Cultural representations of mental illness in contemporary Japan

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Abstract

This paper presents the results of a research project aimed at studying the cultural representations of mental illness and related interventions models in contemporary Japan, and providing the basis for a comparison between Japanese and Italian mental health cultures. The research methodology is based on interviews with scholars and professionals from multiple disciplinary areas and fields of practice, in order to analyze the interactions between medical, social sciences' and humanities' discourse on mental illness. The results highlight the significance of home custody within the modernization of the country, between Edo and Meiji periods; the cultural frameworks of contemporary psychiatry's action; what anti-psychiatry and the 'critical' reflection on mental illness represented within the academic debate; the new demands and potentialities connected to the spread of psychology within the mental health sector; remarkably new experiences of social integration with the contribution of arts.

Keywords: mental illness; cultural representations; Japan; international comparison; multidisciplinary study.

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Introduction

In this paper I will discuss the first results of a research project aimed at exploring the cultural representations of mental illness and related intervention practices in contemporary Japan and laying the groundwork for a comparison between Japanese and Italian mental health cultures.
The more recent history of mental health institutions has been characterized by a trend towards the progressive reduction of hospital-based treatments and the promotion of community-based interventions. International monitoring organizations extensively agree on the need to convert a hospital-centered system, based on the seclusion of the person from her/his own environment, into a system based on a network of outpatient and community services, oriented towards the empowerment of the person with mental illness and his/her social environment. In recent international surveys, a low number of psychiatric hospital beds has even been considered an indicator of national health care quality (OECD, 2013). Nonetheless many studies point out the difficulty and nonlinearity of this shift (Rickter, 1999; Thornicroft, Tansella, & Law, 2008). Furthermore, within this global trend, the states' response shows a high and interesting variability.
An emblematic case of such variability and nonlinearity is offered by the comparison between Japan and Italy.
Japanese mental health services system is mostly based on hospital treatment, while outpatient and community services have begun to develop very slowly. Conversely Italy was a pioneer, among European countries, in the adoption of legislative reforms which, starting in the '70s, led to the shutdown of psychiatric hospitals and to the set up of new community services. Strongly aimed at supporting the social rehabilitation of people with mental illnesses, the Italian system is now exhibiting signs of a critical impasse.
Looking purely at the number of beds - as data presented by the OECD (Organization for Economic Co-operation and Development) in 2012 show - the two countries seem to be positioned at the opposite polarities of a homogeneous phenomenon: Japan is the country with the highest number of beds for the treatment of psychiatric problems, among member countries; Italy is conversely the country with the lowest number of psychiatric beds per population (OECD, 2013).
The basic hypothesis from which my research starts is that, by themselves, these data suggest a difference between Japanese and Italian mental health systems, whose meaning and social implications are however still not evident at all: this research project aims at exploring the complexity of the cultural foundations from which such diversity stems, which in my mind cannot be represented in a linear form. The objective is to go beyond the descriptive dimension and to build analytical hypotheses on the cultural models and contexts which contribute to shape representations of mental illness in contemporary Japan and healthcare practices that are in line with these representations.

The relationship between culture and practices in a psychosocial perspective
Throughout the twentieth century a wide international literature (written both by Japanese and foreign authors) has been produced on the problem of mental health care models in Japan. Across this literature, we can find two prevailing ways of interpreting the role of culture in shaping intervention practices: *culture as progress* on the one hand; *culture as essence* on the other.
I suggest a re-interpretation of these two models, on the basis of a psychosocial perspective.

- *Culture as social efficacy*: because of its focus on hospitalization, Japanese mental health system has been recurrently criticized in terms of backwardness when compared with the best practices developed in western countries. In contrast to the universalistic ideal contained in the notion

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of progress, the hypothesis I intend to investigate is that the social efficacy of a determined healthcare practice depends on the Local Culture specific to each context. In this sense, the hospital/community antinomy does not contain in itself either a universal or a developmental value. On the contrary, I suggest that the efficacy, the change as well as the decline of models and structures of intervention depend on the cultural expectations which are shared by those who actively participate in the context and ultimately historically founded.

- *Culture as dynamic polysemy*: some studies have been proposing the existence of a Japanese cultural uniqueness which would hinder the application of models drawn from foreign contexts to Japan[1]. These studies tend to essentialize the cultural dimension converting it into an analogous of a natural datum, as such exempt from change, exchange or development. In accordance with the construct of cultural representations that leads this research, culture is considered as a dynamic process, not internally homogeneous, but rather polysemic, multi-faced and changeable. The comprehension of this polysemy extends the range of categories we can use to direct actions on the level of social reality and demands.

Starting questions

This project comes from several years of research on and work in Italian mental health services (Carli, Paniccia et al., 2008; Carli, Giovagnoli et al., 2008). As a result of such experience, it became clear to me the anomic isolation that is diffusively afflicting Italian psychiatry and in particular the SPDCs, the psychiatric wards inside general hospitals entrusted with crisis intervention. These facilities have been suffering a longtime negative stigmatization connected to the cultural meaning that the psychiatric hospital and its closure at the end of the Seventies had in Italy. The fight against the confinement of mental illness became symbolic of a wider struggle for valuing diversity and for the creative emancipation of powerless subjects. This ideological background, which was in those days the driving force of the change, is currently the root of an impasse in the Italian mental health system.

Meanwhile we are seeing a significant rise in and diversification of demands for mental health services on the part of the users. Thus, while psychiatry seems to be facing a major crisis in its image and social function, on the one hand, social demand grows and becomes more heterogeneous, on the other: at the center of this gap, mental health professionals are struggling to reorient their competence towards a system of aims and actions that might be coherent and effective with respect to the problems perceived by users.

Starting from these questions, I decided to investigate the cultural representations of mental illness in today's Japan, by analyzing the point of view of professionals and scholars of the sector. I carried out interviews with Japanese scholars and professionals from different disciplinary areas and areas of competence (psychiatry, psychology, psychoanalysis, anthropology, history, social work, mass media, arts), dealing with mental illness as central issue of their research and work.

We are interested in exploring how different disciplinary perspectives and competences, which are active in the field of mental health, are influencing the cultural representation of mental health in contemporary Japan, and which specific resources they offer for the intervention. By collecting multiple interpretative frameworks (not only medical but also social sciences' and humanities' discourse) and studying their possible interactions, we intend to investigate the different contexts from which mental illness is currently emerging as a problem in Japanese society.

The interdisciplinary research design is fundamentally linked to a theoretical interest towards mental illness as a relational event - i.e.: an event that produces crisis within social coexistence. Since it directly affects the relationship between normality and deviance, common sense and strangeness, the field of mental health may represent a revealing case study of more general dynamics underlying social coexistence: namely, through which strategies social systems regulate the relationship between

[1] One representative case of this position is offered by the interesting psychoanalytic literature on the Ajase's complex, elaborated as evidence of the need for a Japanese counterpart of the Edipo's complex (Radich, 2011).

subjectivity and purposes of the social coexistence, or how the problems of diversity's integration as well as of founding systems and experiences of belonging are tackled[2].

The research context: on the history of practices and institutions for mental illness in modern and contemporary Japan

As time frame of this study, I decided to consider Japanese modern and contemporary history, more specifically the period running from the Meiji era up to the present. Within this century-and-a-half time frame, it is possible to identify some epoch-making events, concerning both the general history of the country and the history of the institutions for mental illness.
Why starting from the Meiji period? The Meiji period (September 1868-July 1912) is certainly one of the most studied and debated eras of Japanese history, by both Japanese and international historiography; the number of diverse labels which have been coined for this transition – Meiji restoration, revolution and more recently renewal – shows the intensity and complexity of the debate.
Since the end of the eighteenth century and the first decades of the nineteenth century, international interest towards Japan heightened as well as pressures from foreign countries asking the *bakufu* to authorize trade relations; Japan responded embittering the seclusion policy which had been characterizing the Tokugawa domination[3]. Finally, two United States naval expeditions leaded by Commodore Perry brought these tensions to the higher point: under the threat of war Japan accepted to sign a treaty with the United States whose terms were soon extended to other foreign powers; these treaties are known as "unequal treaties" because Japan surrendered to definitely disadvantageous conditions concerning tariffs of trade exchanges and legal jurisdiction over ports and foreign nationals in Japanese territory. The signing of the unequal treaties and the opening of trade certainly represented powerful drives towards the political change by which the country was soon enough concerned.
The notion of Meiji restoration refers to the complex process that marked the end of Tokugawa shogunate, after more than 250 years of domination, and the rise to power of the emperor Meiji: the term restoration, used by the group of *samurai* and feudal lords that leaded the armed revolt against the *bakufu*, was intended to emphasize the restored apogee of an imperial line dating back to an ancient-mythic past. The international historiography also named this period as Meiji revolution or renewal, in order to underline the intense modernization of the country promoted by the Meiji government: Japan adopted, especially from European countries, innovations in every sphere of social life (technology, institutional forms, economic models, lifestyle, sciences). The ultimate aim was to release the country from the semi-colonial condition established by the unequal treaties (escaping from a fate in common with China and other Asian countries) and to make Japan a competitive power on the international scene.
The Meiji era was therefore a time of profound cultural transformation: while Japan was modernizing by means of a radical innovation movement, at the same time she was building and strengthening her

[2] Concerning this, I have found of great interest the analysis proposed by De Munck and other authors (De Munck et al., 2003) on mental health services in Belgium, their formation and development, where changes in the concept of mental illness as well as in healthcare supply, occurred over the years, are systematically related to concurrent changes in models of citizenship and of public action within the country.

[3] The Edo period or Tokugawa period is the era of Japanese history (from 1603 to 1868) when the country was ruled by the shogunate (*bakufu* or military government) of Tokugawa family. The first Tokugawa shoguns (particularly Ieyasu e Iemitsu Tokugawa) settled on an elaborate system of agreements aimed at neutralizing every possible opposition from rival warlords, the imperial court, samurai, peasants, merchants, Buddhist monks. They established an era of political stability and peace founded on the conservation of a very strict social order. Within the framework of this power control strategy, the Edo period was characterized by strong limitations to travels and trade relations with foreign countries, as declared in the 1635 Edict known as the *Sakoku* Edit (the Edict of the Closed Country).

traditions. A broad literature on Japanese modernity has emphasized the process of inventing traditions carried out by Meiji oligarchs - knowingly or unknowingly assisted by intellectuals and scholars - in order to build a strong myth of the imperial Japan. On this point, the historian Andrew Gordon reminds that: «in modernizing Europe, no less than in Japan, artists and poets were among many who turned to their own past to find or invent spiritual traditions in the face of a modernity seen as inhumane or excessively materialistic» (Gordon, 2003, pp. 108-110).
By this looking back, modernity has invented traditions not only as an artifice planned by the leading class in order to manipulate the popular consent, but also for that constructive process of memory, peculiar to the modern experience, according to which some aspects of the past have been chosen as representing the whole and so essentialized. The Noh theatre and the tea ceremony, as well as the ukiyo-e, were embedded in a broader context of habits and social relations. During the Edo period they were not symbols of Japanese culture. They acquired such role during the Meiji era.
Within these complex dynamics of pursuing innovation and tradition, I want to investigate which was the place and meaning of mental illness.

The historical development of mental health services in Japan, in the time frame we are considering, can be divided into three macro-periods.
In the first part of twentieth century an "*institutionalization" of mental illness* was accomplished. By the term institutionalization, here I mean the creation of institutions - legally ruled systems of general validity - formally in charge of mental illness issues. Differently from European countries and the United States where, since the second part of the nineteenth century, national systems of mental asylums had been established, the main institution for the care of the mentally ill in Japan at that time was home custody.
In the years following the Second World War up to the '70s, the *psychiatric hospital* became the central apparatus for the treatment of mental illness. Instead of public hospitals, private hospitals will come to play a dominant role in mental health care in Japan.
From the end of the '80s up to the present, legislative innovations, within a broader movement of cultural innovation, triggered a dynamic of *"social integration" of mental illness*.

The first half of the twentieth century:"institutionalization" of the interventions on mental illness

The **Law for the Care and Custody of the Mentally Ill**[4] (*Seishin-byosha Kango Ho)* of 1900 has been the first act of national legislation concerning mental illness in Japan. The law aimed at codifying a longtime practice of domestic custody (*shitaku-kanchi*) of the mentally ill.
It has been possible to count around 29 facilities, mostly based in shrines and temples, that housed persons with mental illness as well as vagrants and otherwise sick people, during the Edo period until the eve of the Meiji era; nonetheless the primary locus for the care of mental illness was family (Suzuki, 2003).
Under the new law, domestic confinement had to be authorized by the local government of the village or the town, by means of the designation of a guardian, responsible for the person with mental illness.
The institutionalization of home custody in Meiji Japan meant the introduction of a meticulous procedure aimed at regulating even measures and materials of the room-cage (*sashiko or zashikirō*) inside the house where the person was confined; the architectural plan of this space itself had to be approved by the local administration (Suzuki, 2003).
Apparently everything was turning towards a standardization and rationalization of actions. This process, in my mind, fostered an objectivation-reification of mental illness that changed the social perception of the problem (Bucci, Campagnola, Taguchi, 2014). It is within the discourse on Meiji

[4] Different translations of the title of the law appear across literature: the one I have chosen (Kitanaka, 2012); Mental Patient's Custody Act (Suzuki, 2003); The Law of Confinement and Protection of the Mentally Ill (Ito & Sederer, 1993; Totsuka, 1990); Law for the Custody for Insane Persons (Nakatani, 2000).

home custody and the 1900 law that the images of patients locked in the cages or testimonies on the horrors of that experience appear in literature.
A decisive contribution to this cultural shift came also from the simultaneous development of psychiatry as professional category, based on an autonomous disciplinary statute. Under the guidance of leading figures such as Kure Shuzo – the second professor of psychiatry at the Imperial University of Tokyo and scholar with a European background – the new psychiatric science took roots in more and more sectors of social life: it contributed to the spread of a new cultural interest in public hygiene and health education, particularly among the emergent cultured and wealthy middle class; it began dealing with infancy and educational issues as well as efficiency in the industry and the army (Kitanaka, 2012). The pressure of psychiatrists, through their associations and journals, actively weighted on the emanation of the second national law concerning mental illness, the **Mental Hospital Act** (*Seichin Byoin Ho*), in 1919, during the "Taishou democracy"[5].
The Mental Hospital Act emphasized mental illness as an illness, hence requiring medical treatment in hospital (Kumasaka & Yoshioka, 1968) and empowered the central government to order the prefectures (local administrative unites) to build public hospitals, whose building and maintenance costs would have been partly covered by the State. At the time there was only one public hospital of larger dimension in Tokyo and a certain number of small privately-run entities.
Also the 1919 law codified a practice already active under various forms in the past: it established that privately-run hospitals could admit patients whose recovery was paid by public funds (a certain number of beds for public patients were appointed to private hospitals - "substitute" beds) (Suzuki, 2003).
Nonetheless, under the financial hardships of the post-war period, the project of a future centrality of public hospitals proved to be an impossible task (Nakatani, 2000).
Over the twenty years after the law was passed, although the great majority of patients registered as mentally ill remained still without any custody, the whole number of patients under domestic custody or in hospital increased and, especially in the most urbanized centers, the main locus of care moved from family to hospital. The new law must not be considered the only responsible for this change; an increasing social demand in favor of hospitalization (particularly in private hospitals) was rising meanwhile (Suzuki, 2003).

The second post-war: the development of the psychiatric hospital
The **Mental Hygiene Law** (*Seishin-Eisei Ho*) of 1950 marked a strong historical discontinuity. It was approved during the United States occupation of Japan following the Second World War. The law forbade home custody (Asai, 1999) and ordered the medical treatment of mental illness in the psychiatric hospital (Ito & Sederer, 1999). One important feature of the law, for its consequent structural effects, was the introduction of a legal definition of mental illness and of the recovery procedures: the law established the principles of compulsory admission by administrative order in case of "danger to self and others" and of involuntary admission by request of the family or a legally responsible person. Up to 1987 compulsory-involuntary admission has been pervading in Japan: according to some authors almost the 90% of admissions occurred under these principles (Asai, 1990). Such trend was strengthened by the fact that the expense for involuntary patients was subsidized by the government and hospitals tended to apply involuntary admission also to patients who were not an obvious threat to society (Ito & Sederer, 1999; Nakatani, 2000).
During the 1960s the number of mental hospital grew and hospitalization definitively overcame home custody (Ito & Sederer, 1999).

[5] The Taishou period (1912-1926) which was characterized by the so called "Taishou democracy", was a time of intense popular mobilization for better life and work conditions especially for workers in the industry which was rapidly developing at that time. The government responded to these requests by planning the first national measures for welfare and health care (the first health insurance national system was launched).

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This process, however, occurred within the framework of strong tensions. On the one hand, national policies encouraged the multiplication of psychiatric hospitals by authorizing staff:patient ratios less than half of those required for general hospital and providing low-interest loans for building private institutions. On the other hand, during that decade, criticisms of Japanese mental health system intensified, both at the international level and inside the country. The anti-psychiatric movement took off by the late '60s, spread nationwide - particularly in the academic milieu - and found its symbolic core in the more than 10 years long occupation of the psychiatric unit of Tokyo University (Kitanaka, 2012).
As Kitanaka suggests, while on the one hand the anti-psychiatric thought interrupted the longtime dominance of neuropsychiatry in Japanese psychiatric tradition, on the other, the break-up of the movement left a conceptual vacuum which was quickly filled by the DSM III, whose "operational" diagnosis well suited to be absorbed by the common sense (Kitanaka, 2012). In a very peculiar and unpredictable way, on a long-period, seeds sprouted by that experience prepared the conditions for the later widespread medicalization of depression (Kitanaka, 2012) in particular, and the more general entrance of psychiatric diagnosis in everyday life.

From the end of the '80s until the present: "social integration" of mental illness
In 1985, the International Commission of Jurists and the League for Human Rights organized a mission in order to examine the functioning of Japanese mental health services system. Under the pressure of these international bodies, in 1987 the Japanese parliament approved the **New Mental Health Act**, which, for the first time with respect to all previous laws, included measures for the protection of patient's human rights. The law prohibited restrictions on the patient's freedom such as the use of seclusion rooms for more than 12 hours or the prohibition to send or receive correspondence or to meet visitor. Psychiatrists were under the obligation to inform the patient of his/her rights at the admission in hospital. Patients who were involuntary admitted could appeal to the Prefectural Governor. A new entity, the Psychiatric Review Board, was set up to regularly monitor compulsory-involuntary admissions and order improvement of treatments or discharge. Moreover, the law recognized different typologies of admission: voluntary admission, admission for medical care and custody, involuntary admission by the Prefectural Governor, emergency admission. Finally it empowered the Prefectures as well as other local governments and non-profit organizations to establish outpatient and day-care facilities, funded by national and local budgets, for the social rehabilitation of patients.
Some jurists highlights that up to the 1987 law, the concept of voluntary admission did not exist in Japanese legislative corpus (Totsuka, 1990). The acknowledgement of the possibility of a voluntary nature of the admission can be read as the sign of an increasing proximity between normality and pathology within the social representation of mental illness.
The more recent change, within our historical overview, is linked to the **Mental Health and Welfare Law of 1995**, which recognized mental illness as a disability (Ito & Sederer, 1999). The law was based on two previous laws, the Basic Law for the Disabled (1993) and the Community Health Care Law (1995) and its project was to incorporate welfare measures into a model of intervention until then mostly based on medical treatment, in order to promote the independence of people with mental disabilities and their participation in socio-economic activities. Within the scene of developing outpatient and community-based services, welfare homes and workshops as well as training and work services became active.
Starting from the 1990s clinical psychology has been reaching a more formalized disciplinary status[6]. In 1992 the Ministry of Education decided to employ clinical psychologists as educational counselor

[6] For an overview on the current status of the qualification procedures in clinical psychology and psychotherapy, particularly psychoanalysis, and the general conditions for training and clinical practice in these fields in Japan, see Shingu, 2008.

in all country schools. Currently psychologists are negotiating with the government to obtain a national licensing system.
During this period, particularly since the 2000s, psychiatric diagnosis has been having a crucial role in the battle between families and lawyers on the one hand and companies on the other concerning the tragic problem of overwork suicide (Kitanaka, 2012).
While psychiatric categories penetrate diffusively into the explanation of more and more problems in everyday life, at the same time the psychiatric hospital remains a central element for mental healthcare in Japan.

Methodology

The research methodology is theoretically informed by the clinical psychology notion of *Local Culture* (Carli & Paniccia, 2003) that refers to the process of sharing symbolic-subjective meanings within social relations which forms the basis of sensemaking and behavior regulation in social groups. The analysis of the *Local Culture* allows to understand a social group's or organization's experience regarding an object by which they are concerned, the set of symbolic meanings that object acquires in the representation shared by those who are in relation with it.
A set of 18 semi-structured in depth interviews, with Japanese scholars and professionals dealing with mental illness as principal focus of their research and work, was conducted. For the selection of the research participants, two illustrative variables were taken into account: 1- disciplinary area (psychiatry, psychology, psychoanalysis, anthropology, history, social work, mass media, arts); 2- field of practice (mental health service/academia/both). The interviewees' group comprehends highly distinguished Japanese professionals and scholars in the field of mental health as well as key figures in the history of mental health institutions in Japan. The interviewees were selected also paying attention to enlarge as much as possible the research geographical area. We gathered interviews in some major urban areas of Honshu, the central island of Japanese archipelago: Tokyo, Kyoto, Kobe, Yokohama, Hyogo, Okayama.

The interview setting
The interviews were based on three open questions (the same questions have been posed to all the interviewees): a) the first question allowed the interviewee to speak freely about her/his considerations on mental illness in Japanese society, according to her/his academic and professional experience; b) the second question concerned the principal aims towards which scholars and professionals who deal with mental illness in Japan are currently pointing their efforts. The interviewee was asked to compare the present situation with the past; c) the third question inquired if there have been significant changes in the social image of mental illness in Japanese society over modern and contemporary age, possibly connected to other important changes for social life in Japan.
All the interviewees were invited to indicate in which language they preferred to talk, whether in Japanese, in English or in Italian and to move from one language to another, during the interview, in case something they wanted to talk about was difficult to express in a foreign language. The interviews in Japanese - the majority in this research - were conducted with the assistance of an interpreter. It is interesting to point out that in more than one occasion our interlocutor, during the interview, decided to shift from Japanese to English, the latter being a language shared by all the participants in the interview, as a way to reduce the distance and facilitate the exchange.
I will further discuss the linguistic dimension later because it represents one important component of the relationship with the research participants and consequently of the setting institution. This is a relevant issue since the quality and nature of the setting determines the research results' validity and readability.

It is to be considered that the international exchange was neither the core nor the direct topic of this study but represented its framework. One could say it was a substantial condition for establishing the specific reflection on mental illness in which we were taking part. Each interview was introduced giving to the interviewee some basic information: the research has been funded by a Foundation active in the promotion of cultural and scientific relations between Europe and Japan; the research was directed by an Italian scholar within a wider project of cross-cultural comparison focusing on mental illness. We thus can assume that the analysis of the interviews will also give us information about our interlocutors' symbolization of the international exchange, its dynamic and possible outcome.

The Emotional Analysis of the Text

The interviews were recorded, transcribed and analyzed by means of Emotional Analysis of the Text (AET). AET is a method for the analysis of the discourse whose purpose is to investigate in the fieldwork the theoretical construct of *Local Culture* (Carli & Paniccia, 2002).

The sharing of the same contextual topic – contained in the interview questions – allows to put together the texts of all the interviews to form a single textual corpus.

At a first stage the textual analysis is conducted by selecting within the vocabulary those words which we refer to as "dense" words, that means words of the local discourse containing highly interesting information on the affective symbolization of the research object. At a second stage, the co-occurrence of the dense words within the text is analyzed by the statistical techniques of multiple correspondence analysis and cluster analysis. These procedures consent to draw from the text those groups of dense words that more frequently and significantly recur together: thus we obtain some clusters or repertoires of dense words positioned on a factorial space (Fig. 2). Each cluster represents a specific feature of the *Local Culture*, a specific way in which the research participants symbolize their relationship with the research object; the relationship between the clusters provides information on the overall dynamic that enlivens the *Local Culture*: main criticalities as well as main resources and development perspectives (Fig. 2; Tab.1).

Given the central role of words and co-occurrences in this method of textual analysis, linguistic choices have been accurately considered, particularly because of the variety of languages involved and the consequent importance of translations.

The interviews were first transcribed in the original language, and finally translated into Italian. The textual analysis was conducted on the Italian version. Two translators were entrusted with the translations from Japanese to Italian, one Japanese native speaking, the other Italian native speaking, both specialized in the translation between the two languages. During the translation process, two vocabularies were created, the first containing the lexicon from the interviews in Japanese, the second from the interviews in English, and related translations in Italian. The two vocabularies were created to obtain coherence in the translation choices over the whole text and as essential basis for the following choice of dense words and cluster interpretation.

The cluster interpretation presented in the next paragraph was conducted through a clinical psychology method based on the analysis of the emotional polysemy of words, that is the capacity for a word to have multiple, potentially infinite related meanings and cross-references to symbolic universes. From a psychological-psychoanalytical perspective, each word is inscribed into a metaphorical tradition which consists of the discursive contexts of which the word has been part over the course of time. For this reason, in this kind of analysis, one normally studies etymology of words and, as far as this research is concerned, we also studied the meaning of the kanji used for writing the Japanese words[7].

While we are talking about a determined topic or object - clearly identifiable and univocal in terms of external reality - at the same time we are evoking multiple contexts of experience - in terms of

[7] The following dictionaries and etymological dictionaries have been used for the cluster interpretation: Breen (2013), Cortellazzo & Zolli (1999), Harper (2013), Klein (1971), Matsumura (1998).

subjective reality - which contribute to found what that object represents to us, our subjective relation with it. Thus, while we are talking about a certain object, we are also talking about what it represents. It is important to clarify that this is by no means a philological analysis. The focus of our interest is which value a certain etymological or ideographic content of a word might potentially have in terms of the unconscious emotional symbolization, for its capacity to generate symbolic links. The relevance of these symbolizations, as we will see, is then verified by studying the co-occurrences of words throughout the discourse (Tab. 2).

Results: analysis of the Local Culture

Figure 1. Illustrative variables

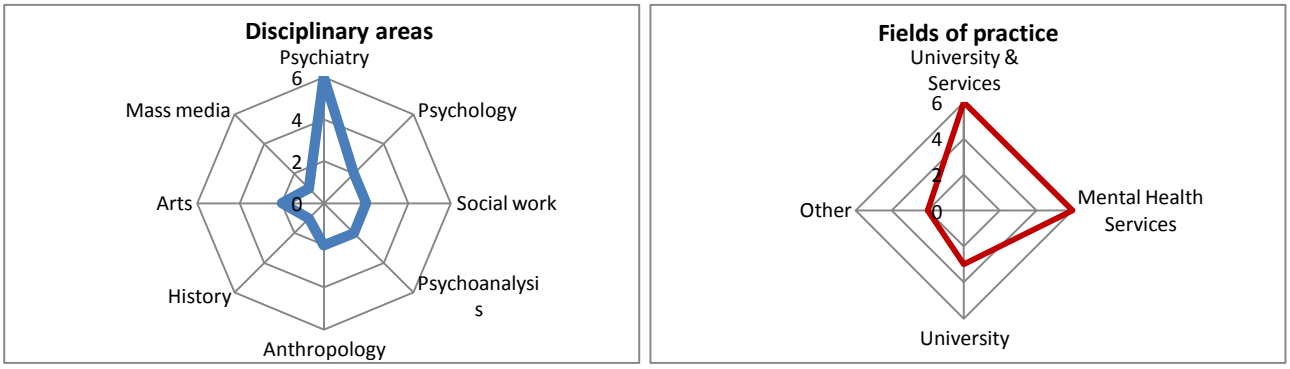

Figure 2. Factorial space (clusters and illustrative variables)

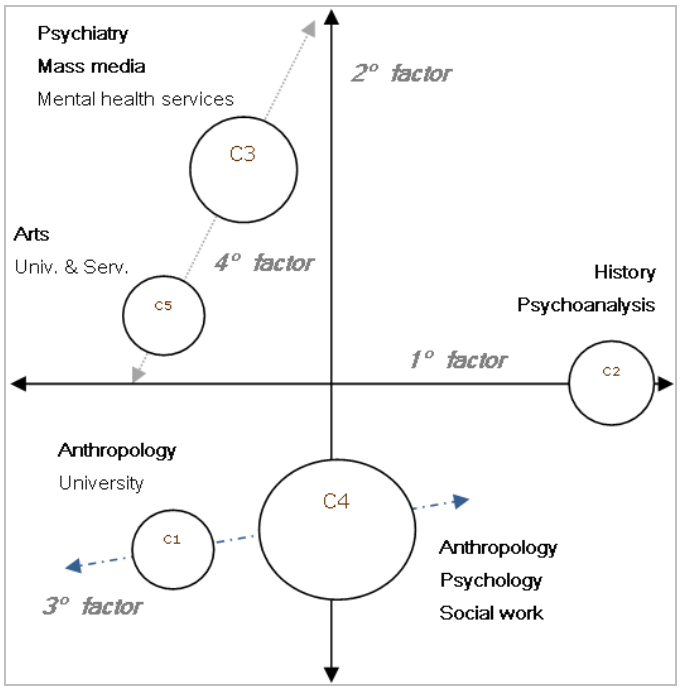

Table 1. Relationship between clusters and factors (cosinus)

	Factor1	**Factor2**	**Factor3**	**Factor4**
Cluster 1	-0,283	**-0,579**	**0,763**	-0,042
Cluster 2	**0,968**	0,034	0,146	0,203
Cluster 3	-0,213	**0,777**	0,193	**-0,561**
Cluster 4	-0,148	**-0,538**	**-0,798**	-0,226
Cluster 5	-0,300	0,238	-0,018	**0,924**

Table 2. Clusters of dense words and illustrative variables (ordered by Chi-square*)

Cluster 2 (14.42 %)		**Cluster 3 (24.29 %)**		**Cluster 1 (11.44 %)**		**Cluster 4 (39.03 %)**		**Cluster 5 (10.82 %)**	
78.76	edo	133.49	hospital	77.84	interest	45.49	work (hataraku)	196.76	music
78.76	zashikirou	89.31	private	77.68	critical	25.64	psychology	144.03	music_therapy
59.14	meiji	76.1	bed	54.78	perspective	25.13	problem	135.34	disability
58.8	world	56.19	doctor	46.88	antipsychiatry	23.67	company	74.44	art
54.49	kichigai	51.3	psychiatry	46.88	notion	18.32	achieve	58.37	improvisation
52.99	war	46.3	admission	39	biologic	15.87	spread	49.95	intellective
41.2	meaning	35.1	reduce	39	foucault	15.31	work (shigoto)	49.39	activity
35.95	lineage	28.45	pay	39	trasnsform	14.95	sick	46.95	organize
35	family	25.85	insure	32.3	understand	14.24	phisical	42.43	instrument
33.98	word	25.58	medical care	31.15	dilemma	14.01	community_ based	41.16	enjoy
32.31	europe	23.85	nurse	31.15	fierce	13.78	school	33.19	play
29.91	kyouki	23.13	increase	31.15	fight	13.56	young	29.52	future
29.91	possession	23.13	schizophrenia	30.89	medicalization	13.2	ask	27.13	parents
29.91	restoration	21.2	nation	30.62	social	11.89	happen	22.44	explain
29.91	showa	20.14	dementia	30.16	become	11.69	outside	18.41	good
29.91	wife	17.14	institution	29.68	sort	11.09	emotion	16.69	child
29.15	husband			26.6	clinical	11.06	desire	16.17	depend
						9.7	person	13.02	use
								12.64	like
Illustrative variables									
203.87	Psychoanalysis	186.53	Psychiatry	474.73	Anthropology	81.81	Social work	284.96	Arts
154.42	History	122.39	Mass media	160.51	University	68.47	Anthropology	92.20	Univ.&Services
		65.78	Services			30.68	Psychology		

* Minimum Chi square for the selection of a word: 2.34.

Cluster 2
The cluster is placed on the positive polarity of the first factor (Fig. 2, right side) with a high correlation. It is representative of approximately the 14% of the textual unites identified as significant by the analysis. It indicates an important but delimitated cultural position, not largely shared within the research context. Some illustrative variables are linked to this cluster: the disciplinary areas of **psychoanalysis** and **history.**

This repertoire is characterized by the co-occurrence of the following dense words: edo, *zashikirou*, meiji, world, *kichigai*, war, meaning, lineage, family, word, Europe, *kyouki*, possession, restoration, shouwa, wife, husband.
Edo (江戸) is the ancient name of Tokyo, the present capital of Japan, and the name of one era of Japanese history. During the Edo period, although Kyoto remained formally the capital of Japan and the residence of the imperial family, the Tokugawa shogunate chose the city of Edo as elective base of its system of power. In a very short time frame the city saw an impressive development becoming one of the most influential and lively metropolis in the world. The kanji of the word literally mean "the door on the bay" or "the door on the estuary": Edo is located by the sea and was initially a small fishermen's village. On a symbolic level, the proximity to the sea means a lively source of sustenance, trade and exchange with the world but at the same time a doorstep, a threshold, a boundary.
The second word is **zashikirou** (座敷牢): the room inside the house used to confine the person with mental illness. It was the main tool in the practice of family custody in Edo and Meiji periods. The kanji of the word combine three images: the idea of being seated squatting; the idea of spreading out, laying out, giving room, imposing widely; finally the jail, the prison.
The meeting between the first two dense words highlights a dynamic relation between inside and outside, passing through a boundary. The boundary plays the role of gathering, protecting what is inside, even to the extent of confining, imprisoning, but at the same time it gives access, opens up to the relation to the world, contains a request for expansion, for conquering larger spaces.
Meiji (明治) literally means "the reign of the light" or "enlightened reign". It was the name chosen by the oligarchs, who leaded the restoration of the imperial power, to highlight the ideal affinity of the latter to the enlightened monarchs of the European tradition. Such name expresses the intent of releasing the country from the seclusion and darkness experienced during the Tokugawa era.
Thus, the *zashokirou* seems to represent a connecting element between Edo and Meiji Japan. As we have seen, modernization did not happen at all as a radical break with the past. On the contrary, home custody, as other social practices coming from the Edo tradition, persisted in modern Japan. On a symbolic level the *zashikirou* stands for the complexity and ambivalence of the experience of modernity: the wish to gain an international perspective seems to coexist with the wish to remain separated from the outside world, gathered inside.

Then follow the words: world, *kichigai*, war, meaning, lineage, family, word, Europe.
Sekai (世界) **world**, literally means "what is well-known outside Japan's confines" and "society, universe, sphere". It comes from Buddhist literature where it originally meant "realm governed by one Buddha". The opening of the country to the international exchange seems to lead up to a new belonging, a larger sphere, quickly able to restore a sense of entirety.
The word ***kichigai*** (気違い), translatable as madness, contains a very significant notion for our research aims. It is formed by two kanji: *ki*, spirit, mind, air, atmosphere and *chigau*, difference; it literally means "the spirit is different". The concept of *ki*, adopted from the *qi* of the Chinese tradition, concerns a dimension that can be referred to as the breath of vital energy which presides over the organic coherence and order of all living beings (Cheng, 2000). Here we meet a concept of madness as spiritual change, which is someway comparable to the humoral theories of the western tradition, but with a peculiarity: *ki* as vital breath is a dimension that does not concern the individual and never only the body; it concerns the relation among all living beings.

Strongly associated to a specific moment of Japan's history – the Meiji transition - madness in this cluster refers to the experience of the difference, of the relationship with what is unknown. On the one hand, such experience means the access to a new belonging, to an universal; on the other, it represents a **war**, a deep life-threatening break, because it imperils that function of order which is the foundation itself of the living thing. Faced by the new, the identity seems to fall: a crisis opens up on the system of cultural **meaning**s[8] which give vital coherence to social processes.
At this point, the reference to **lineage** (in English) and to **family** (*kazoku* 家族) is very significant. Family is a primary locus of belonging and identity. Moreover a specific model of family is here evoked: the family based on the lineage, the line of descendants from one ancestor. Also the **word**, the language are fundamental means of belonging and identity: through words we can grasp the external reality, domesticate it within a system of socially shared meanings. At the same time, while the lineage refers to natural, reproductive, linear bonds, the word suggests relationships where exchange, learning, variability, choice seem more possible.
Europe appears as interlocutor of the experience presented in the cluster. Compared to the world, mentioned before – as universal sphere able to instantly absorb diversities - Europe is a delimited interlocutor, with its own identity, with which an exchange is possible.

The final words of the cluster are: *kyouki*, possess, restoration, Showa, wife, husband.
Kyouki (狂気) literally means insane spirit[9]. It contains again the concept of *ki* but this time linked to the kanji of *kyou (kuruu)* insane, from Chinese *kuang*, uncontrolled, wild animal. Insanity is associated with wild, non-domesticated animality. **Possession** (*monotsuk*i 物憑き), according to an ancient Japanese tradition, means to be possessed by a spirit, usually associated to an animal provided with special powers (the fox for instance or the wolf). In this representation of insanity - even more ancient than the notion of *kichigai* - the spirit transforms, changes its nature due to an external agent that houses in it, takes possession of it (*tsuku* literally means to lie, base on, depend, adhere, attach, infest).
Restoration (*ishin* 維新) from *I*, fiber, tie, rope (the kanji appears in many words containing the meaning of "repair": the sewing thread) and *shin*, new: literally means "the new bond"; it evokes the action of repairing or restoring in the sense of renovating something which pre-exists. The term "Meiji restoration", as we have seen, refers to the political idea of restoring the power of the original Japanese imperial line. The ever-changing interpretation of this period of Japanese history in the historiographic debate - underlining sometimes the conservative aspect of the process (restoration) or its radically innovative side (revolution) or an in-between interpretation (renewal) – is symbolically coherent with the main question focused on by this repertoire: is it possible to experience continuity within change? Encountering the New, the Other arouses the experience of being possessed, of losing one's own identity and that, as we will see, seems connected to an idea of identity as pureness of the origin.
The word ***Shouwa*** (昭和) formed by *shou*, "shining" and *wa*, "harmony, peace, Japanese style, Japan", can be literally translated as "era of peace and shining harmony" or "era of shining Japan". It is the name of the period of Japanese history corresponding to the reign of the emperor Shouwa, best known with the name of Hirohito, from 1926 to 1989. The concept of *wa* is an important notion in Japanese cultural history. *Wa* is the more ancient name of the country reported in Chinese and Korean literatures. Later this term has become representative of a Japanese ideal of harmony[10]. The notion of *wa* had a central role in the theorization of *Kokugaku* ("studies of our country", also translated as

[8] *Imi* (意味) meaning, is formed by *I*, idea, mind, heart, thought, desire as well as care, attention, and *Mi*, flavor, taste (this kanji appears in many Japanese words that mean "interest"). It signifies the function of matching an object of the external reality with an internal referent which is the basis of knowledge. How do things taste? What do I desire? What do I direct my interest to? Both external and internal reality seem to be called into question, no longer obvious in themselves or clearly connected.
[9] It can be opposed to *shouki* 正気 that means correct spirit.
[10] It appears in many current ways of saying meaning "the Japanese way" or "the traditional Japanese way".

"native studies") an intellectual movement and philosophical school founded during the Edo period, by the end of eighteenth century, in opposition to the *Kangaku* ("Chinese Studies", the study of Confucian works). The *Kokugaku* movement criticized the study of the Confucian classics which represented the canonical object of study in early modern Japan, and emphasized the importance of focusing on earliest Japanese works (Burns, 2008). Through the philological study of Japanese ancient texts and poetic forms, such as the *waka*, the *Kokugaku* intended to recover an intrinsically "Japanese" mode of subject-ness that had existed in archaic times. Kamo no Mabuchi, a relevant figure for the formation of *Kokugaku*, asserted that the original fifty sounds of Japanese - before the cultural contact with China and the introduction of writing - were derived from nature itself. They contained the original harmony, the immediate (unmediated) unity of man/nature/sound that had characterized existence in ancient times and were later lost[11] (Burns, 2003).
Finally the words **wife** and **husband** refer to the system of roles which gives order to the family sphere and guarantees the reliability of family as social unit entrusted with normative functions such as the custody of the mentally ills. At the same time the relationship between wife and husband once again involves the central problem of difference: their meeting dismantles the line of families' descendants, mixes the lineages. Because of the variability and the otherness that such meeting entails, it is as much dangerous as vital and generative.

In summary, the central problem emerging from the cluster - from a *historical* and *psychoanalytical* perspective[12] - is that of identity in the modern age: national identity as well as subjective identity.
In the ideas of *kichigai* and *kyouki*, madness is experienced as a difference that appears in the *ki*, the breath connecting and ordering all living things. It is therefore associated to a principle essential for life that is a principle of order and relationship. Family is entrusted with the custody and care of this problem as it is more generally entrusted with a central normative role within society.
Confined into the *zashikirou*, in the family house, mental illness seems to represent an area of seclusion inside a country that meanwhile is rapidly changing through the exposure to a global scene, to new cultural references that are changing the meaning of things. Modernity in Japan - with respect to the symbolic meaning here emerged - seems characterized by the encounter with Otherness. Encounter that has been experienced with strong ambivalence - access to an universal on the one hand, war, invasion, possession on the other - because constantly linked to the theme of identity: what does one come from? what does one belong to? what is familiar? which is the original and vital order of reference?

Cluster 3
The cluster is placed on the positive polarity of the second factor (fig. 2, in high) in opposition to clusters 1 and 4, placed on the negative polarity of the factor (fig. 2, down). It represents approximately the 24% of the textual unities taken in exam, and therefore indicates a rather largely shared and significant cultural position within the research context. It mainly represents the discourse of interviewees from **psychiatry** and **mass media**, as well as of those working in **mental health services**.

The cluster is characterized by the co-occurrence of the following dense words: hospital, private, bed, doctor, psychiatric, admission, reduce, pay, insure, medical care, nurse, increase, schizophrenia, national, dementia, institution.
This repertoire, more than any other within this research, focuses on the social function of contemporary psychiatry and its cultural frameworks. There seems to be two pillars of contemporary

[11] *Kokugaku*'s discourse has been later the object of a long lasting critique focusing on its possible contribution to the formation of nationalism and then of fascism and militarism in modern-contemporary Japan. Among the critics Maruyama Masao was one of the most influential voices (see Masao, 1974).
[12] *History* and *Psychoanalysis* are the illustrative variables associated to this cluster.

psychiatry's action: on the one hand the hospital as the locus *par excellence* of medical knowledge and practice, on the other hand the economic discourse with its quantitative parameters.
Here we can find the principal terms of the debate, which has become dominant in psychiatry, concerning the transition from a hospital-centered system to outpatient and community services. This goal is today inscribed into a more general trend in healthcare delivery towards a reduction of hospital-based (bed-rest) treatments, as a strategy to reduce healthcare expenditures.
Thus, while in modern Japan the problem of mental illness is associated to family (as cluster 2 shows), in contemporary Japan the social unit under problematization is the hospital, and in particular the private hospital.
The international criticism of Japanese mental health system for the high number of psychiatric beds still in existence today in the country is mainly based on the point that psychiatric hospitals in Japan are for the majority privately-held entities. This argument rests implicitly on a cultural representation that associates private to free market and assumes it as an entity opposed to the public sphere, to the public interest, the latter strongly associated to the State.
It is important to consider that Japanese private psychiatric hospitals are non-profit organizations, which do not operate in competition with each other on prices, since the cost of each service is fixed by a national pricing system all hospitals, both public and private, have to comply with.
In this regard, the first two dense words of the cluster are particularly meaningful: the word *byouin* 病院, **hospital**, is composed by *byou*, illness and *in*, institution, temple, palace, school; *minkan* 民間, **private**, is made up of two kanji: *min*, people, nation, subjects, and *kan*, space, interval, what is in the middle, term used to mean the relationship; it literally means the bond, the relationship between people of a nation.
I agree with the interpretation of this notion given by Kyu Hyuu Kim in his work on parliamentarianism and the national public sphere in Meiji Japan (Kim, 2007): he uses the word *minkan* to define the civil society, that is the combination of social organizations which exist outside the State and represent the limit of the state sphere. Similarly to the State, the civil society takes part in the construction of a national public space. I suggest that assuming a sharp opposition/division between the private and the public might be ineffective to understand the relationship between these two spheres in Japanese society and their role with respect to mental illness care.
Another sequence of dense words in the cluster gives us interesting information of the cultural models at the basis of contemporary psychiatry's action: insure, medical care, nurse. The **medical care** (*iryou* 医療, formed by *I* doctor and *ryou* heal, care) appears wrapped in between two terms, both referring to the action of protecting: **insure** (*hoken* 保険) means literally to protect, to guarantee, to preserve from what is precipitous, steep, inaccessible, impregnable; **nurse** in Japanese is *kangoshi* (看護師) that means the expert, the teacher, the master who watches over, safeguards, protects.
Thus, in the culture of Japanese contemporary psychiatric hospital we can find a deep rooted expectation to accomplish a protective function.
By looking at the following dense words, it is evident how such expectation is linked to a specific representation of mental illness and of the recipients of psychiatric intervention.
While in cluster 2 mental illness appeared as *kichigau* and *kyouki* - difference, transformation of the spirit, wild power, upheaval in social life and order - here in cluster 3 it appears as schizophrenia and dementia. **Schizophrenia** in Japanese, likewise in the Latin-derived word, is *seishinbunretsubyou* (精神分裂病), the illness of the split, rend mind[13]; **dementia** is *ninchishou* (認知症) the damaged intellect (the kanji of *nin* and *chi* together indicate precisely the notion of intellect, of cognitive function).

[13] *Seishin* (精神) "mind, soul, heart, spirit" is the contemporary term used to express the concept of mind in the words *seishinbyou* (精神病) "mental illness" or *seishinka* (精神科) "psychiatry".

In the psychiatric culture, the intervention is clearly and mainly addressed to people with damaged minds. The stress goes on the deficit, the incompetence, the incapability and consequently the need for a protective function.
In the final part of the cluster, two other words co-occur with the diagnostic categories: national and institution. As suggested before, the word **national** (*kuni*, 国) here represents the symbolic referent connecting the private to the public sphere, within the larger, synthetic domain of what is relevant to the country. The psychiatric discourse as well as the discourse on psychiatry in Japan is strongly and constantly referred to the national sphere. During the interviews with the psychiatrists participating in the research project, I was stricken by their readiness, not at all obvious, to connect their professional experience to data deriving from national surveys, about trends and changes concerning the Japanese social system as a whole: for example the increase in psychiatric admissions for dementia linked to the progressively aging population, a particularly serious problem for Japan.
Finally, the word *shisetsu* (施設) which can be translated as **institution**, establishment, facility, represents in a very meaningful way how the action of caring is interpreted and experienced in Japanese psychiatric hospital: *shi* (施) contains the meaning of giving, bestowing and performing; *setsu* (設) means to establish, provide, prepare. It is the action of establishing and providing a service in response to a warrant, to an entrustment; this founds in terms of affective symbolization the institutional dimension (in such terms a dimension which can be cross-public and private).
We find Japanese psychiatry being culturally strongly based on what we could refer to as "social warrant". Since the main recipients of the psychiatric intervention are - according to the cultural representation showed by the cluster - people supposed incapable to express by themselves a demand for care, psychiatry's action primarily responds to and must be legitimated by a collectively sanctioned will[14]. We will come back on this point in the conclusions.

Cluster 1
It is placed on the negative polarity of the second factor (fig. 2, down) near to cluster 4[15] and in opposition to clusters 3. It is representative of approximately the 11% of the textual unites under study, that is a rather delimited experience, and mainly associated to the disciplinary area of **anthropology** and to the discourse of interviewees working in the **university** sector.

Cluster 1 is characterized by the following dense words: interest, critical, perspective, anti-psychiatry, notion, biologic, foucault, transform, understand, dilemma, fierce, fight, medicalize, social, become, sort, clinic.
It is the repertoire that most intensely focuses on the relationship between knowledge and life, questioning the contribution that academia can offer to deal with the problem of mental illness.
The co-occurrence of the first three dense words expresses a specific question. **Interest**, from Latin *inter esse*, means to be between, to be part of, and consequently to concern, to matter, to be of importance. **Critical** derives from Greek *kritos* (through the Latin *cernere*) and means to separate, to choose, to judge, to decide (from the same linguistic root come also the words crisis and criterion). **Perspective** from Latin *per*, through and *spicere*, look at, means to look through, to catch by the glance the depth of things, their occurring over time and space.

[14] By looking at the illustrative variables, we see that the cluster mainly represents the discourse of psychiatrists and journalists. This is interesting if we consider how much the social image and legitimacy of psychiatry has been depending on the mass media. The history of mental illness, in Japan as much as on the international scene, have been characterized by epoch-making scandals, where journals denounced the abuses suffered from patients inside the psychiatric hospitals. Nonetheless it must be noted that, from a symbolic point of view, both these perspectives (so much antagonist on the social scene) share and contribute to produce a representation of the person with mental illness as an incapable subject in need for protection.
[15] Clusters 1 and 4 contribute also to the third factor of the cultural space, on which on the contrary they are opposed. We will see later on the meaning of such double relation.

The interest refers to the experience of being involved, concerned by something, and at the same time closed in, squeezed by. A separation is needed so that a judgment, a decision might stem from such involvement. The action of separating, contained in the critical attitude, stands for the opposite of being squeezed by, closed in: by separating yourself from your object of interest, you can look at its developments and contexts, you can gain a perspective on things, a glance on the future.
Follows the word **anti-psychiatry** that specifies further the terms of the problem expressed in the cluster. Being interested in issues related to psychiatry, does it inevitably mean to take part in, to become involved in, to be militant within a conflict between two parts where *terzium non datur*[16]? Or is a critical interest possible, that is an interest which can offer a perspective, lead up to a development, where a "third (possibility) is given"?
Anthropology launches this question: this disciplinary area (the more significantly represented in this cluster) seems to be looking for a new perspective from which pursuing its interest in psychiatry, after the cultural turning point marked at the international scale by the anti-psychiatric movement, since the Sixties.
Follow the words notion, biologic, Foucault, transform, understand, dilemma, fierce, fight.
The aforementioned search for a perspective seems to concern primarily one issue: the **biologic** sphere (from Greek *bios*, life) and how to consider, how to conceive it, through which **notions** and interpretative models. The work of Michel **Foucault** seems to be recalled here as a turning point responsible for a radical change in our understanding of mental illness and at the same time of our notion of biologic[17]. On a symbolic level Foucault's thought is associated to a **transformation**, that means the experience of going "across the form": from Latin *trans formare*, the term *form* entails etymologically the experience of keeping, containing within the limits, the perimeter of a stable configuration. Thus here we can find references to an experience of profound intellectual insight; at the same time the containing function of knowledge - the capacity of notions and intellectual categories to construct meanings, as stable reference frames - is called into question.
Understand, from old English, *under*, between, among and *stand*, to assume and maintain an upright position, also to bear, tolerate: it recalls again the experience of being in the middle, captured by a **dilemma**, which is the word that follows. A dilemma is a two-way argument, formed by two opposite propositions, as far as the content is concerned, but having the same consequence, whatever is your choice. A dilemma can be considered as a false question, because it does not offer a real solution. Again *tertium non datur*. The resulting emotion is that of being part of a **fierce fight** (fierce comes from Latin *ferus*, wild beast, or from *ferre*, to let oneself get carried away) devoid of rules but at the same time enthralling. We see again the risk of being captured by an interest as much involving as oppressive because without development.
The final sequence of dense words –medicalize, social, become, sort, clinic - tries to introduce a change. We are confronted again with a dilemma, a conflict between two apparently opposite views of mental illness: a medicalizing perspective on the one hand[18] and a perspective which emphasizes the

[16] It must be considered the violence intrinsic to a movement which assumes in its own denomination the purpose of annihilating a disciplinary area.
[17] Foucault's notion of "biopower" (Foucault, 1976) is significantly connected to his reflection on mental illness and more specifically on the contribution of psychiatry and psychology to a fundamental epistemological change. According to the author, in the Eighteenth century, madness revived under a new representation: as ultimate truth on the human being. While until the *âge classique*, madness had been kept quiet within the miscellany of the *deraison*, associated to mistake, nonsense, illusion, animality; from that moment on it becomes a matter concerning specifically the human being. As a consequence the latter becomes definitively, even in its interiority, an object of knowledge (and of political control) (Foucault, 1972).
[18] The term "medicalization" has been largely used, within the contemporary debate on the interpretative models of mental illness, to point out the spread of psychiatric diagnostic categories for the explanation of more and more problems in everyday life, and the consequent risk of overlooking the social, historical and political basis of such problems.

social components on the other. The emerging question concerns the destiny (**sort**, from the Latin *sors-sortem*, destiny, fate, lot) of such binary oppositions as well as the need for an outcome, for a product (**become**, from old English *becuman*, means to happen, come about and also to meet with, arrive). At the closure of the repertoire, the **clinic** appears to represent the urgency and the possibility to anchor knowledge by a relational experience: the clinic is that part of medical examination and medical training which is carried out near the patient's bed (from Greek *klinè*, bed); it contains figuratively the action of tilting forward and of laying. The clinical competence seems to introduce an integrative, non-conflicting link between the medical and the social components of the intervention, since the relationship with the patient is in itself the principal method of knowledge and intervention.
In summary, this cluster - representing mainly the experience of the research participants who work in academia, particularly the anthropologists - points out an important issue: the critical reflection on mental illness and psychiatry emerged within academia, over the last fifty years, has contributed to radically transform our relationship with some basic aspects of life, such as the body and the political role of medicine as science entrusted with acting on the body; at the same time such "critical" debate seems to be presently associated with very primitive and violent experiences of conflict, where one is prisoner of binary oppositions, called to join one part or another, within strongly self-centered dynamics. The potential clients, users of the scientific endeavor seem to be ignored, replaced by no-exit dilemmas which remain separated from life experience.

Cluster 4
As the previous cluster, also this cluster is positioned on the negative polarity of the second factor (fig. 2, down) in opposition to clusters 3. It is representative of approximately the 39% of the textual unites taken in exam; therefore it indicates the most largely shared experience among the research participants. Precisely because of such large significance, it does not show remarkable associations with any illustrative variable: it is weakly associated to the disciplinary areas of **social work**, **anthropology** and **psychology**.

The repertoire is characterized by the co-occurrence of the following dense words: to work (*hataraku*), psychology, problem, company, achieve, spread, work (*shigoto*), sick, physic, community_based, school, young, ask, happen, outside, emotion, desire, person.
It is the repertoire that most specifically focuses on the "clients" of mental health services and on a demand for care connected to problems of achievement.
The word work appears twice (since in Japanese there are two different words: one for the verb, the other for the substantive) and represents a cornerstone of the cluster. The kanji of the word *hataraku* (働く), **to work**, refers specifically to the Latin idea of *labor*: it emphasizes the transformative dimension of work, as effort – also physical effort – that generates effects, give birth to.
Follows the word **psychology**, *shinrigaku* (心理学) formed by the combination of *shin*, mind, heart, spirit and *ri*, reason: the Japanese word referring to the psychological sphere highlights an interesting problem of integration between an affective-spiritual-existential dimension on the one hand and a rational-logical dimension on the other. Both of them are essential mediators of the relationship with external reality – i.e. of our subjective understanding of reality - and of adaptation to social contexts (Matte Blanco 1998).
Then come the words problem, company and achieve.
Problem, *mondai* (問題) contains specifically the meaning of asking a question. **Company**, *kaisha* (会社) is formed by *kai*, to meet, join, gather, participate and *sha*, originally shrine, then firm, office (the same two kanji but in reverse order form the word *shakai*, society): this word indicates the importance of belonging to the company at the center of working experience. **Achieve**, *dekiru* (出来る) means a potential which finds the way to be expressed, to realize, put in effect, emanate: again we encounter a transformative experience, the generation of new resources.

This is a particularly meaningful sequence. For the first time within the cultural context that we are examining, we encounter actions and relationships aimed at achieving a product (in the previous clusters, the issue of mental illness was associated to family and hospital, both represented as social contexts apparently devoid of productive goals): here we find problems concerning work and specifically the purpose of adapting to, belonging to the workplace, by achieving results, by being effective. These problems are associated to the demand for an area of competence in particular: psychology.

Follow the words spread, work (*shigoto*), sick, physic, community-based.

Such demand is currently **spread**ing across mental health services. As the cluster shows, this appears to be the result of a very interesting crossover between new forms of crisis that are concerning social contexts, such as workplaces, on the one hand, and changes in models and places of mental health care's supply, on the other: while sickness and health (as necessary counterpart) are more and more becoming crucial issues on the workplace, mental health services change their position and become more accessible for the community.

The word *shigoto* (仕事), **work** (subst.), underlines the experience of work as service (*shi*, means to serve, official, to attend): to provide a service being officially entrusted with it, to attend, to be present as a sign of commitment. The attendance as well as the performance of the worker on the workplace are compromised by sickness (*byousha*, 病者, this word specifically means the **sick person**). Sickness appears primarily as **physic**al disorder. This is interesting because suggests how much the issue of mental health-illness must be experienced as something extraneous, alien on the workplaces: the demand for psychological intervention, related to problems at work, is assimilated to physical illness, like something more familiar, more acceptable.

The final words of the cluster are: school, young, ask, happen, outside, emotion, desire, person.

The development of **community-based**[19] mental health services seems to trigger new demand also from another social context: **school**. In the word *wakamono* (若者), **young person**, the kanji of *waka* means young, if, perhaps, possibly, immature: once again the theme of a potential to be expressed appears, together with the dimension of **ask**ing, of the demand for.

Such recurrences specify that the central focus of this culture is the relationship with a "client", that is someone who actively asks an intervention in relation to specific purposes or developmental tasks that he/she is experiencing. Similarly to workers, also concerning young people the main issue at stake seems to be the achievement.

Happen, *okoru* (起こる) contains the meaning of waking up, rousing, coming back to reality. How to integrate the external (**outside**) and the internal (**emotional,** *kanjou*, 感情) reality?

The words **desire** (in English) and **person** (*ningen*, 人間) point out the importance of the subjective experience. It is interesting to note that, from its Latin etymology (*de*, away from and *sidus-sideris*, star) "desire" means to turn away from the stars and stop looking for omens, thus recognizing one's own aspiration. It refers to the problem of considering the emotional sphere as something which separates from reality – an illusional-idiosincratic dimension and therefore a potential source of conflicts - or as something that connects to reality – as subjective meaning founding one's own involvement in social contexts, actions, relations and purposes.

It seems more possible, more socially legitimated, for young people to express a demand for intervention related to the emotional sphere, to the sphere of subjectivity; on the contrary in the case of workers, psychological problems tend to be assimilated to physical disorders.

It must be noted that, in both cases, the cluster shows a tendency to move the focus of attention from the organizational contexts where problems arise (company as well as school) to the individuals: problems on the workplace tend to be assimilated to physical illness (concerning the sick person), problems related to the scholastic experience tend to become problems concerning personal emotions

[19] The expression community-based corresponds to the Japanese words *chihou*, 地方 and *chiiki*, 地域.

and desires. The word person, ending the cluster, fully represents the core of the experience here outlined[20]: in this emerging culture, achievement within the working environment is connected to the person, it is no more and not just a matter of adaptive and effective behaviors, but also of subjective meanings; the possibility to achieve results depends on the possibility to ask for, question, actively give meaning and share the meaning of actions on a subjective level, so to connect action and purpose. The novelty suggested by the cluster concerns a culturally meaningful link between subjectivity and product[21]. But how to deal with the subjective sphere within the working environment? Is it a matter which concerns exclusively the individual or does it rather include the relationship between the individual and the context? That seems to be the emerging challenge for psychology.

Cluster 5

This is the last cluster of our cultural space. It is positioned on the positive polarity of the forth factor (fig. 2) with a very high correlation, in opposition to cluster 3. It represents the 11% of textual unites. In terms of illustrative variables, it is significantly associated to the disciplinary area of **arts** and to the discourse of interviewees working both in **academia and mental health facilities**.

The repertoire is characterized by the co-occurrence of the following words: music, music-therapy, disability, art, improvisation, intellective, organize, instrument, enjoy, play, future, parents, explain, good, child, depend, use, like.

As we will see, this repertoire has a strong internal coherence in terms of symbolic meanings.

Music, from Greek *moysikè* (*technè*) means everything concerning the art of the Muses, every art and science aimed at rousing the idea of likable and orderly things. **Music-therapy**: music has to mix with therapy when it deals with **disability**.

Mental illness in this cluster is associated to disability. This interesting cultural shift is grounded in the recent legislative development before mentioned: in 1995 the Mental Health and Welfare Law recognized mental illness as a disability and increased welfare measures within mental health care system.

Art, from Latin *artem* (from root *ar*) indicates the action of going, moving towards something, from which derive the meanings: to adapt to, to fit in, excellent because well composed, perfect as brought to perfection, things put in order according to a purpose. The artistic action, the way in which art moves to reach excellent compositions, is associated to **improvisation**: from Latin *improvisus*, not foreseen, unexpected, to act not in relation to a given, stated purpose. Art seems to match favorably with disability, since it is based on a movement towards excellence that does not start from given purposes. From a symbolic point of view, we could consider art as the counterpart of ability: the notion of ability refers to a normative model of performance, to a conformist way of adaptation; in arts, on the contrary, what counts is not the expected outcome, but the movement itself of going towards excellence, of pursuing it. The meeting between art and disability has the power to overturn our conformist view of adaptation.

Follow the words intellective, activity, organize, instrument, enjoy, play.

This sequence is interesting because it shows how music-therapy intervenes on the problem of mental illness-disability by promoting experiences which restructure the symbolization of the problem.

The kind of disability focused on by this cluster is the **intellective** disability: music-therapy responds to a problem concerning the intellective sphere by proposing **activities**: from Latin *agere*, to do, act;

[20] Watsuji Tetsuro differentiates the Japanese notion of "*ningen*" (人間), from the Western "person"; while *ningen* can be used like its Western counterparts to denote the individual, it originally signified the betweeness of human beings. "We Japanese have produced a distinctive conception of human being. According to it, *ningen* is the public and, at the same time, the individual human beings living in it. Therefore, it refers not merely to an individual "human being", not merely to "society". What is recognizable here is a dialectical unity of those double characteristics that are inherent in a human being." (Watsuji, 1996, p. 15).

[21] See Kitanaka, 2012. *Cf.* De Munck et al., 2003.

the word indicates an experience based on action, on being agent rather than subjected to the other's action. **Organize** from Greek *organon*, instrument, organ; the organs are parts coming from different systems to form a whole, where each one has a specific function in relation to each other: so organize means forming a whole of interdependent parts. The word **instrument** underlines again the importance of the functional dimension. Music-therapy works with disability by proposing activities where the experience of organizing, combining, harmonizing differences is fundamental. Each one's contribution is not evaluated in terms of ability, as a quality intrinsic to the individual, but in terms of functionality for the performance as a whole.

Enjoy, from Latin *en gaudere*, make joyful. **Play** from West Germanic *plegan* (from root *dlegh*) to occupy oneself about, engage oneself, and from Middle Dutch *pleyen*, to rejoice, be glad, take care of, cultivate. We encounter an experience of joyful engagement.

Finally come the words future, parents, explain, good, child, depend, use, like. The final part of the cluster focuses on the clients of the aforementioned experiences and on how the relationship with such clients is symbolized. The **parents** of the person with disability are here represented as a demanding client, asking for **explanation**s about sense and outcome of the activities. The issue of the outcomes, of the product, is called into question: parents are concerned about the **future**; the joyful engagement experienced by their children by taking part in the musical projects is not enough.

On the one hand the musical experience seems to have a remarkable integrative and developmental power: a methodology based on improvisation allows to suspend normative expectations, thus to tolerate and value differences, variability, strangeness. On the other hand the relationship with parents follows another logic: the need for clear and predictable results, for anticipating the future, appears urgent.

Such ambivalence is related to a specific representation of the users: at the center of this culture we find the person with disability and particularly the **child**. This is a crucial point. While in cluster 3 (opposed to this cluster on the fourth factor) psychiatric action was represented as mainly addressed to people with schizophrenia and dementia (the latter presumably older people), here one deals with disability and childhood; this mitigates the experience of intolerable strangeness, of negative, expulsive stigma which is typically associated to mental illness. Childhood represents something good, cared, loved, close. **Good** means virtuous, desirable, considerable; from Proto-Germanic *gothaz* (from root *ghedh*, to unite, be associated, suitable) originally meant to fit, adequate, belonging together. Initiatives aimed at promoting the participation of people with disability to high quality (sometimes professional) artistic projects are recently spreading in Japan - like in many other countries - and are changing the social image of disability, making it more desirable and valued. When associated to childhood, disability inspires more hopes for development and at the same time a more demanding expectation on the part of families regarding the results of the interventions.

The word **dependence**, at this point, is a key-word because it represents both the experience of parents concerning the relationship with their disabled children, and the experience of artists and professionals who work in music-therapy projects: their work cannot be self-centered, on the contrary it depends on the negotiation with the client, the family in this case. Thus, the word dependence points out the strong client orientation that characterizes this cluster. By the expression client orientation we refer to a model of intervention based on the expectation that the intervention's result is not fixed *a priori*, on the basis of a certain technique or specialized knowledge, but it is strongly dependent (actually interdependent) on the relationship with the client: on the client's aims and satisfaction.

Follow the words use and like. **Use** recalls again the idea of functionality, of making use of something; it suggests an experience of productive, useful exchange. **Like**, from old English *gelic*, similar (from Proto-Germanic *galika*, compound of *ga,* with, together and *lik,* body, form) literally means with a

corresponding body, having the same form. It tells how much the experience of pleasure rests on the feeling of being close, similar within a relationship[22].

Conclusions

The first significant discovery I made through this research concerns the conditions of the possibility of a shared symbolic heritage. The international and multi-linguistic framework of the research significantly influenced the participants' reflection and discursive production: thus, our study of the cultural representations concerning the problem of mental illness in Japan took advantage of a metaphorical and symbolic heritage that one could consider as trans-national and trans-linguistic. The language, each language, by its spread and practice, contributes to the generation of specific traditions of metaphors and symbols, available (for the speakers) in order to give meaning to experience. One question could be: does the international exchange increase the *thinkability* of experience? Could we assume it as a heuristic tool?
Such questions could be of interest in the field of languages and cultural studies as well as for a methodological cross-disciplinary reflection on comparative studies. As we have seen, a broad literature concerning Japan tends to deal with the problem of cultural differences by resorting to universalistic or essentialist solutions (see the paragraph *Introduction*). By carrying out this research project, I have become convinced that it is not a study on Japan, as an alleged cultural unity; on the contrary, it is a study on mental illness through the contribution of Japanese scholars and professionals to an international reflection. It must be considered that in our study the international exchange is not the research object but the research setting, its methodological tool – according to a psychosocial research methodology (see the paragraph *Methodology*).

The second emerging discovery could be synthesized as follows: the more one assumes an interdisciplinary perspective, the more it becomes evident how the cultural representations of mental illness are historically grounded (see the paragraph *The research context*). Within the constellation of repertoires produced by the textual analysis - each one illustrating different disciplinary viewpoints - we find significant references to some crucial points in the history of mental health care in Japan: the domestic custody and the meaning this practice acquired within the modernization of the country,

[22] The enjoyment coming from art as experience of interdependence, coordinated movement - well outlined by this cluster - reminds of an extraordinary excerpt from Michel Foucault's *Histoire de la folie* on the importance of movement as rhythm, consonance with, typical of certain therapeutic experiences during the *âge classique* (Foucault, 1972, pp. 338-342). I give here the English translation of the excerpt by Richard Howard. «If it is true that madness is the irregular agitation of the spirits, the disordered movement of fibers and ideas […] it is then a matter of restoring to the minds and to the spirits, to the body and to the soul, the mobility which gives them life. The animating idea of this therapeutic theme is the restitution of a movement that corresponds to the prudent mobility of the exterior word» (Foucault, 1972/1988, p. 173). Horseback riding, the rolling of the sea - the most regular and natural movement in the world – travel with its variety of landscapes as well as the imaginary voyages of literature and theater, are examples of such therapeutic idea of movement. «The therapeutics of movement conceals the idea of a seizure by the world of the alienated mind. It is both a 'falling in step' and a conversion, since movement prescribes its rhythm, but constitutes, by its novelty or variety, a constant appeal to the mind to leave itself and return to the world» (Foucault, 1972/1988, p. 175). Outside the experience of *deraison,* when madness becomes something concerning exclusively the human being (as psychological and moral entity), these techniques still remain, but with a completely changed significance. Modern "therapeutics" reduce the movement to a mechanism which generates isolation: «All that was sought was a mechanical effect or a moral punishment. It was in this manner that the methods of regulating movement degenerated into the famous "rotatory machine" […] In this reinterpretation of the old method, the organism was no longer related to anything but itself and its own nature, while in the initial version, what was to be restored was its relation with the world, its essential link with being and with truth» (Foucault, 1972/1988, pp. 176-177).

between Edo and Meiji periods; the contemporary experience of the psychiatric hospital; what the anti-psychiatric movement meant and how Michel Foucault's thought influenced the academic reflection and production; the new demands and potentialities introduced by the spread of psychology within the mental health sector, starting from the Nineties; remarkably new experiences of social integration fostered by the fundamental contribution of arts.
Considering the limited number of interviews - in relation to the number of modalities for each illustrative variable – the research results are indicative of significant associations but further researches could increase the complexity of our understanding of the different disciplines' and professions' contribution to the cultural representation of mental illness.

I want to conclude the paper with an overview on the Local Culture as a whole (see the paragraph *Results*, Fig. 2, Tab. 1).

On the *first factor* of the factorial space, cluster 2 has showed the role of mental illness in the formation of the modern State: on a symbolic level the experience of modernity in Japan seems characterized by the encounter with otherness, with strangeness, where identity is called into question.
In modern Europe as well, the problem of mental illness has been significantly linked to the theme of identity. In Italy, for example, the establishment of psychiatry as modern science - holding an autonomous corpus of techniques and categories - corresponded to a specific project of mental health. The human being was defined as an indivisible unit of consciousness and perception, and as such as a subject endowed of free will. Mental illness was depicted as a division, an internal breakup hindering subjective freedom (Fiorino, 2002). The problem of freedom has been and remains a central issue in Italian psychiatric thought. In Japan, on the contrary, one central issue seems to be that of belonging, of bringing back diversities to an order of social roles - for instance, between wife and husband – which might found and maintain a sense of identity. Such difference on the symbolic level appear to be related to a relevant difference on the historical level, as discussed above: in Japan the modernization of the country did not correspond to the rise of the psychiatric hospital, because for a certain time, the main institution for the care of the mentally ills remained domestic custody. While the project of psychiatry as modern science is fundamentally a project of emancipation, family, as we have seen, has a fundamental role in preserving the link to the past, the history, the tradition. It represents the need for being rooted in one's own past, that becomes even more urgent when one is confronted with the change.

On the *second factor* we encounter the two main components of Japanese contemporary mental healthcare system: psychiatry and the hospital, on the one hand (cluster 3); psychology and the community, on the other (cluster 4). These two clusters are the most significant ones within the Local Culture. *In primis*, cluster 3 highlights a change in the cultural representation of mental illness, connected to the rise of a psychiatric interpretation: while in the notions of *kichigau* and *kyouki*, mental illness means a powerful encounter with the difference, in the notion of *seishinbyou* the otherness appears assimilated, domesticated, explained as illness and incompetence. Furthermore, through the analysis of the cluster, we find out how the public/private division, so much at the center of the debate on Japanese mental health system, is actually a secondary question: what appears to be fundamental for the establishment and regulation of psychiatry's action today is the "social warrant", the punctual and strong reference to matters of importance at the national level. Unlike Italian psychiatry, that is currently passing through a profound crisis of its social image and role, Japanese psychiatry's action seems still strongly based on a demand on the part of the social system for dealing with its incapable members. The target groups are clear: people with schizophrenia as well as older people with dementia. The model of intervention appears clear as well: giving them protection, while protecting the social system from the breakdowns due to their incapability.

On the opposite side of the second factor, cluster 4 presents a completely different model of intervention, where the central focus is the relationship with a "client", that is someone who actively asks an intervention in relation to developmental tasks that he/she is experiencing. The dynamic of asking is crucial in order to understand this culture: a new and increasing demand for psychological intervention is emerging from social sectors like the workplace and school (the places *par excellence* of productive action and preparation for productive action); as the cluster points out, the demand for care is mainly related to problems of achievement, not in terms of behaviors' efficiency, but in terms of the subjective experience to achieve, the subjective possibility to give meaning to the endeavor one is taking part in.

Cluster 1 shows how the anti-psychiatric experience does not appear as a significant point of reference in the discourse of Japanese psychiatrists; on the contrary it proves to be an important issue for the study of psychiatry by other disciplinary perspectives – for example anthropology - and more generally for what this experience represented within the academic debate. The critical reflection on mental illness and psychiatry have been playing a fundamental part within the debate on the political role of sciences, or in other terms on the relation between what can be considered "nature", therefore outside the political sphere of influence, and what can be considered "social"[23]. By looking at the opposition between cluster 1 and 4, on the *third factor*, it becomes evident how such academic debate is suffering more and more for an highly risky impasse: the crisis in the subjective experience of achieving which is emerging in workplaces as well as in school could be connected with the cultural tendency of academia to close in violent and apparently no-exit fights between opposite views, where *tertium non datur*. This is relevant if we consider the critical role of university in the transition from education to work.

Finally on the *fourth factor*, the opposition between cluster 3 and 5 addresses the problems of diversity integration and of dependence within social relationships (how is vulnerability symbolized? How does a social system take care of its vulnerable members?). On the one hand, in cluster 3, psychiatry contributes to a symbolization of dependence as asymmetry of power: under this interpretation, a conformist framework of purposes (technically or politically sanctioned) is needed in order to categorize and deal with diversity. On the other hand, in cluster 5, arts – particularly music – contribute to a symbolization of dependence as interdependence: each one's capability is not evaluated as a quality intrinsic to the individual, but in terms of functionality for the performance as a whole. Apparently freer, compared to clinicians, from the expectation to generate therapeutically or politically relevant changes, the main concern for artists who works with disability seems to be that of doing art, in an excellent way. Art seems to match favorably with disability, since it is based on a movement towards excellence that does not start from given purposes. This is not at all exempt from crisis, conflicts, negotiations. On the contrary negotiation is fundamental in absence of stated purposes. Family comes back as a powerful interlocutor, this time not for its role in preserving a link to the past – i.e. to tradition (cluster 2) - but as an agency concerned about the future of the person with mental illness, demanding to be informed by experts about the interventions' results.

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[23] See Latour, 2009.

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