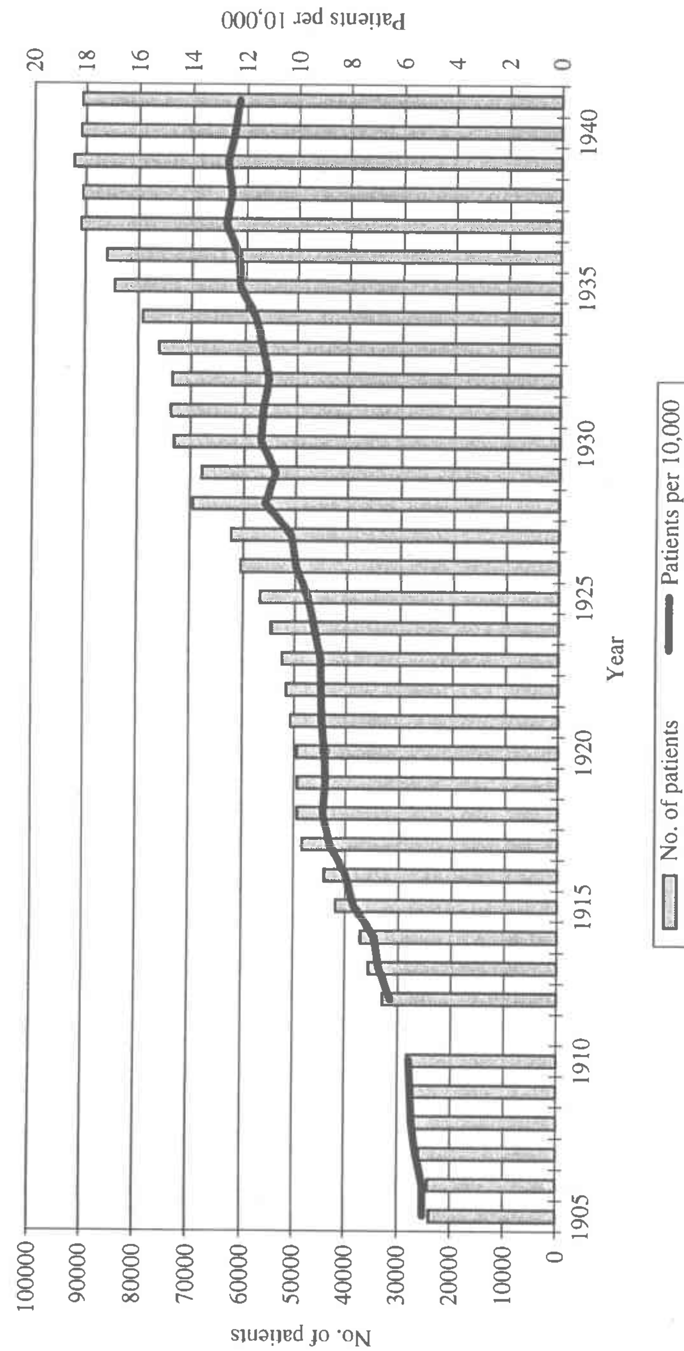

Figure 8.1 – Number of patients

Yoshihito in 1926 in Tama Hill in the west of Tokyo and the increased concern of the police to guard the sacred place, led to tighter regulation of patients staying for hydrotherapy at waterfalls in Takao, a mountainous region close to Tama.[38] An increasingly intense cult of the emperor in the early twentieth century, and the resultant intense scrutiny of the population must have contributed to the steady rise of the number and rate of the patients.

On closer examination, however, it turns out that the extent of the contribution of the search for the undesirable elements of the population was not very great. Figure 8.1 shows two periods of rapid increase in the reported rate of mental disease, namely in 1911–18 and 1924–35. Although the beginning of the first sharp rise coincided with the coronation of Emperor Yoshihito, the start of the second rise was prior to the accession to the throne of Emperor Hirohito. Moreover, it should be noted that those two intense phases of massive surveys did not necessarily result in the increase in institutionalization. Figure 8.2 shows: the number of patients hospitalized; the number of the patients confined in 'other places'; the rate of those hospitalized against the entire patients' population; and the rate of those in 'other places' against the entire patients' population, again from 1905 to 1941.[39] Although the number grew almost steadily, the rate of confinement both in the hospital or at 'other places' remained almost stable during the two phases of rapid growth of the number of the patients. In fact, the rate of those put under home custody sharply declined during the first rapid rise of the number of registered patients. This almost certainly suggests that the intense search of the population in preparation for the sacred ceremonies did not lead to confinement of the insane, either at home or in hospital. At least at the national level, *pace* Fujino, the direct impact of imperial rituals on the *confinement* of the insane does not seem to have been great.

The patients under home-custody will be our next subject of attention. Although the number of the cases of home custody slowly grew, their proportion to the entire patient population was in constant decline during the entire period (Figure 8.2). If examined vis-à-vis hospitalization, the growth in home custody was clearly outstripped by hospital provision. During the period 1905 to 1940, home-custody cases only doubled, while the hospitalized population grew 9.2 times. Certainly the Japanese psychiatric provision in the early twentieth century

[38] W. Omata, *Seishin-byoin No Kigen* [Origins of Psychiatric Hospitals], 2 vols. (Tokyo, 1998–2000), I, 67–8. Omata's work is based on staggeringly ambitious research, collecting numerous pieces of patchy evidence from more than a millennium of Japanese history.

[39] The exact details of the category of 'those confined at other places' remain elusive. Perhaps they included those kept at municipal poorhouses, as well as the home-custody cases. Numerically speaking, no doubt the most important contribution was made by home-custody cases. Fragmentary evidence suggests that municipal poorhouses were far from a major player in the provision for the insane. In 1918 Kure estimated that about 200 patients were confined in such places all over Japan, while in the same year 4,750 patients were confined 'at other places'. Kure and Kashida, 'Seishin Byosha Sitaku Kanchi', case 524.

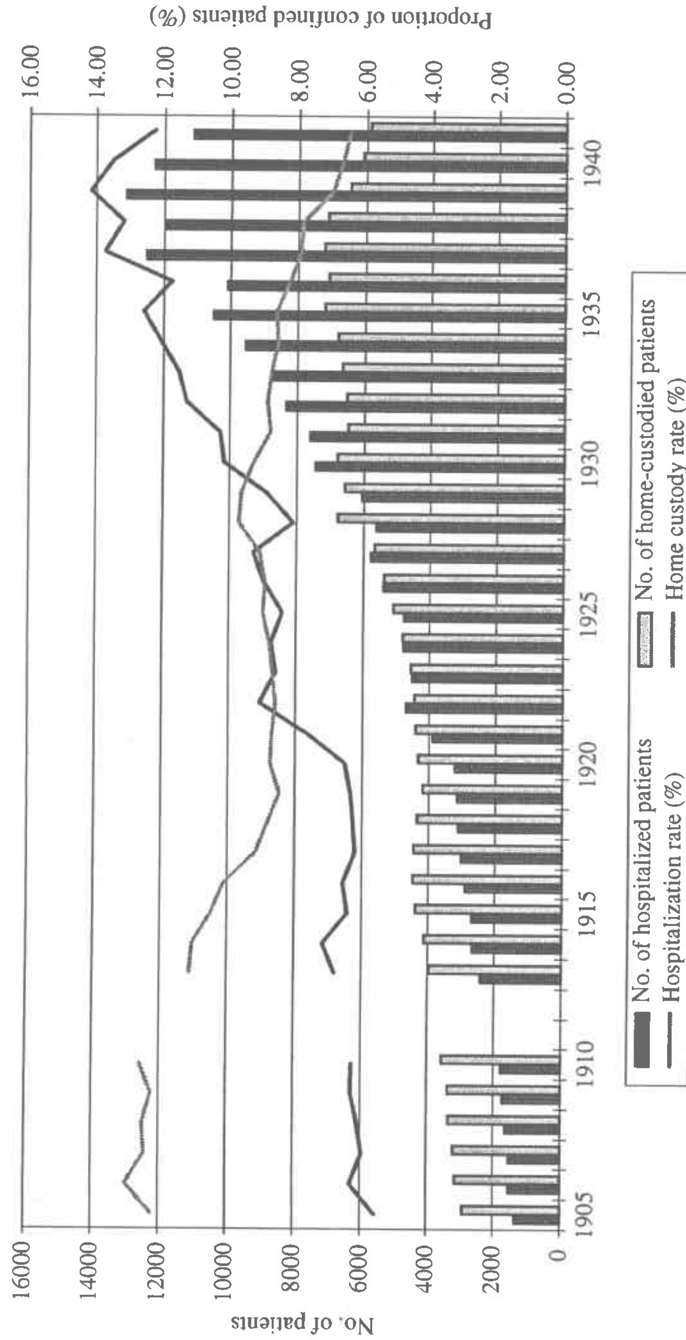

Figure 8.2 – Patients confined in hospitals and at home

witnessed a marked shift in the locus of the confinement of the insane, from their own private home to the hospital governed by a doctor. Especially important was the period of the most sharp decline in the custody rate, which took place from about 1911 to 1920. This suggests that, proportionally speaking, home custody was a means of confinement which was becoming increasingly unpopular, even *before* the passing of the Mental Hospitals Act. Perhaps this decline in home custody had something to do with the urbanization of early twentieth-century Japan. Although there is no conclusive evidence at the national level, home custody seems to have been a rural phenomenon, while hospitalization was an urban solution to the problem posed by insanity.[40] Exactly why urbanization prompted confinement in a hospital instead of at one's own house is unclear. Availability of mental hospitals in cities, sheer lack of space to set up a cage in terraced-houses in major cities, urban sensibility and sense of privacy, and the internalization into urban mentality of the cultural hegemony of medical discourse – all these factors might have contributed to the relative decline of home custody.

Nevertheless, one should not mistake the early signs and dawn of asylumdom with its full arrival: the number of home-custody cases continued to grow until the late 1930s, and it remained a crucial part of the psychiatric provision during the entire period under consideration. Hospitalized patients outnumbered those confined in 'other places' only in the early 1930s, and one-third of confined patients were still placed at home in 1940. Although the private-house-custody is still a historical *terra incognita*, there existed a colossal and invaluable survey conducted by Shuzo Kure as noted above.[41] Kure sent fifteen students and assistants of his to fifteen prefectures to personally visit about 360 patients under home custody, interviewing the patients and their families, sketching the plan of the place of the custody, and photographing the cages as well as the patients. The surveyors spent several days or a few weeks in each area during the summer. Apart from a few cases, the majority of cases were clearly in rural areas. As noted above, the apparent ultimate motive of this survey was to demonstrate the shortcoming of home custody and promote hospital or asylum care, a finding which is more than predictable from the professor of medicine who had studied in Germany and who was at the time involved in the installment of a non-restraint system at Tokyo Metropolitan Asylum at Matsuzawa. The general impression one gets from the survey is, however, not propaganda for asylum care and against home custody, but an

[40] Although no correlation can be statistically established at the national level between urbanization and the ratio of hospitalization or home custody, two prefectures with remarkable high hospitalization rate remained Tokyo and Osaka.

[41] Kure and Kashida, 'Seishin Byosha Sitaku Kanchi'. For a detailed account about the making of this paper, see Y. Okada, K. Komine, S. Yoshioka, 'The Making of "Home Custody of Mental Patients" ', *Rinsho Seishin Igaku* [Journal of Clinical Psychiatry] 13 (1984), 1457–69.

Table 8.1 *Types of places of custody*

Detached cottage	8
A room in another house	19
Warehouse	12
Shed	43
In the main house	43
Extension to the main house	18
Extension to the warehouse	4
Unfloored part of the main house	7
Kitchen	3
Others	5
Not in the private abode	13
Total	175

even-minded and rigorous social survey, which requires some closer attention here.

Reflecting that home custody was practised widely across the social classes, the situation and quality of home custody varied greatly. The place of custody varied from purpose-built detached house within the same premises, refurbished warehouse close to the main house ('*dozo*', a common feature for wealthy agricultural households), a part of the main living space ('zashiki'), to a part of a shed ('*mono-oki*', a place to store tools and straws), a shabby extension to the main house, a cage set up in an unfloored part ('*doma*') of the house (see Table 8.1). Although the space of the cage also varied according to the wealth, space availability, and perhaps the extent of compassion towards the patient, mostly each cage was about 3.3 m^2. Personal care of the patient by the family also varied. Some families treated the patient with exemplary kindness and attention, others did not hide their hope to be able to get rid of the patient. One thing in common in those hugely varying places of confinement was the wooden bars or lattice, which seems to have been almost compulsory in order to be approved by the local police. Although seeing a combination of a cage and private home is surreally shocking to our modern sensibility, the lattice allowed the light and the air to the space. Also it secured high visibility of the patient, which must have facilitated vigilance and supervision, as well as exposed the antics of lunatics through the latticework to neighbours and visitors to the house.

An important insight is gained through the analysis of the reasons given for the custody (see Table 8.2). The reasons given by the families reveal an important aspect which has not been fully addressed by historians who have studied the Custody Act. It is true that some of the patients were obviously put under home custody through the concern of the police to confine disorderly and dangerous elements and to secure public order. The reasons attributed to 'public order' in the list above are, however, a decided minority. 'Offence against public

Table 8.2 *Reasons given for home custody*

Domestic violence against person and property	145
Violence to persons and property of others	90
Wandering and vagrancy	72
Arson and threat of arson	31
Offence against public morals	9
Attempted suicide	9
Intrusion into field and woods	7
Intrusion into public places	6
Violence at religious places	2
Public disobedience	1
Others	43
Total	415

morals', 'intrusion into public places', 'violence against religious places' and 'public disobedience' comprise only 4 per cent of the total. By far the largest category is that of 'domestic violence', which suggests that the major motive for putting the patient in custody at home was for the family to protect themselves from the violence and disturbance of an insane person who lived with them, and to facilitate the management of the unruly and dangerous member. The second largest category was that of violence against the person and property of others. In the context of a rural community, this 'others' must have meant 'neighbours'. A culture of domestic responsibility as well as law made the family members responsible for the safe-keeping of their insane family member. If the lunatic at large committed some misdemeanour, the family would be morally blamed by their neighbours, as well as facing the possibility of criminal persecution. The predominance of these two categories clearly demonstrates that home-custody cases were prompted by concrete concerns generated in a small social world of the family and the local community. The initiative for home custody mainly came more from the interaction, negotiation and shared beliefs between the family and the local neighbourhood than from the dictates of public authorities. The role of the public authority, with its concern over public security, was perhaps that of *encouragement* and *sanctioning* of the family's recourse to home custody, not its *enforcement*.

Another important insight gained from this report concerns the attitude of the surveying medical students to the practice of home custody. Despite the sonorous condemnatory tone assumed by their mentor Kure in the end-product of the survey, some students did not universally find signs of glaring cruelty, abuse, or neglect in the places they visited. Actually, their reports suggest their ambivalent attitude towards asylum care and hospitalization. One of the visiting students, Tamao Saito wrote about the area he had visited:

> This prefecture is a place of small industries, with the gap between the rich and the poor still small. Each household has modest property, and the people's behaviour is not very competitive. Accordingly, chronic mental patients are taken care of by their neighbours, and a few wander on the street. This state, however, will not continue for long. The population will grow year by year, highways will be opened, and major industries will arise. Then, if the poor and the weak become insane, their only help will come from the public and the state.[42]

Here, one can sense a kind of nostalgia for a 'traditional society' which modern Japan was quickly losing. Saito appears to have believed that, in this mythical world of the traditional society, people had been kind to each other, and the able helped the unable within their community. He was, however, sure that this idyllic society would before long be washed away by the merciless advent of capitalism. The public psychiatric hospital was, Saito seems to have believed, only necessary in the harsh society whose ominous arrival was impending. He was a half-hearted modernizer, so to speak.

We should now direct our attention to the mental hospital, Saito's antidote against an evil capitalist society. Figure 8.2 clearly shows the rapid growth of psychiatric institutions during our period. The absolute number of institutionalized patients grew more than nine times, and the rate of those hospitalized per population grew nearly three times. It also establishes the impact of the Mental Hospitals Act, which took effect in 1923. The rate of institutionalization had stagnated until 1922, after which the rate increased rapidly until the late 1930s.

After the Mental Hospitals Act, there existed three categories of mental hospitals. First, there were public hospitals, which were maintained at the cost of prefectures with help from the state, and which accepted (mainly) public patients. Second, there were substitute hospitals, which were maintained as private businesses and accepted private patients, 'substitute' patients supported by the prefecture and the state, and public patients whose fee was paid by the city, town or village. Third, there were private hospitals, some of which accepted only private patients, but many of them keeping both private and public patients, but no substitute patients.

The first public psychiatric hospital in Japan opened in Kyoto in 1875. It was situated on the premises of Nanzenji Temple. This venture lasted only for seven years and in 1882 was sold to a doctor who renamed it Kyoto Private Mental Hospital (later Kawagoe Hospital). Before 1920, the only public psychiatric hospital in operation was Tokyo Metropolitan Mental Hospital formerly in Ueno and Sugamo and then at Matsuzawa, in the western outskirts of the suburb. This housed about 350–450 patients between 1905 and 1920, about 700 patients in the 1920s and, after 1930, about 1,000 patients. In 1926 a second public asylum with a capacity for 300 patients opened in Osaka, which soon expanded its capacity

42 Cited in *Ibid.*, 1464.

to 450. These were followed by one in Kanagawa (1929), Fukuoka (1931), Kagoshima (1931), Aichi (1932) and Hyogo (1937), all created through the Mental Hospitals Act.[43] By 1940, there were seven public hospitals operating. These public asylums, however, housed a distinctively small share of patients. In terms of their size many remained modest: Tokyo excepted, each housed only 120–400 patients, whereas in England the average number of inmates per public asylum exceeded 1,000 in the early twentieth century. The limited provision at public asylums means that the burden of the mass-hospitalization was born by privately run mental hospitals, either substitute or private ones. In 1928 there existed about seventy privately run mental hospitals, and in 1941 the number grew to 160. The ratio of patients at public hospitals to all institutionalized ones remained below 20 per cent between 1921 and 1941. Public mental hospitals in Japan played a decidedly small role in actually carrying the burden of the growth of institutionalization in the early twentieth century. The task was done by privately run hospitals.

The conceptual prototype of these numerous private institutions for the insane was inns built around religious places of healing, such as Shintoist shrines, Buddhist temples, and waterfalls.[44] During the Edo era, a highly developed market economy and the completion of major highways both by the Tokugawa Shogunate and local feudal lords facilitated a travel and tourist industry. Numerous hot-spring baths boasted inns built around it for those who sought the pleasure of bathing as well as cure from various chronic diseases. Profit-making institutions built around places of religious-medical healing were a common business in Edo Japan. In the late eighteenth and early nineteenth century, the Daiunji Temple in Iwakura in northern Kyoto had several inns for those seeking a cure from diseases of the head and the eye. These inns merged with each other and developed into a private mental hospital established there in 1884.[45] Similar patterns abounded elsewhere, in which a guesthouse catering for the patients staying at the place of religious healing of insanity evolved into a centre of care or private asylum.[46] The ways in which early private psychiatric hospitals in Tokyo attempted to attract patients betrayed their inn-like character, although many of them did not have their origins in the hotel business. Tokyo Mental Hospital, the largest private asylum in 1903, sent touts to the gates of the Tokyo Metropolitan Asylum, in order to catch and steer the patients to their own institution, and Tokyo Brain Hospital set up a large billboard next to the public asylum, stating 'IN-PATIENTS INFORMATION OFFICE'.[47]

43 Except in Kagoshima, these prefectures were all urbanized and industrialized areas.
44 Omata, *Seishin-byoin No Kigen*, I, 47–192.
45 N. Kato, 'Iwakura Wo Shu-To-Shita Minkan Ni Okeru Seishin Iryou-Shi' [History of Folk Psychiatric Therapy, with Particular Emphasis on Iwakura], in Matsushita and Hiruta (eds.), *Seishin-iryo No Rekin*, 237–50.
46 Omata, *Seishin-byoin No Kigen*, I, *passim*.
47 *SHDH*, 207–8, 214–15.

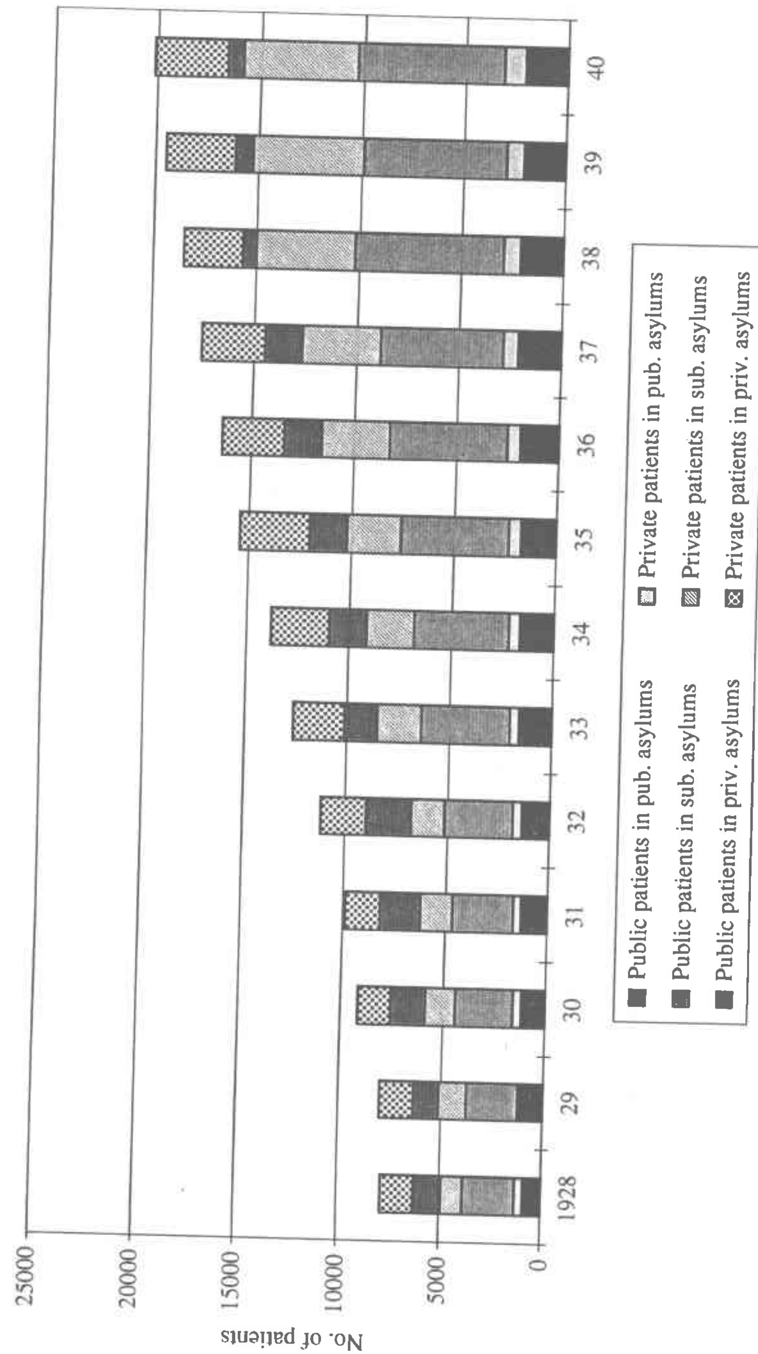

Figure 8.3 – Public and private patients in public, substitute, and private asylums

These touting and advertising activities suggest not only the commercial nature of the early private psychiatric hospitals in Tokyo but also the close liaison between the public sector and the private one in psychiatric provision. The public asylum in Tokyo played the role of the magnet attracting the patients, some of whom were directed to the profit-making sector, in a way very similar to the situation in eighteenth-century London, where two public hospitals for the insane (Bethlem and St Luke's) stimulated the growth of private madhouses.[48] For private institutions in Tokyo, personal connection with public officers was crucial to secure the patients. An officer of the Hygiene Department of the Metropolitan Police contributed money for the foundation of Toyama Hospital for Lunatics, and Tokyo Mental Hospital forged close ties with the hygiene officers at the boroughs of the metropolis.[49] In 1906, about one-third of 601 patients hospitalized by the cities, towns and villages in Tokyo were sent to the private hospitals. In 1918, on the eve of the Mental Hospitals Act, the rate increased to about one-half.[50] The 'substitution' clause of the 1919 Act confirmed this close interdependence between the private and public hospitals, and under this Act both sectors grew hand in hand, creating a large mixed sector in psychiatric provision. The public sector needed the private facilities in order to supplement its severely limited provision, and the private sector wanted the supply of patients and income from the public sector.

The mutual stimulation between the public and private sector seems to have been the main engine behind the increased institutionalization of the insane. Figure 8.3 itemizes the patients in mental hospitals into six categories: patients supported in public asylum at public cost and paying patients in public asylums; patients in substitute asylums at public cost (including substitute patients and other public patients) and paying patients in substitute asylums; patients supported in private asylums at public cost and paying patients in private asylums. Both paying and public patients at public asylums grew steadily but slowly, whereas private asylums kept increasingly larger number of patients until the late 1930s, when they changed status to 'substitute' hospitals and their numbers dwindled. The largest increase in terms of numbers came from respectively public and paying patients kept at substitute asylums. If we lump together the substitute and non-substitute private asylums into 'commercial' and examine the *proportions* of paying and public patients kept there as well as those for public asylums, we get the results shown in Figure 8.4. Purely public patients (patients kept at public asylums at public cost) remained stable or declined very slightly in terms of proportion. The contribution of the mixed sector, i.e., public patients kept at commercial (both substitute and non-substitute) asylums

[48] For the close link between charity and voluntary hospitals for the insane and the profit-making institutions in England in the eighteenth century, see R. Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London, 1987).
[49] *SHDH*, 196 and 208. [50] *ARH* (1906) and *ARH* (1918).

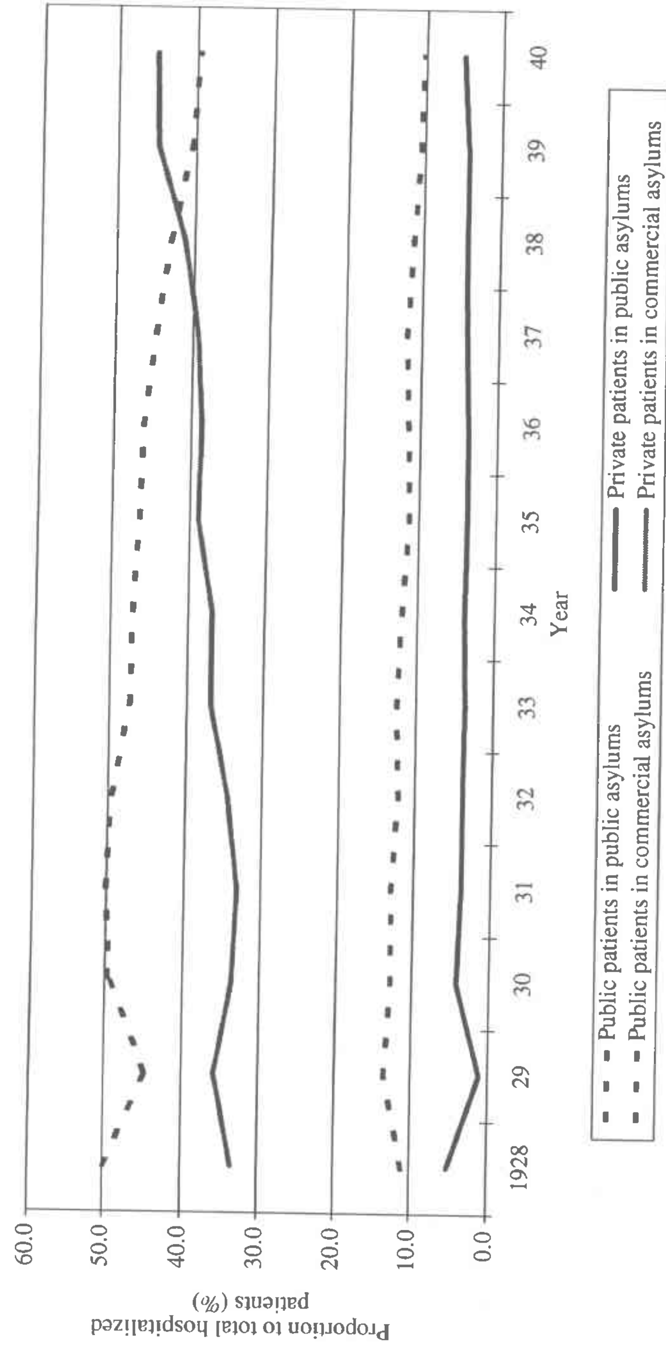

Figure 8.4 – Proportions of public and private patients in public and commercial asylums

declined gradually but more markedly. The sector that had the largest share in 1939 was the private sector, private patients staying at commercial asylums. The numerical and proportional growth of the private sector tells a hitherto little noticed factor in the rise of mental hospitals in pre-war Japan, namely 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 clients with *demand* for psychiatric service made the greatest contribution to the making of a society that segregated a large number of the insane.

It should be emphasized, however, that one should not call this a 'great confinement'. Figures 8.5 and 8.6 show the numbers of entire known patients, and those patients regarded as not needing confinement or custody, with the latter's ratios to the former from the years 1905 to 1927 and from the years 1928 to 1941.[51] These two figures conclusively show the persistence of informal domestic care without recourse to either hospital or home custody, long after the Mental Patients' Custody Act and Mental Hospitals Act. Although the ratio declined steadily from 79.5 per cent to 70.8 per cent from 1928 to 1941, at the end of the period, we are still talking about a society that put only about 30 per cent of publicly recognized psychiatric patients in confinement.

The everyday lives of those who were left to the family or 'at large' are hard to know, and here again the survey by Kure throws invaluable light on the lives of the largest category of patients. Kure's students were able to find and interview eight patients publicly recognized as insane but not in home custody.[52] One of them, a lower civil servant, was forced to live on rotten *tatamis* and his son 'does not treat the father with kindness', although the patient was not under

[51] Figure 8.5 and Figure 8.6 represent slightly different categories of patients. Figure 8.5 represents only those confined under the two Acts. Figure 8.6 represents those actually confined in mental hospitals. The general table of mental patients of the *ARH* had included only the number of patients hospitalized, confined, or put in custody either through the Mental Patients' Custody Act or through the Mental Hospitals Act, until 1939. In that year, however, the table started to list patients who were 'hospitalized or confined NOT through the two laws'. This is not a minor group of patients: 9,979 patients coming under this category in 1939. Looked at in detail, this group could be broken into: (1) private patients in private and substitute mental hospitals, (2) public patients supported in private and substitute mental hospitals outside the two laws, (3) patients in the psychiatric wards of hospitals for medical schools, (4) patients in the psychiatric wards of general hospitals, (5) patients maintained in non-medical places of confinement, and (6) patients maintained in nursing homes at temples, shrines and waterfalls. From 1929 on, the exact figures for the sum of categories (1) and (2) were available in table of mental hospitals annually published in *ARH*. The numbers of categories (3) – (6) were, however, unavailable in any of *ARH*. Fortunately, we have exact figures for the numbers of the four types of institutions and their capacity for the years 1929 and 1935, and of the actual number of patients for 1929. Figures for 1929 are taken from the Department of Hygiene's *Survey of the Places for Confining Mental Patients* (1929). Those for 1935 are taken from Osama Kan, 'Hon-Pou Ni Okeru Seishin-byosha Narabini Kore Ni Kinetsu Seru Seishin-Ijousha Ni Kansuru Chousa' [Statistical Survey of Mental Patients and Similar Mentally Abnormals in Japan], *Shinkei-gaku Zasshi* 41 (1937), 793–884. See table 8.5.

[52] Kure and Kashida, 'Seishin Byosha Sitaku Kanchi', cases 106–14.

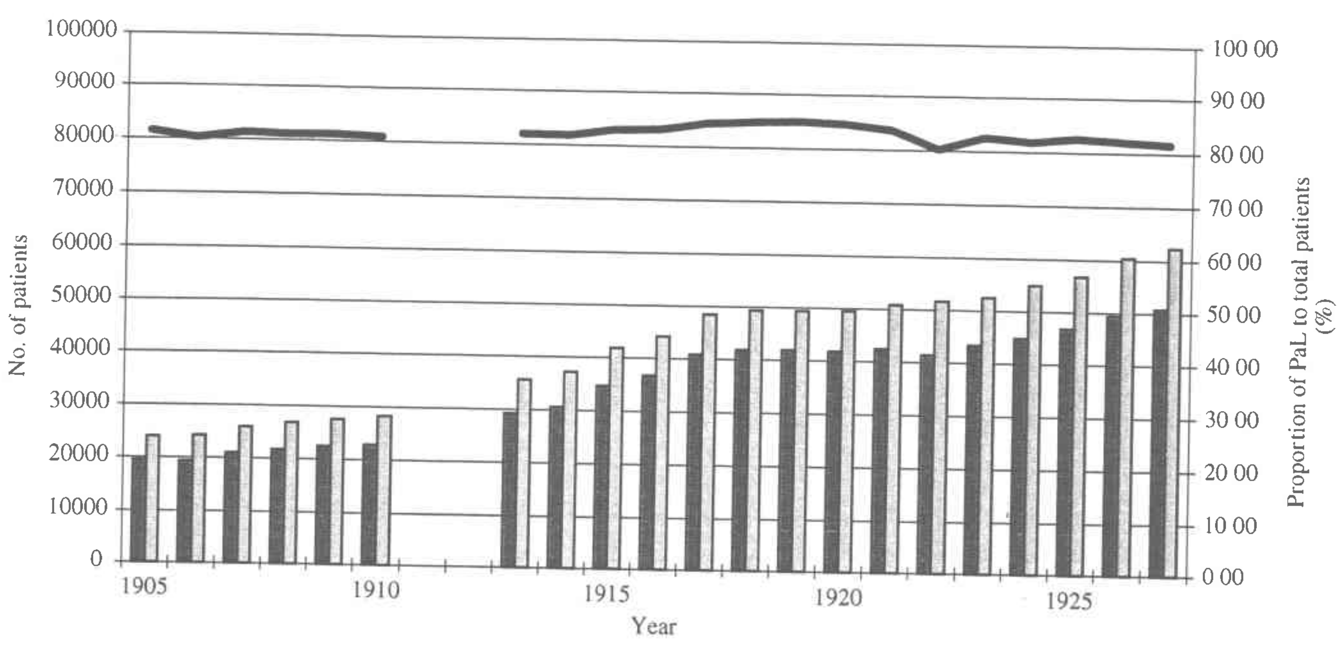

Figure 8.5 – Patients at large (PaL), 1905–1927

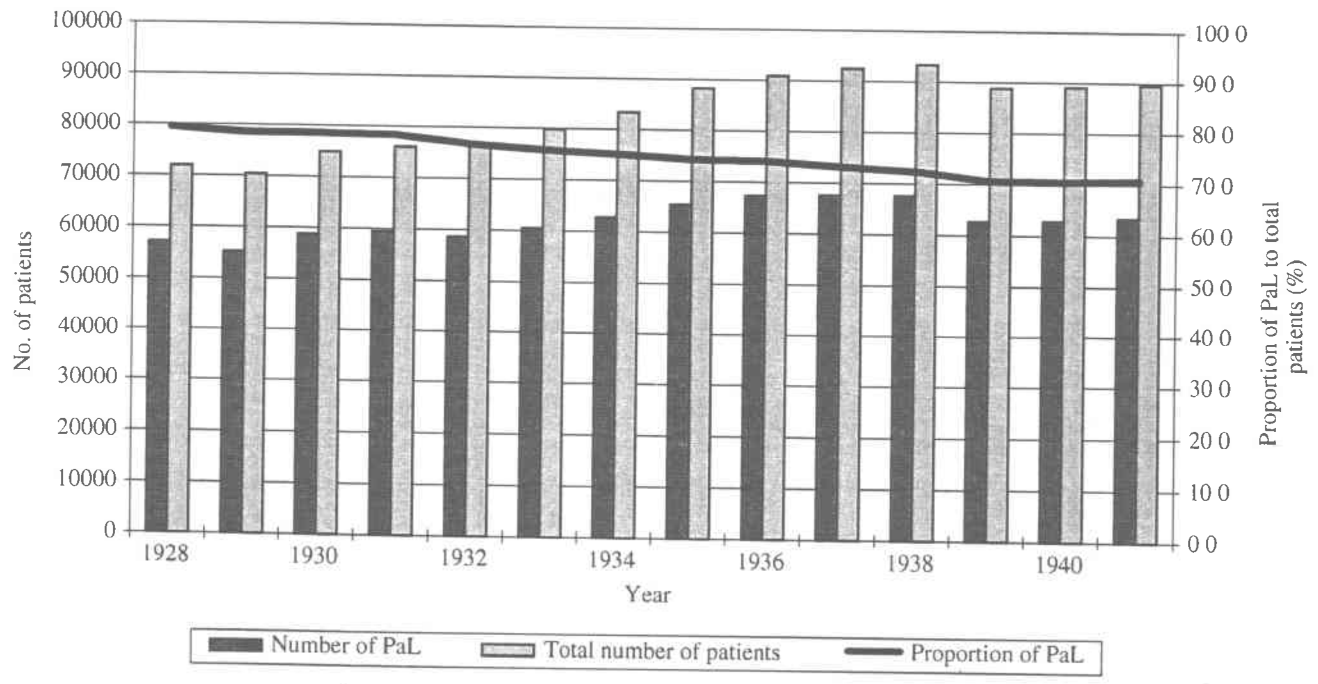

Figure 8.6 – Patients at large 1928–1941

threatening or instrumental coercion. Another patient was reported that 'he does not receive any particularly kind treatment from the family due to his disease', and quarrels with his younger brothers and sisters. Despite these somewhat critical comments, the surveyors did not find widespread glaring abuse or cruelty. Also it should be emphasized that the demonstration of particularly praiseworthy care was rare. In one case, the brother of a female patient made her open and run a haberdasher's shop without any hope of making profit, which must have been conceived both as a kind of work therapy and as a way to keep the outlook of normality. Such generosity was, however, an isolated expression of special concern in the eight samples of Kure, and is highly unlikely to be prevalent in the vast number of the mental patients at large. The common picture emerging from Kure's sample is a life of dependent, sub-normal, troubled, but essentially the same life as the rest of the family. Many patients were 'left to themselves' and the families 'don't meddle with the patients'. They were made to do what work they could. One of them volunteered for outside work without telling her family, for she wanted to be useful.[53] One was explicitly stated to be taking meals with the family.[54] They were not treated either with particular kindness or with particular cruelty. As an disabled person living with able family members, they may have been a source of irritation and no doubt received at least occasional scolding or even punishment. But conflicts or minor punishments were a part of normality in life, without the status of 'sick role', and they do not necessarily mean active cruelty on the side of the family. Rather, they suggest the normal life that the patients were *both allowed and forced* to live.

Oji Brain Hospital and its patients

Against the background of psychiatric provision sketched above, we can now examine the Oji Brain Hospital and its patients. OBH was one of several psychiatric ventures which were started by doctors and entrepreneurs in Tokyo around 1900, counting on the increase in the demand for hospital-based psychiatric service created by the Mental Patients' Custody Act in the metropolis.[55] The only material we now have about its beginning in 1901 is the exposé of abuses, corruption and negligence which occurred at seven psychiatric hospitals in Tokyo, serialized in the *Yomiuri News*, a popular daily paper.[56] Naturally, a historian should treat such an account with caution, but there is a ring of truth in the reports. The beginning of OBH told by *Yomiuri* epitomized one of the origins of Japanese private psychiatric provisions: the intersection of medicine and hotel, a business of providing accommodation associated with a medical facility.

[53] Accordingly, she boasted about being very useful, although in reality her contribution was very small. This led to frequent quarrels with her sister-in-law, who was sometimes hit by the patient. Kure and Kashida, 'Seishin Byosha Sitaku Kanchi', case 110.
[54] *Ibid*., case 107. [55] *SHDH*, 183–223. [56] *SHDH*, 202–3.

Zenjiro Komine had owned an inn mainly catering for those who travelled to and stayed in Tokyo to be treated at University of Tokyo Hospital. This innkeeper and a few doctors working at another asylum in Tokyo joined forces to start a brand-new and purpose-built psychiatric hospital in Oji, a remote agricultural suburb of Tokyo. *Yomiuri*'s comical account suggests that there were personal disagreements between the governor of the hospital (Komine) and its medical staff, mainly due to the shortage of patients and the very small profit that the hospital was able to make in its early years. The report also satirized Komine as a parvenu rising from an innkeeper to a hospital governor in its depiction of his daily inspection of the hospital kitchen:

> [Komine] threw off his stylish waistcoat to inspect the kitchen of the hospital, and immediately the governor's eyes are fixed on pickles' portions to be served to the patients. He could not tolerate such a generous serving of the pickles. Such was his penny-pinching interests in this kind of matters that he not only scolded the cook but also cut the pickles himself as thin as possible.[57]

Allowing for a certain amount of comic licence, this sketch effectively captures the characteristics of early OBH and many other early psychiatric ventures in Tokyo, that is the mentality of a small family trade, for whose survival the apportioning of pickles made a great difference. Despite such lowly behaviour and personality of its owner (or, perhaps because of his disarmingly unpretentious down-to-earth character), the *Yomiuri* reporter was somewhat sympathetic, hoping that the hospital's perseverance under chronic financial crisis would some day be rewarded.[58]

Yomiuri's ironic and satirical well-wishing materialized. From such an inauspicious beginning, OBH made a meteoric rise in the social ladder. Shigeyuki Komine, Zenjiro's adopted son, studied medicine at Saisei Gakusha, a private medical school in Tokyo, and worked briefly at Tokyo Metropolitan Asylum until 1908, when he assumed the post of OBH's medical superintendent around the age of twenty-five.[59] Shigeyuki was an able superintendent, a well-read medical scientist, and he became a leading member of the profession. Perhaps with Shigeyuki's arrival, OBH had finally solved its chronic problem of the absence of a medical officer and started to flourish. When the Mental Hospitals Act was passed in 1919, OBH was one of the first that was appointed as a substitute hospital, an honour that only eight other private mental hospitals in Japan were able to enjoy at that time. In the mid-1920s, a brand-new three-storied western building, complete with recessed arches, was erected at the old premise, which housed the Komine Research Institute and newly added wards for private patients. Patients from all over Japan flocked to the hospital, whose success allowed the Komine Institute to conduct serious research into

[57] *SHDH*, 205–6. [58] *SHDH*, 207. [59] *Nihon Seishin Byou-i Kyoukai Kiji*, 74.

Table 8.3 *Admissions of private and substitute patients at Oji Brain Hospital (1935)*

	Male	Female	Total
Private	272	119	391
Substitute	43	34	77
Total	315	153	468

Table 8.4 *Lengths of stay of the discharged Oji Brain Hospital patients*

Time Length	Private Male		Private Female		Substitute Male		Substitute Female	
	No.	%	No.	%	No.	%	No.	%
0–10 days	22	16	7	9	0	0	0	0
11–30 days	29	21	14	19	0	0	0	0
1–3 months	46	33	29	39	2	12	1	11
3–9 months	21	15	11	15	1	6	3	33
6–9 months	6	4	3	4	1	6	0	0
9–12 months	4	3	2	3	2	12	0	0
1–2 years	6	4	3	4	3	18	1	11
1–4 years	3	2	3	4	5	29	3	33
over 4 years	2	1	2	3	3	18	1	11
Total	139	100	74	100	17	100	9	100

most up-to-date therapeutics, such as malarial therapy and insulin-coma therapy. Recognition by professional brethrens soon followed. Shigeyuki played important roles in psychiatric associations, and in 1932 was elected a Representative Governor of the Japanese Association of Public and Substitute Mental Hospitals. Komine and his hospital thus represented the flourishing private practice and the upward mobility of Japanese psychiatry in the early twentieth century.

As a Substitute Hospital, OBH accepted both private and public patients. In terms of the number of patients staying at the end of the year 1935, OBH housed fifty-five private patients and 108 public patients, and the ratio between the private and public patients remained about 1:2 during the period of 1927–41. In terms of the number of admissions, however, private patients vastly outnumbered public patients, with their ratio being 5:1 (see Table 8.3 and Table 8.4).[60]

This higher number of private admissions was certainly because the private patients at OBH stayed for much shorter periods than the public patients. The

[60] The male : female ratio of the patients admitted in 1927 was about 32 per cent, not very different from the national average of institutionalized patients.

Table 8.5 *Capacities of places other than mental hospitals, 1929 and 1935*

	Medical schools	General hospitals	Confinement houses	Nursing homes	Total capacity	Total patients
1929	856	192	439	708	2195	1365
1935	1237	127	423	1074	2861	1802[a]

[a] an estimated figure

distribution of the length of stay among the patients discharged (including cured, relieved, uncured, and dead patients) in 1935 is given in Table 8.4. This shows that a long-term stay (more than half a year) was rare among the private patients, while public patients tended to stay much longer. The median length of stay for private patients discharged in 1935 was forty-four days (average being 134) for male patients, and sixty-three days (average = 183) for females, while the corresponding figures for public patients was 717 (average = 869) for male and 404 (average = 575) for female patients. For the majority of private patients, their experience of OBH was a trial for a relatively shorter period than an extended stay. Figures published in the *ARH* mask a large number of private patients who had been admitted but discharged before they were counted into the statistical tables. Experimenting with a spell at a psychiatric hospital was a more widespread practice among relatively well-off sectors of the society than tables in *ARH* suggest.

The general pattern of the patients' experience of OBH briefly discussed above suggests that OBH's major role for the private patients was that of *supplementing* care given at another site, which was often the patient's own home. Numerous cases indicate that hospitalization to OBH was a trial to see whether the patient would recover at the beginning of the disease, an emergency measure to cope with a particularly difficult manifestation of the disease, or a change of scene inserted in long-term domestic care. M.N. first stayed at OBH in about 1921, secondly in 1930 for three months, and thirdly in 1935 for another three months. For the most time during his disease, he stayed at home and often troubled his family and neighbours by his violence.[61] G.T. had been insane for about twenty-five years when he was admitted to OBH, during which time he worked as a farmer at his own house. C.M. had been mentally ill and had stayed at her own house for about eight years before her admission: she quarrelled and occasionally wounded another insane sister of hers during the period. M.G.'s three years of mental disease before admission to OBH had been spent mainly at her own house, interrupted by two brief terms of hospitalization and one longer stay at her relative's in the country for change of air. N.A. had been a

[61] Case Record (hereafter CR) of Oji Brain Hospital for M.N., discharged on 10 September 1935.

highly troublesome patient for about one-and-a-half years, during which she went out naked and used abusive language to her family and neighbours. She had experienced a brief spell at another private asylum, from which she had been discharged 'for financial reasons' and had stayed at her own home until admitted to OBH.[62] Although increasing numbers of private patients were hospitalized, for many of them, staying at an asylum seems to have been shorter episodes inserted in the major framework of care at home.

Conclusion

My account above has done little more than scratch the surface of the vast and rich area of psychiatry in Japan in the early twentieth century. Much of my argument remains tentative, to be further examined through research into psychiatric archives. Having said that, however, in the light of what I have argued above I should like to offer one historiographical point which might be pertinent to the theme of this volume.

The point is about the origin of the major driving forces of psychiatric modernization. The two major laws, the Mental Patients' Custody Act and the Mental Hospitals Act, provided the basic framework for psychiatric provision until the post-war Mental Hygiene Act (1950). Although they were conceptualized in very different spirits and aims, it should be emphasized that these two Acts had one thing in common. Note well that home custody and the mixed sector of psychiatric hospitalization, respectively the core part of each piece of legislation, had already been a well-established practice *before* the Acts codified them. In their crucial aspects, these pieces of legislation followed what people then were practising, not the other way round. The historiographical implication of this pattern of the law heeding the practice is that one should look for factors other than legal or legislative for the *real* driving force of historical change in Japanese psychiatric provision. Social and cultural forces 'from below' created trends, patterns and models of the care of the insane, some of which were selected to be confirmed and encouraged by the law 'from above'. Another implication is that one should not overestimate the influence 'from the West', which has been one of the major frameworks within which the history of Japanese psychiatry during the period under review has been described. Instead of the select few who were enlightened and westernized and who drafted Bills and rules or wrote textbooks of psychiatry, a mass of patients, families and neighbours set the basic trends of psychiatric provision, some of which in turn were selectively codified by the elite with the ambition to 'Westernize' Japanese psychiatry. Needless to

[62] CR for G.T., discharged (dead) on 10 November 1935; CR for C.M., discharged (dead) on 28 February 1935; CR for G.M., discharged on 31 December 1939; CR for N.A., discharged on 7 May 1935.

say, the influence from the West was tremendous in almost every aspect of life in Japan at that time and the care for the insane was no exception. This does not mean, however, the programme of Westernization was the major driving force in the making of basic paradigms of Japanese psychiatric provision.

Instead of seeing the progress of psychiatric confinement in early twentieth-century Japan as an attempt to import western systems of care of the insane, this chapter set out to understand it within the complex interaction and negotiation between various basic social units, such as the family, community, local and central governments, and psychiatrists. This chapter has also tried, whenever possible, to throw light on the larger contexts in which those interactions took place, such as the market economy, urbanization, totalitarian policing of the population, and medicalization. I can only hope that my attempt will encourage future researchers in the comparative social history of psychiatry to tackle big issues at which this chapter is only able to hint.