7. Gemma Blok and Joost Vijselaar, *Terug naar Endegeest. Patiënten en hun behandeling in het psychiatrisch ziekenhuis Endegeest 1897-1997* (Nijmegen: SUN, 1998).
8. G.A. Lindeboom and M.J. van Lieburg, *Gedenkboek van de Vereniging tot christelijke verzorging van geestes- en zenuwzieken, 1884-1984* (Kampen: Kok, 1984).
9. Http://www.qsrinternational.com/; for general information about computer assisted qualitative data analysing software: http://caqdas.soc.surrey.ac.uk/index.htm
10. 1932-4-2 END; 1937-05-31 WOL.
11. 1922-5-10 VOO; 1932-03-17 VOO.
12. 1922-7-1 END; 1932-03-17 VOO.
13. 1937-02-19 WOL; 1937-01-06 VOO; 1937-1-6 WOL.
14. H. Jelgersma, *Voorzorg verpleging en nazorg* (s.l.: s.p., 1928), 9-10; Blok and Vijselaar, *op. cit.* (note 7), 97.
15. 1912-04-04 VOO; 1902-05-03 END.
16. 1942-4-4 WOL.
17. 1932-7-19 END; 1941-12-31 VOO.
18. 1922-3-7 END; 1927-9-26 END; 1947-01-03 VOO.
19. 1902-2-1 VOO.
20. 1912-10-24 END.
21. 1942-2-11 VOO.
22. 1922-4-21 END.
23. 1942-01-19 VOO; 1942-6-10 WOL; 1892-3-8 VOO.
24. 1937-7-13 WOL; 1927-01-03 VOO.
25. 1892-3-8 VOO.
26. 1942-4-4 WOL.
27. 1937-2-12 VOO.
28. R.V. Bijl and A. Ravelli, 'Psychiatric Morbidity, Service Use, and Need for Care in the General Population', *American Journal of Public Health*, 90 (2000), 602-7.

Psychiatric Cultures
Edited by Marijke Gijswijt-Hofstra, Joost Vijselaar, Harry Oosterhuis, Hugh Freeman
Amsterdam Univ. Press (2005)

CHAPTER 12

Were Asylums Men's Places?

Male Excess in the Asylum Population in Japan in the Early Twentieth Century

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Introduction

The subject of psychiatry and gender has attracted considerable scholarly attention in the last two decades.[1] From the late 1980s, the cultural history of women's madness has become an established sub-genre within the history of psychiatry and madness, through path-breaking works by Elaine Showalter and Mark Micale, to name just two.[2] More recently, the gender history of insanity has incorporated various approaches and historiographies, such as men's history and colonial history.[3] This chapter attempts to further expand the subject by bringing in the perspective of international comparison. Although it discusses mainly Japanese material, I have tried to go beyond a regional study and take a step towards a genuinely international social history of gender and psychiatry. Throughout, I will use one index that can be easily obtained for other countries: the ratio of male to female psychiatric patients (M/F ratio, or the number of male patients divided by the number of female patients).

In the first half of the twentieth century, Japanese psychiatric statistics presented a striking male excess. Between three-fifths and two-thirds of all hospitalised patients were men, M/F ratio fluctuating between 1.4 and 1.9.[4] Public and private patients shared roughly the same M/F ratio, despite their stark contrasts in many aspects.[5] Chronologically speaking, the national M/F ratio was roughly constant during the pre-war period of 1900-1940. Regional fluctuation existed, but in none of 47 prefectures did female patients outnumber male ones. This male predominance is supported by very robust evidence.

This characteristic of the Japanese psychiatric population deserves close attention, particularly because few, if any, countries in Europe and North America reported so large an excess of male 'lunatics' in the nineteenth and early twentieth century. In the 1830s and 1840, when Esquirol in France and Thurnam in England established asylum-based epidemiology as a genre of psychiatric research, psychiatrists did not obtain any clear-cut and uniform bias in the distribution of men and women in asylums.[6] When, in 1845, Thurnam claimed he

finally found 'decided' evidence of a male excess in British asylums, he was talking about 13.7 per cent (M/F ratio being 1.14), a tiny excess if compared with the Japanese data that showed up to 100 per cent.[7] In 1899, in the 6th edition of his *Psychiatry*, Kraepelin maintained that 'statistical frequency does not reveal any considerable and reliable difference between both sexes'.[8] The Japanese M/F ratio of around 1.4-1.9 during the early twentieth century might well have been unique at that time, although the scope of my research into international comparisons is still very limited. The exceptionally large M/F ratio of Japan thus provides us with a solid and robust statistical basis for making a clear-cut analysis of the question of gender and psychiatric committal.

Psychiatrists in pre-war Japan were certainly aware of the disparity between their data and those reported in Europe. They knew, for instance, that Kraepelin and other German psychiatrists found that a decidedly higher proportion of manic-depressive admissions were female, and that men and women had roughly matched numbers in dementia praecox, while Japanese data almost invariably showed a substantial male excess in both diagnostic categories.[9] Seen from the viewpoint of present historians, these differences are very intriguing, inviting us to examine them and speculate on the causes that created them. In contrast, Japanese psychiatrists in the early twentieth century were more interested in finding Euro-Japanese similarities than studying their differences, being more comfortable in confirming what their German teachers had said. The large disparity between the M/F ratio of the European asylum population and that in Japan puzzled rather than interested pre-war Japanese psychiatrists. Moreover, they studied the statistics of psychiatric hospitals to investigate the prevalence of mental diseases and their causes, rather than to analyse the mechanism of committal to institutions. In other words, the psychiatric epidemiology of two sexes, not the analysis of gender-related factors underlying hospital statistics, was their major goal.

This chapter attempts to investigate what they failed to do. My focus will be on the gender-difference in the mechanism of committal of patients from their home to an institution. Although the M/F ratio may have been skewed in certain diagnostic categories because of the difference in the exposure to causal agents (e.g. addiction to alcohol and drugs), I will demonstrate below that the mechanism of committal was more important than the prevalence of mental disorders in creating the huge male excess in the early twentieth century.

Psychiatric Provision in Pre-WWII Japan

The treatment and confinement of the insane in Japan has a long history. By the late nineteenth century, a diversified system of care for the mentally ill already existed. On the eve of the Meiji Restoration in 1868, at least 29 medical and religious institutions took care of the insane. Large cities had developed custodial institutions which housed the mentally ill together with vagrants, the physically sick, and the destitute. The most elusive but undoubtedly most important locus of care had been the family. They provided care and security by confining the patient in a cage ('sashiko') set up within the house, with the permission of the local authorities.[10] This indigenous system of provision for the insane was the background into which Western-style psychiatry was implanted from the 1870s.

'Modern' provision for the insane by the central government was provided through two Acts of Parliament – the Mental Patients' Custody Act (1900) and the Mental Hospitals Act (1919), both of which were repealed by the Mental Health Act in 1950. The Custody Act demanded that a lunatic be confined only by the officially appointed custodian, who was normally a family member, with the authority of the local government of city, town or village.[11] When a competent custodian could not be found, the administrative head of the local government would assume that status. The place of custody was usually the patient's own home, rather than a specialist institution. In 1905, about 12,000 patients were confined in their home, while about 5,500 were in institutions.[12] A cage with a heavy lock had to be set up in or close to the house, according to a detailed plan submitted to the local administrative office.[13] Perhaps 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 those now in their sixties or seventies still retain vivid memories of the chilling horror and fascination with which they watched a 'furious' patient through the lattice.

The Custody Act essentially left the care of the insane to the patient's family. The Mental Hospitals Act, on the other hand, assigned a more active role to the public authorities, particularly the state, and attempted to expand institutional confinement. To achieve this goal, the act empowered the central government to order the prefectures (a larger local governmental unit, comparable to counties in England) to build public asylums. Half of the cost of building 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, for the public sector in psychiatric provision was very small in Japan at that time. In 1918, there was only one public asylum, which was in Tokyo and housed about 450 patients. In contrast, in the same year, 57 private psychiatric hospitals already existed, which together housed about 4,000 patients.[14] Moreover, many of the private hospitals regularly admitted patients whose cost was paid by their local authority, either through the Custody Act or otherwise.[15] This large mixed sector of psychiatric provision was codified through the Mental Hospitals Act in 1919. Several private asylums were allotted a certain number of 'substitute' beds and accepted public patients up to that number. Private mental hospitals that were thus appointed were called 'substitute hospitals' and were to become a major provider of the care for the insane for the next couple of decades.

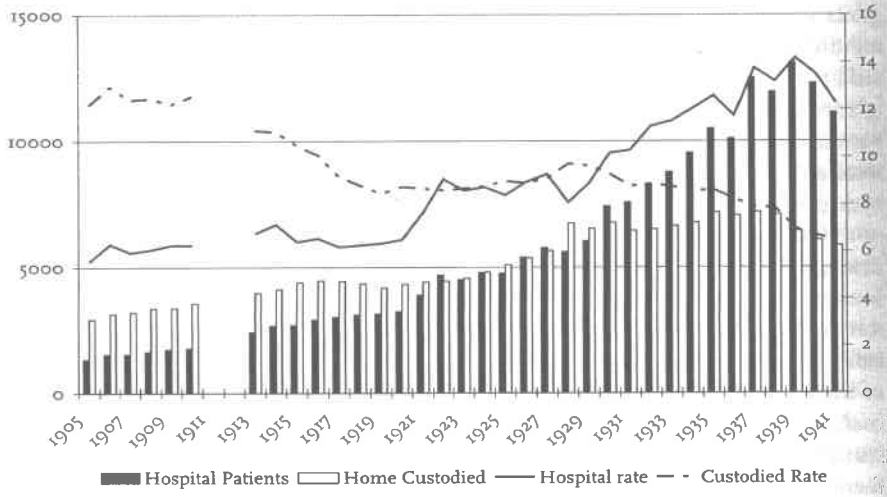

Figure 1 *Number and Percentage of Hospitalised and Home-Custodied Patients, 1905-1940*

The two acts structured pre-war psychiatric provision, which had somewhat contradictory aims, one centring on home custody and the other on hospitalisation. Figure 1 indicates a clear shift in the locus of confinement from home to hospital. The hospital, the cornerstone institution of the Mental Hospitals Act, was on its way to success, presenting the familiar picture of medicalisation and institutionalisation of the care for the insane.[16] On closer examination, however, the first point to be noted is the timing of the decline of home custody. In proportion to the total number of registered patients, this decline started around 1910, about ten years before the passing of the Mental Hospitals Act and before the significant rise in the number of hospitalised patients. Despite the image promoted of mental hospitals as the modernising institution against the evil of home custody, the latter had started to decline on its own, rather than being overwhelmed by the former. This is not very surprising if one recalls that the Custody Act imposed strict regulation on the private confinement of the insane, making it more official and difficult. The other point to be noted is the ambiguous impact of the Mental Hospitals Act. This act undoubtedly contributed to the dramatic rise in hospitalised patients after 1920: the number of public hospitals and substitute hospitals grew from 8 (one public and 7 substitute hospitals) in 1919 to 84 (7 public and 77 substitute ones) in 1940. However, neither the public nor the mixed sector bore the major burden of care for the insane. Table 1 shows the proportion of publicly supported and fee-paying patients in mental hospitals in total, taken from statistics in *The Annual Report of Hygiene*. While the proportion of publicly supported patients resident in private institutions actually *declined*, the purely private type of hospitalisation, i.e. patients who paid for their

stay at privately run hospitals actually *grew*. The proportional growth of privately funded confinement reveals a hitherto little-noticed aspect of the rise of mental hospitals in pre-war Japan: 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 services contributed significantly to the evolution of a society that segregated a large number of the insane. The demand for psychiatric services at hospitals became larger, but it was met only partially by public provision, the gap between the demand and the public supply being filled by private means.

Table 1 *Percentage of Public and Fee-Paying Patients in Public and Private Hospitals*

	Public Hospitals		*Private Hospitals*	
Year	*Public Patients*	*Fee-paying Patients*	*Public Patients*	*Fee-paying Patients*
1928	11.0	5.1	50.0	33.4
29	13.6	4.7	44.5	35.8
30	12.7	4.2	49.4	33.6
31	13.0	3.8	50.1	33.1
32	12.1	3.7	49.5	34.6
33	12.5	3.6	47.3	36.9
34	12.0	3.9	47.1	36.9
35	11.3	3.7	46.5	38.9
36	11.5	3.8	46.1	38.7
37	11.9	4.1	44.7	39.3
38	11.3	4.3	43.0	41.2
39	10.5	4.3	40.4	44.8
40	10.3	5.0	39.6	45.1

The importance of the demand side vis-à-vis the supply side suggests that to understand the mechanism of the growth of psychiatric provision in Japan in the early twentieth century, we should examine the role of the family as an important actor in institutionalisation. The family normally brought its insane member to a psychiatric hospital. It is true that there existed cases in which the police brought troublesome lunatics to the hospital, but such cases were few. Likewise, public authorities did occasionally organise a large-scale 'hunting' of wandering lunatics, but such forceful confinement was exceedingly rare.[17] Without denying the indirect influence of such activities of public authorities on the demands of families for psychiatric care, the initiative for confinement normally came from the patient's family. Moreover, the family continued to provide a major locus of care of the insane: thousands of patients were registered as lunatics but were not confined either at home or in a hospital – just remaining in

their own home. Those patients were called 'non-custodied' patients, and they vastly outnumbered both home-custodied and hospitalised patients. For most of the period under review, about 80 per cent of the registered patients were 'non-custodied'. Although the figure became slightly lower in the 1930s, in 1941 about 70 per cent of registered mental patients still remained at home, nominally under no restraint. The family thus had a large pool of home-residing patients, from which psychiatric hospitals drew their inmates.

This account of the intersection of the family and the asylum illustrates the key role played by the families of patients in their institutionalisation. Psychiatric hospitalisation largely resulted from the family's decision, for one reason or another, to send the patient to an institution. In this context, the question of M/F ratio of Japanese hospitalised patients will next be examined. To avoid complications due to the mixture of gender-biased diagnoses (e.g. war neurosis, alcohol and drug addictions, hysteria, puerperal insanity), below I shall largely concentrate on one diagnosis, namely schizophrenia.

Schizophrenia and the Social Meaning of Symptoms

Schizophrenia or dementia praecox was the most frequently employed diagnosis for pre-war hospitalised patients. In 1935, schizophrenic patients accounted for about 44.7 per cent of the admissions to about 130 mental hospitals. The condition's share of the resident population was even higher and reached 63.1 per cent, since schizophrenics were more likely to become chronic cases and to stay longer in the hospital than those suffering from other mental disorders.[18] In the post-war years, schizophrenia continued to dominate the psychiatric hospitals: in 1952, it accounted for 56.2 per cent of the resident patients, vastly exceeding manic-depressive insanity (9.0 per cent) and GPI (7.6 per cent).[19] The M/F ratio of hospitalised schizophrenics during the years between 1927 and 1931 was 1.91, meaning roughly two male patients to one female. It has continued to show male excess up to today, although the male excess has become progressively smaller – from 1.91 in the 1930s to 1.45 in 1975 and 1.30 in 1987.[20]

No historical data are available which would throw light on whether the causes of schizophrenia were differently distributed between men and women. Nevertheless, from several pieces of indirect evidence, one can reasonably assume that the respective male and female prevalence of the condition itself did not differ as greatly as the M/F ratio of hospitalised schizophrenics. The evidence concurs in suggesting that the male excess of hospitalised schizophrenics in pre-war Japan was a product of gender differences in the mechanism of committal to psychiatric institution, rather than a reflection of differences in morbidity. In other words, schizophrenic women were missing from the asylum statistics, so they must have been taken care of – or neglected – at home.

This is most clearly shown in the discrepancy between the M/F ratio of hospitalised schizophrenics and that of total schizophrenics, including both hospitalised and non-hospitalised patients. Non-hospitalised schizophrenics had eluded the psychiatrists' attention until the late 1930s, when several large-scale surveys were conducted under the leadership of Yûshi Uchimura, a professor of psychiatry at University of Tokyo from 1936 to 1958. Stimulated by this research, an even larger-scale survey was conducted in a city in Chiba Prefecture in 1946 by the newly created National Institute of Mental Hygiene. The city's rural surrounding region became the subject of another survey in 1953. The momentum that drove these studies culminated in 1954 in a colossal nation-wide psychiatric survey of about 23,000 individuals from 100 regions, which was acknowledged to be the largest and the most systematic of its kind ever undertaken in the world.[21] Thanks to those and other surveys, we are able to measure the M/F ratio of 'hidden' cases of mental disorders cared for at home, with which we can compare hospital data. Table 2 shows the number of people diagnosed as schizophrenic by doctors in the surveys between 1940 and 1972.[22]

Table 2 *Numbers of Schizophrenics Discovered in Psychiatric Surveys, 1940-1972*

Region	*Prefecture*	*Year*	*Type of Region*	*Population Surveyed*	*Male*	*Female*	*Total*	*M:F Ratio*
Hachijo-jima	Tokyo	1940	Island	8318	22	10	32	2.20
Muraoka-mura	Kanagawa	1941	Village	1704	4	3	7	1.33
Ikebukuro	Tokyo	1942	Large city	2712	3	3	6	1.00
Komoro-cho	Nagano	1943	Small city	5207	6	5	11	1.20
Ichikawa-shi	Chiba	1946-53	Medium-sized city	110000	109	115	224	0.95
Koshiki-jima	Kagoshima	1957	Island	6783	29	21	50	1.38
Hachijo-jima	Tokyo	1964	Island	1207	32	25	57	1.28
Henza-jima	Okinawa	1969	Island	2379	10	11	21	0.91
Oki-gun	Shimane	1972	Island	2826	12	12	24	1.00

Sources: Nakane et al., 'Prevalence Rate of Schizophrenia in Japan', 432, Table 2; *Sources of Mental Hygiene* 5 (1957), p. 4, Table 1.

The figures include both hospitalised and non-hospitalised patients, with 'uncertain cases' being excluded. M/F ratios revealed in the surveys fluctuated from one to another, from 0.91 to 2.20. However, with the exception of the survey in Hachijo-Jima Island in 1940, they do not exhibit as large a male excess as was revealed among hospitalised schizophrenics in the same time period. Statistics of the overall number of mental patients tell the same story. The nationwide survey conducted in 1954 found in total 112 males and 114 females suffering from mental disorders of all kinds out of 23,000 subjects between the ages of 18 and

59 (M/F ratio = 0.98), while in 1958, 2,854 men and 1,887 women in total were discharged from mental hospitals (M/F ratio = 1.51).[23] Another set of data suggests the continuity of the same pattern in the 1970s and 1980s: while men consistently and substantially outnumbered women in the hospitalised population (M/F ratio = 1.25-1.41), female outpatients regularly outnumbered male ones (M/F ratio = 0.82-1.06).[24] All these pieces of evidence suggest that the huge male excess in the hospitalised population resulted from differential *hospitalisation*, not differential *morbidity* itself: female mental patients were under-represented in the hospitalised population, and male patients were much more likely to be treated in hospitals than at home.

Why, then, was this the case? What factors kept a greater proportion of mentally disordered women at home, and why were similar men sent to psychiatric institutions more often? I would like to argue that three inter-related factors were at work – the meanings of symptoms, the role of psychiatric institutions, and the capacity of the family to take care of its insane members. Men and women exhibited symptoms whose social meanings were different. The symptoms prioritised for hospital admission were exhibited more often by male patients, while those of female patients signalled that they could be controlled outside the walls of the asylum. The capacity of psychiatric hospitals was still small, while the Japanese family was able or even ready to bear the burden of keeping its mentally disordered member at home, without recourse to his/her institutionalisation. The balance of the capacity of institutions and that of the family thus tipped toward the latter. Under such a regime of psychiatric provision, hospitalised populations skewed towards men, and more women were treated at home. In other words, the sexual composition of the asylum population in early twentieth-century Japan resulted from the intersection of public policy over the nature and number of psychiatric institutions, and the private culture of the family.

Thus, men and women expressed different symptoms, which were construed differently by those around them, in terms of what should be done. The crucial difference lay in the pattern of dangerousness. This is most clearly seen in a study by Saburo Okuda, based on 1576 schizophrenics (873 males and 703 females) who were admitted to Matsuzawa Hospital between 1926 and 1936 and whose case records were detailed enough for retrospective analysis.[25] Table 3, only slightly modified from the original table, lists the types of what Okuda called 'anti-social acts' committed by the patients before their admission. The number and rate of patients who exhibited each type of dangerous behaviour are shown. Okuda divided his 'anti-social acts' into two categories: those which were dangerous to oneself and those dangerous to others. The two categories were further divided into 4 and 12 sub-categories, respectively. He then added up the cases that exhibited each type of dangerous act and calculated their percentages against the total numbers of male or female schizophrenics.

Table 3 *Anti-Social and Dangerous Behaviour among Schizophrenics Admitted to Matsuzawa Hospital, 1926-1935*

	Male		*Female*		*Total*		*M:F ratio*
	Number	*Rate*	*Number*	*Rate*	*Number*	*Rate*	
Anti-Social Behaviour	402	46.0	207	29.4	609	38.64	1.56
– Crime	56	6.4	10	1.4	66	4.19	4.51
Dangerous to Oneself							
– Suicide	109	12.5	80	11.4	189	11.99	1.10
– Disorderly behaviour	57	6.5	12	1.7	69	4.38	3.83
– Vagrancy	53	6.1	38	5.4	91	5.77	1.12
– Wandering	20	2.3	25	3.6	45	2.86	0.64
Total	239	27.4	155	22.0	394	25.00	1.24
Dangerous to Others							
– Murder	20	2.3	12	1.7	32	2.03	1.34
– Injury	30	3.4	3	0.4	33	2.09	8.05
– Abuse of Weapons	22	2.5	5	0.7	27	1.71	3.54
– Disturbance	94	10.8	39	5.5	133	8.44	1.94
– Theft	19	2.2	1	0.1	20	1.27	15.30
– Arson	30	3.4	18	2.6	48	3.05	1.34
– Litigious	30	3.4	6	0.9	36	2.28	4.03
– Lese Majesty	12	1.4	1	0.1	13	0.82	9.66
– Offence of the Order Act	6	0.7	0	0.0	6	0.38	-
– Clever crime	5	0.6	0	0.0	5	0.32	-
– Gambling	3	0.3	1	0.1	4	0.25	2.42
– Bilking	10	1.1	1	0.1	11	0.70	8.05
Total	281	32.2	87	12.4	368	23.35	2.60
Total	873	100	703	100	1576	100	

M:F ratio = Male rate / Female rate
Source: Saburo Okuda, 'Clinical and Statistical Study of Dementia Praecox', 900-901, Table 14.

The overall difference is striking: before admission, male schizophrenics were decidedly more likely to have committed acts that were, and were perceived to be, 'anti-social': 402 out of 873 men (46.0 per cent) and 207 out of 703 women (29.4 per cent). In other words, male schizophrenics admitted to Mastuzawa Hospital were 1.5 times as likely to have committed anti-social acts which were dangerous as their female counterparts. One can also assume that anti-social acts committed by women were of a less serious nature, for men had committed crimes or gravely anti-social acts about four times as often as women. Moreover, men were much more likely to be dangerous to others, while roughly the same proportion of men and women committed various types of violence against

themselves. All the sub-categories of dangerous acts against others exhibit massive male proportional excess, while those of dangerous acts against themselves do not show as large a male excess, apart from 'disorderly behaviour', whose inclusion into this category is somewhat questionable. Men's symptoms were more likely perceived to be seriously dangerous to others, while women's were regarded as less serious, and as directed more towards themselves.

Okuda's results are striking in showing that male and female hospitalised schizophrenics exhibited different patterns of symptoms in terms of dangerousness. His findings are, however, somewhat difficult to interpret. Do they mean that men and women tended to show different types of symptoms, due to their biological differences? Or did people employ different standards to gauge and measure men and women's disruptive behaviour? Perhaps all of these factors might have been at work. The most likely and broadly inclusive explanation is that since men and women in Japan at that time lived in separate spheres, they posited different types of danger when they suffered from schizophrenia. The male excess in dangerous acts against others was, to a considerable extent, a reflection of the fact that men were much more likely to be active in the public sphere and to be engaged in situations that had a potential of disturbance to a larger number of people. For example, the most political offences committed by schizophrenics – *lèse majesté* and offences against the Maintenance of the Public Order Act – are all infringements of norms or laws in the public sphere, which was almost exclusively a man's world in Japan at that time. It is therefore understandable that schizophrenics who had exhibited these types of dangerousness before their confinement were almost exclusively male. Public disorder and the use of violence (murder, injury, abuse of weapons) were largely a male schizophrenic's problem, since these criminal acts were largely committed by men, whether sane or insane. The only category of public dangerousness that did not show a large male excess was arson: this was understandable, for the use of fire could be widely practised by women for cooking and domestic heating. Men, who led lives in both the private and public spheres, were likely to cause a wider variety of disturbance. Their dangerous abnormality was also expressed in a manner more visible than that of women, because men normally led a more public life – taking part in politics, conducting business, etc. To sum up, the 'open' sociability of the men's world resulted in their exhibiting more visible and publicly dangerous symptoms under insanity, while the 'closed' world of women meant their schizophrenic symptoms were of a more private nature.

It should be noted that more than one-third of schizophrenics admitted to Matsuzawa Hospital exhibited tangibly 'anti-social' behaviour. Confining visibly dangerous patients was one of the major functions of the psychiatric hospital, however hard psychiatrists emphasized the role of medical cure and humanitarian care provided there. It has been a commonplace cliché of anti-psychiatric criticism that a mental hospital was more a place for social control for confining disturbing individuals than one in which to practise medicine, but such a characterisation is valid for pre-war psychiatric hospitals in Japan.[26] When one of the major functions of the psychiatric hospital was to confine dangerous individuals, it is quite natural that it accepted more men than women, for men were more visibly and gravely dangerous. The priority given to publicly dangerous cases for hospital admission directed more men to asylums.

One should not assume, however, a consistent social policy or ideology that assigned psychiatric hospitals the role of confining visibly dangerous individuals. Rather, it was a product of a balance between the hospital and the family. Firstly, it should be emphasized that psychiatric facilities were very small in Japan before the 1960s. Japanese psychiatrists had painfully to admit this as a sign of the 'backwardness' of their country. In 1928-29, England, Germany, Switzerland and USA had more than 250 beds per 100,000, while Japan had only 21.1, lagging behind Czechoslovakia (82.6) and Greece (30.0).[27] In 1952, the Japanese figure was still about 22.6 per 100,000, less than one-twelfth of the USA (278), and about one-fourteenth of England & Wales (313).[28] Psychiatric beds were naturally occupied by those who were severely insane and who exhibited grave symptoms, among which highly visible danger must have been given priority. Necessity, as well as social policy, dictated that confining 'hard core' patients should be a major function of psychiatric hospitals. In other words, psychiatric institutions, having only a limited number of beds, could not afford to take care of those who were 'just' insane. To enjoy the 'privilege' of being admitted to an institution, one needed to be insane in a noisy or highly visible way. The capacity of psychiatric hospitals, especially that of public ones, was too small to meet all demands, and private beds were too expensive for people with modest means to stay there for long.

On the other hand, the Japanese family at that time had a considerable capacity to take care of its insane member, due to its system of household formation. Most typically, a household consisted of two married couples and their unmarried children. Normally, the first male child continued to live with his parents after his marriage. This 'stem family' system provided a Japanese family with a large capacity for the care of its dependent member: there were normally two male breadwinners, with two adult women who contributed to the family in various ways – doing household chores, tending young children, or earning a smaller income. When one or both of the older married couple became incapacitated due to old age, the younger couple bore the burden of supporting and nursing the elderly parents. The Japanese family thus had as its built-in function a capacity to take care of its disabled members. This meant that the family had a larger capacity to cope with any crisis of mental disorder of a member than was the case for a nuclear family system. Moreover, a strong socio-cultural norm dictated that the head of the household, who was normally one of the husband-fathers, should support, manage and control other members of the family. This

strong sense of patriarchal responsibility must have been a strong disincentive to refer a mental patient who was a dependent member of his family to a psychiatric hospital for long-term care. On the other hand, the incentive to send publicly dangerous patients to institutions of confinement must have been very strong, since under the Old Criminal Code of 1880, the family was liable to a heavy penalty if it let an insane family member wander around and do any harm.[29] The Japanese family could thus contain an incapacitated mentally disordered member relatively easily, though at the same time, it needed to put strict restraint upon a patient who was manifestly out of the family's control, to avoid the heavy fine. The priority given by hospitals to overtly dangerous cases was thus largely a response to the family's demand. On the other hand, families were unlikely to ask the hospital to take care of manageable patients, particularly when they had to pay for the hospitalisation. The large male excess in the asylum population thus resulted from this differential choice for different types of symptoms, which was necessitated by the balance between the family's demand and the hospital's supply, and was made possible by the large capacity of the domestic care.

The explanatory model sketched above is largely a theoretical construct. Hard and direct evidence for the applicability of this model is difficult to obtain, for one cannot demonstrate from hospital statistics the existence of 'hidden' female mental patients taken care of at home, so that this must be inferred from fragmentary or circumstantial evidence. Such evidence, however, abounds and is of three types. The first is a negative correlation between a prefecture's number of psychiatric beds and its M/F ratio: the smaller the number of psychiatric beds in a region, the larger its male excess of hospitalised patients.

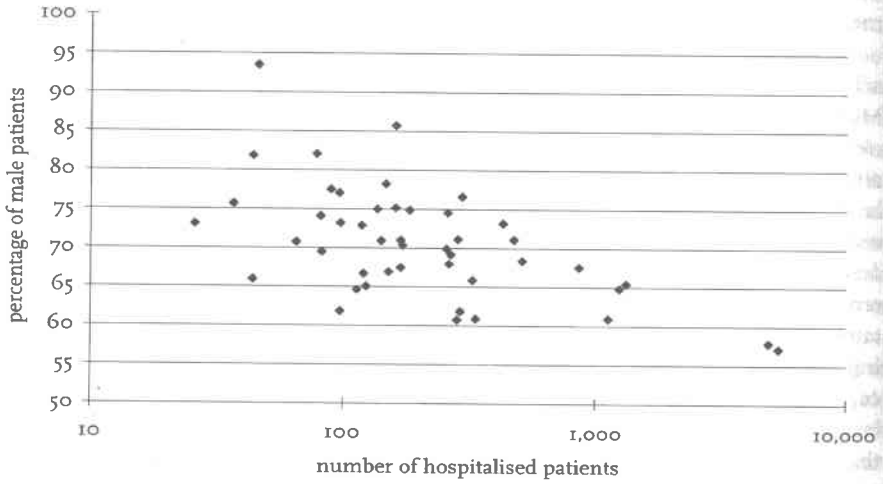

Figure 2 *Number of Hospitalised Patients and Percentages of Men, 46 Prefectures, 1940*

Figure 2 indicates the number of hospitalised patients of 46 prefectures on the x-axis and the percentage of men against the total patients of both sexes on the y-axis in the year 1940.[30] There is clearly a negative correlation. This suggests that if a prefecture had a large institutional facility, it had more room for patients who exhibited less overtly dangerous symptoms, which led to the institutionalisation of more women. The fact that prefectures that enjoyed a larger number of psychiatric beds were urbanized ones might also have been relevant, since in urban areas, the transition to a nuclear household system was already in progress, and this shift decreased the family's capacity to take care of its insane member at home.

The second kind of evidence is qualitative and episodic. The argument above claims that in psychiatric hospitals, men outnumbered women because women were more likely to be cared for at home. The missing lynchpin of this argument, however, is hypothetical 'hidden' female patients, who were cared for at home and whose families did not knock at the door of a psychiatric hospital. As Nancy Tomes admitted in her attempt to prove 'the case of the missing female depressives', explaining the absence of hospitalisation from the records of a hospital is riddled with fundamental difficulties.[31] Nevertheless, one can frequently encounter such 'missing female schizophrenics' in case histories of the Ohji Brain Hospital (hereafter OBH), a flourishing private psychiatric hospital.[32] A.B., a 37-year-old woman married to a clerk, had been treated at home for five or six years, occasionally with doses of narcotics, before she was admitted to OBH. C.D. had been treated at home for 15 years, after a stay of two or three years at another private mental hospital. The death of her husband six months before was specified as the reason why the family asked for admission to OBH in 1928. E.F., a 46-year-old wife of a cosmetics-seller, was hospitalised at OBH twice in 1936 and 1942, each time for less than a month. During the intervening five years, she was taken care of at home. Although this type of evidence is episodic and impressionistic, it nevertheless appears in the case histories of OBH with such frequency as to make one suspect a hidden but established pattern of home care of insane women.

The third type of evidence is concerned with manic-depressive illness. The argument in this section has been so far mainly based on dementia praecox, leaving manic-depressive disorder aside, mainly because of its smaller sample size. Nevertheless, the M/F ratio of hospitalised manic-depressives is important because it brings in some further international perspectives. International comparison of the symptomatic differences of hospitalised manic-depressive illness confirms that male excess and the priority given to dangerous cases due to the small capacity of institutional provision were strongly related. As mentioned above, Japanese psychiatrists were somewhat puzzled by the statistical difference between Japanese manic-depressives and their German counterparts. While in the latter there was a clear female excess and a dominance of depressive

cases, the former showed reversals in both respects – an excess in male cases and manic cases.

Table 4 *Types of Manic-Depressive Insanity*

	Manic		*Depressive*		*Manic-Depressive*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Matuzawa Hospital (Tokyo)	41.3%		21.7%		29.3%	
	38.7%	44.8%	26.3%	15.7%	31.8%	26%
Iwakura Hospital (Kyoto)	62%		17%		21%	
Kraepelin	14.6%		48.9%		34.5%	

Source: Hidehisa Matsumura, 'So-utsu-byo No Ippan-teki Tôkei [Some General Statistics of Manic-Depressive Illiness]', *Seishin-Shinkei-gaku Zasshi* [Journal of Psychiatry and Neurology], 41 (1937), 965-977.

In a rare attempt to explain the difference, one psychiatrist at a private asylum in Tokyo stated that the limited availability of hospital beds created the dominance of manic cases: manic and excited cases, particularly 'those trespassing into other people's houses or wandering around the Palace', must be confined, while depressive cases could be cared for and supervised at home.[33] He further enviously speculated that the excess of depressive types in Europe was due to the admission of what he regarded as 'milder' cases, because of the large institutional provision and people's readiness to refer milder cases to hospitals. This speculation grasped the core problem of the bias toward overtly dangerous cases in Japanese asylums. Indeed, several doctors were ready to admit that those who were just depressed or who harboured harmless delusions could be easily cared for at home, sometimes with the occasional help of large doses of strong sleeping pills or opium-based drugs.[34] The Japanese mental hospitals' priority for dangerous and excited patients skewed the asylum population toward men, because men were more likely to exhibit 'dangerous' manic symptoms and were therefore difficult to treat at home.

Conclusion

I have tried above to explain why the population of Japanese mental hospitals in the earlier part of the twentieth century was skewed towards men. Men might well be more exposed to causes of mental disorders than women, but such epidemiological aspects of the question have not been investigated. Rather, I have focused upon the gender asymmetry both in the meanings of symptoms and in the family's choice of institutional committal. Men and women exhibited different symptoms, which sent different messages to those around: male disorders were perceived to be of a more public nature and more threatening to others, while female afflictions were regarded as more private and more directed against the patient herself. This differential hermeneutics of psychiatric symptoms led, in early twentieth century Japan, to the choice of a different locus of care for male and female patients, respectively, the former committed to psychiatric institutions, the latter taken care of at home. However, the path from the contrast in the readings of symptoms to the huge male excess in hospitalised population was far from automatic. This passage was mediated by the capacity and role of psychiatric institutions on the one hand, and the capacity and readiness of the family to care for its mentally ill members on the other. When the psychiatric facility was intended for those who were dangerous to others and when its service was expensive to purchase, both for private and public clients, the precious resource was assigned to those patients who exhibited symptoms that were visibly dangerous to others. The priority for hospitalisation was thus given to male patients, who were more likely to be perceived as publicly disturbing. On the other hand, when a household had a greater capacity to take care of its incapacitated member, the family was ready to pay the human cost of caring for the patients at home, so long as their disorders could be contained within the private sphere. The option of domestic care was thus more frequently used for female patients, whose disturbing behaviour was less likely to become a public nuisance. The M/F ratio of hospitalised patients in early twentieth century Japan therefore resulted from the intersection of hospital and home, or the balance between the cost of psychiatric institutionalisation and that of domestic care. The financial cost of institutional confinement was high, while the human cost of domestic care was cheap. The large and consistent male excess in the asylum population was thus due to two factors: precious psychiatric beds were allocated to publicly dangerous cases, and the family could absorb privately troublesome cases.

Notes

* Acknowledgements: I would like to thank those who attended the conference in Amsterdam in 2003 and Junko Kitanaka at Keio University for their helpful comments. The research on which this paper is based has been supported by the Japan Society for the Promotion of Science during 2002-2004.

1. For a survey of the literature on the subject, see N. Tomes, 'Feminist Histories of Psychiatry', in Mark S. Micale and Roy Porter (eds), *Discovering the History of Psychiatry* (Oxford: Oxford University Press, 1994), 348-83; Jonathan Andrews and Anne Digby, 'Introduction', in Jonathan Andrews and Anne Digby (eds), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004), 7-45.

2. Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London: Virago, 1987); Mark S. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton: Princeton University Press, 1995).
3. See papers in Andrews and Digby, *op. cit.* (note 1).
4. Pre-WWII national statistics of mental patients and psychiatric hospitals are available in *Eisei-Kyoku Nenpô* [*Annual Report of the Bureau of Hygiene*], which was renamed *Eisei Nenpô* [*Annual Report of Hygiene*] in 1938. Both will be hereafter referred to as *ARH*. I have made extensive use of this material elsewhere. See Akihito Suzuki, 'Family, the State and the Insane in Japan 1900-1945', in Roy Porter and David Wright (eds), *The Confinement of the Insane. International Perspectives, 1800-1965* (Cambridge: Cambridge University Press, 2003), 193-225.
5. I have discussed the difference between public and private patients in Akihito Suzuki, 'A Brain Hospital in Tokyo and Its Private and Public Patients, 1926-1945', *History of Psychiatry*, 14 (2003), 337-60.
6. For early attempts at psychiatric epistemology by Esquirol and his contemporaries, see Ian Hacking, *The Taming of Chance* (Cambridge: Cambridge University Press, 1990).
7. John Charles Bucknill and Daniel H. Tuke, *A Manual of Psychological Medicine* (Philadelphia: Blanchard and Lea, 1858), 243-5.
8. Emil Kraepelin, *Psychiatry: A Textbook for Students and Physicians*, edited with an introduction by Jacques M. Queen (Canton, MA.: Science History Publication, 1990), 2 vols, vol. 1, 60. See also *Dictionary of Psychological Medicine*, edited by D.H Tuke, 2 vols. (London: J.A. Churchill, 1892, reprinted, New York: Arno Press, 1976), 1202-3.
9. Hidehisa Matsumura, 'Sô-utsu-byô No Ippan-teki Tôkei [Some General Statistics of Manic-Depressive Illness]', *Seishin-Shinkei-gaku Zasshi* [*Journal of Psychiatry and Neurology*, hereafter *JPN*], 41 (1937), 965-77.
10. See Suzuki, *op. cit.* (note 4). Waichirô Omata, *Seishin Byôin No Kigen* [*The Origins of Psychiatric Hospitals*], (Tokyo: Ota Shuppan, 1998); Kazuko Itahara and Kuwahara Haruo, 'Edo Jidai Kôki Ni Okeru Seishin Shôgaisha No Kenkyû [The Mentally Disabled in the Late Edo Period]' (1)-(4), *Shakai Mondai Kenkyû*, 48 (1998), 41-59; 49 (1999 & 2000), 93-111, 183-200; Genshirô Hiruta, *Hayari Yamai To Kitsune-tsuki* [*Epidemics and Fox Possession*] (Tokyo: Misuzu Shobô, 1985).
11. *Teikoku Gikai Kizoku-in Giji Sokkiroku* [*Parliamentary Debates in the House of Lords*] (Tokyo: University of Tokyo Press, 1979-1985), No. 12, 20 January 1900 and No. 21, 10 February 1900.
12. For more information on national mental patients' statistics, see Suzuki, *op. cit.* (note 4).
13. For a detailed account of home custody with many photographs, see Shuzô Kure and Gorô Kashida, 'Seishin-byôsha Sitaku Kanchi: Jikkyô 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), 521-56, 609-49, 693-720, 762-806. This invaluable work has been reprinted in the Classics in Psychiatry series, reissued in 2000.
14. *Ibid.*, 524.
15. The mutual dependence and benefit of the public and private asylums in Tokyo are satirically described in the serialised articles in *Yomiuri Shinbun* [*Yomiuri News*]. See Yasuo Okada and Shizu Sakai (eds), *Kindai Shomin Seikatsu-Shi, vol. 20, Byôki/Eisei* [*Social History of the Lives of Populace in the Modern Age, vol. 20, Disease and Hygiene*] (Tokyo: San-ichi Press, 1995), 183-223.
16. The data for Figure 1 are taken from *ARH*.
17. Yutaka Fujino, 'Shôwa Tairei To Minshû No Seikatsu To Kenko [The Showa Grand Accession Ceremony and People's Health]', in *The Records of the Showa Grand Ceremony of Accession*, 65-86; Tsuneo Matsumura et al., 'Tokyo Shinai Furôsha Oyobi Kojiki No Seishin-igaku-teki Chôsa, [Psychiatric Survey of Vagrants and Beggars in the City of Tokyo]', *JPN*, 46 (1942), 69-92.
18. Osamu Kan, 'Honpo Ni Okeru Seishin-byôsha Narabi-ni Kore-ni Rinsetsu-seru Seishin-ijô-sha Ni Kan-suru Chôsa [A survey of the Mentally Ill and the Related Mentally Abnormal]', *JPN*, 41 (1937), 793-884, 836-43.
19. *Seishin Eisei Shiryô* [*Archives of Mental Hygiene*], 3 (1955), 13-14.
20. Kan, *op. cit.* (note 18), 846-7; Toshiharu Fujita, 'Seishin-shikkan-kanjya-sû Ni Ttuite-no Jûgo-nen-kan No Nenji Suii [Yearly Changes in the Number of Mental Patients in the Last Fifteen Years]', *Nihon Kôshû Eisei Zashi* [*Japanese Journal of Public Health*], 38 (1991), 233-45, 299-309.
21. *Archives of Mental Hygiene*, 3 (1955), table 2.
22. The table is based on Yoshibumi Ôta et al., 'Nihon Ni Okeru Seishin-bunretsu-byô No Hatubyô Kikenritsu [Morbidity Risk of Schizophrenia in Japan]', *Seishin Igaku*, 28 (1986), 421-6.
23. The discharges included deaths while staying in the asylum.
24. Fujita, *op. cit.* (note 20).
25. Saburô Okuda, 'Sôhatsu-sei-chihô-shô No Rinshô-teki Toukei-teki Kansatsu [Clinical and Statistical Observations on Dementia Praecox]', *JPN*, 41 (1937), 885-919.
26. This characterisation of Japanese psychiatry has been vigorously maintained by Yasuo Okada. See, e.g., his *Nihon Seishin-iryôshi* [*History of Japanese Psychiatry*] (Tokyo: Igaku-shoin, 2002).
27. Nuboharu Aoki, 'Seishin-ijô-sha No Zouka To Sono Taisaku [The Increase of the Mentally Abnormal and Measures against it]', *Koshû-eisei* [*Public Health*], 53 (1935), 161-8, 234-40, 304-11.
28. *Archives of Mental Hygiene*, 1 (1953), 21.
29. Okada, *op. cit.* (note 26), 130-1.
30. In Figure 2 I have not used the M/F ratio, because in four prefectures there were no female patients hospitalised.
31. Nancy Tomes, 'Women and Depression: A Historical Perspective', in Yosio Kawakita, Shizu Sakai and Yasuo Otsuka (eds), *History of Psychiatric Diagnosis: Proceedings of the 16th International Symposium on the Comparative History of Medicine* (Tokyo: Ishuyaku EuroAmerica Inc., 1997), 55-83.
32. For Ôji Brain Hospital and its patients, see Suzuki, *op. cit.* (note 5).
33. Matsumura, *op. cit.* (note 9).
34. Mitsunao Koseki, 'Katei Ni Okeru Seishin-byôsha No Chiryô-kango-hô [Treatment and Nursing of Mental Patients at Home]', *Iji Kôron* [*Public Medical Gazette*], no. 807 (1928), 14-15. Koseki's paper listed six drugs for excited patients, while only one for depressed patients.