Busy months of reabsorption into the usual family and work routines have not diminished the extraordinary array of memories gathered during 16 days in Japan. Vivid images return of exquisite public gardens, sushi and green tea, Suzuki wheelchairs, meishi cards, engaging school children, Kyoto’s beautifully maintained ancient shrines, palaces, and temples, Osaka’s night-time neons and Pachenko parlors, Hamada pottery in Kurashiki, Kimono-clad officers of the Japanese Occupational Therapy Association (JOTA) at the Tokyo Governors reception, and the amazing graciousness of the Japanese people everywhere—all fueled and sustained by endless anecdotes.

Dominant themes do emerge and are heightened by the distinctiveness of one’s own life experiences. To this native New Yorker, Japan’s exceptional cleanliness, order, safety, efficiency, and courtesy were astounding. Negotiating Tokyo’s subway system with all its mysterious signs and symbols was no more difficult, and far less anxiety provoking, than trying to decipher the graffiti-covered subway maps of Manhattan. Although our travel pace was hectic and exhausting, manifestations of Japanese generosity and esthetic appreciation and the collegiality within our own group provided an important buffer for dealing with the rich cultural stimulation and sometimes paradoxical nature of the country’s people, values, and traditions. There is an illusion that the Japanese are totally predictable, given the structure and form of their strong cultural traditions. Not so, Ruth Benedict described the many contradictions that are the “warp and woof” of Japan:

They are (all) true. Both the sword and the chrysanthemum are a part of the picture. The Japanese are, to the highest degree, both aggressive and unaggressive, both militaristic and aesthetic, both insolent and polite, rigid and adaptable, submissive and resentful of being pushed around, loyal and treacherous, brave and timid, conservative, and hospitable to new ways. They are terribly concerned about what other people will think of their behavior and they are also overcome by guilt when other people know nothing of their misstep. (1, p 2)

Although we did not bear witness to all these dichotomies, the perspective of those more knowledgeable about Japan certainly enhanced our understanding of what was sometimes confusing and illusive.

One of our Japanese-American colleagues characterized the Japanese approach to life as a “slow basketball game” when compared to America’s “fast ping-pong game.” Emphasis upon the group effort, sometimes at the expense of the individual, is striking in contrast to our own pursuit of individuality, originality, and self assertion. The implications of these differences are further dramatized by an old Japanese saying suggesting that “the nail that sticks out gets banged down.” (2, p 135) These motifs served as useful guidelines as we rushed about trying to make each moment count: in awe of our hosts’ natural hospitality and a bit fearful of our own potential for creating an international faux pas. American verbiage often found itself ineffectual in dealing with what appeared to be Japanese evasiveness. Subsequent investigation showed that the Japanese tendency toward “indirection or vague implication” stemmed from a “mistrust of verbal skills, thinking that these tend to show superficiality in contrast to inner, less articulate feelings that are communicated by innuendo or nonverbal means.”
One learned to temper forthright and eager questioning with a gentler pursuit of information, often forsaking "knowledge" for etiquette, knowing that some answers would be found in the literature, and others, perhaps the best, would be learned by following a familiar professional premise—"Actions often speak louder than words." We re-cultivated the art of observing (enhanced by our ubiquitous cameras) and listened with greater care, the most culture-specific way to experience Japan.

Our Tokyo meeting (The U.S.-Japanese Conference on Rehabilitation: The Disabled and Their Potential) took advantage of the International Year of Disabled Persons to reaffirm the dedication and commitment of occupational therapy to rehabilitation. Conference speakers reminded us of rehabilitation's linguistic roots ("habilitaire-competent once again"); of its social implications ("restoration of a person's good name or reputation"); of its early linkage with medicine via Hippocrates who stressed the effectiveness of exercise, encouraged wrestling, horseback riding, and moderate manual labor (3); and of its contemporary assertion that "the patient is more than his illness." (4)

For American therapists, no topic is more relevant to psychiatric practice than the application of this model to the chronically mentally disabled. While our involvement with the chronic patient extends far beyond this single year, recent increased interest and awareness of the needs of the chronic patient has provided new opportunities for OTs to re-evaluate their commitments, articulate their philosophy and methods of practice, and extend their concepts of professional responsibility beyond direct service into research, interdisciplinary education and the political-public arena... on behalf of our patients and our profession. (4)

Our all-too-brief encounter with Japan's mental health system supported the relevancy of this focus for our Japanese counterparts. The dilemmas associated with chronicity, institutionalization, and the role of occupational therapy appear to be major issues there as well. Japanese psychiatry has been influenced most heavily by its prewar exposure to the German Kraepelinean school of descriptive psychopathology and by its post-war exposure to American psychopharmacology and psychotherapy. While today's 4000 Japanese psychiatrists tend to use an eclectic approach, the current state of the art is summarized by Sakamoto as "organic oriented, emphasis on diagnosis and resistant to dynamic concepts." (5, p 72) Psychoanalytic theory was introduced 50 years ago by Marui, who studied with Adolph Meyer; but it has not achieved any notable popularity in Japan. Of major importance in understanding Japanese psychiatry is the awareness that cultural factors strongly dominate any differences in theoretical orientation. Such factors include socially sanctioned dependence, a "close, almost symbiotic relationship between mother and child; intense repression of feelings; conflicts between individuality and collaterality of family members; and especially conflicts between allegiance to traditional values and identification with Western mores." (6, p 88)

The country's only culturally specific therapeutic adaptation has been Morita Therapy, intended for use with obsessive states and interpersonal phobias, which are fairly common because of a tendency to internalize conflict. Based upon principles of Zen existentialism, Morita technique involves four progressive phases of intervention. The first involves total bed rest and isolation for an initial period of 5 to 7 days. "During this period the patient is not allowed to smoke, read, talk, work or engage in any activity other than biological functions. He is instructed to sleep, suffer and worry with complete acceptance of any experiences that might occur," (5, p 75) and is encouraged to be totally dependent upon the doctor. Morita deals neither with the unconscious nor with life history. It aims instead at accepting one's fears and not fighting against symptoms. This approach is highlighted in the interpretive comments of Dr. Morita, written in a patient's diary: "You should become the world's most well known shy person, showing your face can blush more than anyone else's. Don't fight against having a blushing face." (5, p 75) The active keeping of a diary and progressive involvement in graded, increasingly complex tasks of daily living characterize the remaining three phases. Re-entry to the community is the ultimate goal. Some observers have referred to the Morita approach as a "corrective ego experience"; others identify a significant component of it as occupational therapy (7).

It is difficult to estimate whether or not the two mental health facilities we visited were typical examples of contemporary psychiatric practice. They did introduce us to the institutional model that dominates the delivery of services and to the complex attitudes that have influenced the care and containment of the mentally ill over many centuries. Mental health professionals are not proud of their country's history of punitive management of those who have challenged social order by their deviant behavior. While imprisonment in public jail and "incan-
tion, exorcism and bathing under waterfalls” (7, p 95) are things of the past, custodial care and very limited use of community-based resources continue to receive criticism. As recently as 1976, Kuwabara and True reported that:

...psychiatric treatment programs remain generally at a custodial level, as evidenced by an increase in the average length of hospitalization of patients and by a steady increase in the number of beds...stigma could be much reduced by a positive government policy that refused to countenance prolonged confinement and that made stronger efforts to establish community care and rehabilitation programs (7, p 107).

The first of the psychiatric facilities on our itinerary was the Matsuzawa Hospital, located on a sprawling “campus” outside Tokyo. It is the oldest public mental hospital in Japan. Its history, and the teachings of its first superintendent, Professor Kure, have greatly influenced the course of Japanese psychiatry and occupational therapy. It currently has facilities for 1,211 inpatients in a mix of open and closed wards and an outpatient capacity of 91 visits per day (1979 figures). The length of stay ranges from 3 months to more than 20 years, with 31 percent of the patients staying somewhere between 5 and 10 years. Schizophrenia represents the largest diagnostic grouping. In 1979, 647 patients of a total of 1,211 were classified as such, with the next largest group, mental retardation, numbering 64. Affective disorders, psychoneurosis, addictions, epilepsy, neurosyphilis, progressive paralysis and geriatric psychosis are also represented within Matsuzawa’s population. Although alcoholism is grouped within the addictions, it is not viewed as a significant problem in Japan. While national consumption is high, it appears to be one of several socially sanctioned outlets.

Geriatric patients (and those with medical/surgical complications) represent a rapidly increasing segment of this hospital’s population, which necessitated an expansion of psychogeriatric facilities in recent years. The increased need for institutional care for the aged appears linked with both the larger proportion of elderly in the general population and the changing patterns of family involvement. Small urban apartments, increased mobility of nuclear families, and resistance to accommodating retired grandparents is altering the more traditional “stem family system,” which provided for the financial, physical, and psychological needs of the elderly (2).

A re-construction plan for Matsuzawa began in 1962, concurrent with a national trend in bed expansion. Today, newly constructed modern buildings are interspersed with older, dreary structures located on spacious, well-maintained grounds that include farmland, gardens, a greenhouse, ponds, recreation areas, and animal shelters. Future plans include development of new occupational and physical therapy centers and a day care facility. Current occupational therapy programs take place on the wards and in several free-standing buildings. Activity areas are often lined with tatami mat flooring, and work tables are built low to the ground. Programs appear to be identified more by media than for their treatment-based objectives. Outdoor programs involve horticulture, floriculture, weeding and gro and maintenance, and livestock breeding. Indoor programs include printing, paperwork, manual arts, sewing, knitting, handicrafts, and gymnastics. We had little direct contact with patients at Matsuzawa. As we toured the grounds, we observed a softball game in progress, a morning exercise group led by uniformed student nurses, and supervised groups enroute to work assignments in the field, with the livestock, and in the print shop. Opportunities to exchange information informally with our colleagues were greatly hampered by language barriers. Most physicians spoke English; few therapists did. We were made aware of their concerns about inadequate professional staffing and the subsequent difficulties in achieving desired program goals. The hospital’s 1,211 patients are serviced by an occupational therapy department consisting of 2 physicians, 3 full-time and 5 part-time registered occupational therapists, 10 aides, 5 nurses, 2 gymnasts, 1 clerk, and 17 volunteers with special expertise in such areas as music and art.

Private hospitals represent the largest system of mental health providers in Japan. The Sakamoto Hospital, outside of Osaka, is owned by a family of physicians trained in American psychiatric residency programs. This facility is smaller than Matsuzawa, but it is fully modernized and influenced in both architecture and treatment philosophy by Western concepts. Dr. Yushio Sakamoto, trained in psychodynamically oriented community psychiatry at Boston’s Massachusetts Mental Health Center, is referred to as the “Why Doctor” by many of his colleagues. While the full application of dynamic psychiatry poses problems for Dr. Sakamoto in his native country, the effort at integrating Japanese and Western ideas is observable in numerous ways. The professional library was noticeably well stocked with recent American publications on the borderline patient, family and
group therapies, and DSM III. Dr. Sakamoto himself has written extensively on family therapy and is currently involved in translating the work of Anna Freud. Patient day rooms offer both a tatami mat environment and contemporary Western furnishings. A table top in the occupational therapy center contained both an American electric coffee maker and an elegant ikebana floral arrangement. The pre-vocational rehabilitation program provided similar contrast and important flexibility. Several patients sat cross-legged on the floor putting together medical charts as one would bind old books, while another group was seated at a long table packaging hair pins and barrettes for an outside contractor. Even the seclusion room brought both worlds together. It is wood paneled with a Japanese-style toilet recessed into the fully carpeted floor. The room appears both safe and immaculate, and perhaps less frequently used than our own, since violent behavior directed at others is not commonplace among the patients or the population in general. Suicide, however, does represent a more significant risk. The prevalence of suicide is deeply rooted in Japan’s history and in attitudes about “clearing one’s name”—the duty to keep one’s reputation unspotted and fulfill social and professional commitments. This is particularly evident in the high suicide rate among young adolescents who compete under extraordinary pressure for admission to prestigious schools. Poor performance on entrance exams is seen as a serious failure affecting one’s future and the family’s status (2).

Sakamoto’s Occupational Therapy Center is one of the few remaining older structures and is relatively small. Its interior, however, was pleasant and filled with a range of creative materials and equipment not unlike that found in many workshops here. Focused program objectives were somewhat more evident than at Matsuzawa, with referrals asking for such outcomes as increased social interaction and improved work performance. Here too, substantive discussion of occupational therapy issues was hampered by language difficulties and a tendency to defer to the physician.

Independent investigation provided information about historical and contemporary trends affecting psychiatric practice. Specialized training in occupational therapy did not begin until 15 years ago, although its application to psychiatric treatment has a lengthier history. As far back as 1876 a section on occupational therapy was included in the regulations of the Kyoto Asylum at the time of its founding. Historians credit Matsuzawa’s superintendent Kure with establishing the field as part of his larger effort to introduce more humane approaches to the treatment of the mentally ill. Involvement of patients in sewing, agriculture, cattlebreeding and joinery,” some of which was necessary for the administration of the hospital,” (9) was met with both support and criticism. Efforts to distinguish patients’ needs from those of the institution and to separate diversional activity from treatment have been recurring themes. During the prewar years efforts to develop an “open door” system with more purposeful activity for patients are linked with another of Matsuzawa’s superintendents. The famous “Shogunike Pond” and gardens, dug by Dr. Kata, male nurses, and patients over a 4-year period, serves as a landmark. Unfortunately, it also served to mobilize strong negative reactions to patient work programs, viewing them as exploitive rather than therapeutic. This concern continues to impede efforts at fully integrating legitimate vocational rehabilitation services into psychiatric treatment programs.

The post-war period brought with it the introduction of psychotropic drugs, an increased effort at understanding the therapeutic potential of the patient-therapist relationship in individual and group activities, and the importance of the patients’ active involvement in activity selection. Concepts of “suhatsu-ryoko” (life therapy) became popular in the 1950s and broadened the scope of psychiatric occupational therapy to include therapeutic recreation,
work programs, and daily activity training. It was not until 1963 that specialized training for therapists began, and in 1966 the Japanese Ministry of Health established a system of examination and registration.

A fair assessment of psychiatric occupational therapy in Japan requires more time in their facilities and classrooms and a more thorough review of the professional literature. It is not difficult, however, to recognize the strong impact of the country's culturally determined attitudes about illness and the hierarchical social structure and constraints that dictate interdisciplinary relationships. For example, the inherent expectation of rehabilitation—to increase independent function—has some powerful competition in Japan's strong social sanctions for dependency. Whereas Western societies view dependency as something that belongs to childhood and is beneath the dignity of an adult, in Japan one goes to the hospital and stays, dependent upon staff, until "cured." This attitude, no doubt, contributes to the professional and public ambivalence about introducing pre-vocational programs during hospitalization. It is unfortunate and puzzling, for work is a most highly valued aspect of Japanese life. It is viewed as a pleasurable act, an attitude well documented by the superiority of Japanese products. Work-oriented activities are, therefore, important both as a therapeutic method for developing a broad range of functional capacities and as a potential source of support for those returning to the community. "A job in Japan is not merely a contractual arrangement for pay, but a means of identification with a larger entity . . . a satisfying sense of being part of something big and significant." (2, p 131)

Although it is true that the Japanese government and the business community have made important strides in attempting to reintegrate the physically disabled into the workforce, there is ample evidence that equal effort is not being made on behalf of the mentally disabled. A theme of "denial" regarding emotional illness is well documented in an editorial that appeared in one of Tokyo's major newspapers during our visit. A 3-year study of the physical and psychological health of 12,000 employees from 100 leading firms indicated that: " . . . one in every ten employees is suffering from nervous anxiety and needs psychiatric help . . . but it is almost taboo within the company. And there, of course, is where a lot of it is being produced."

Many contemporary attitudes about emotional illness have their roots in traditional Japanese beliefs. While shame is always a component of such reactions, the sick individual is not overly blamed for his or her eccentricities. The illness is viewed, instead, as a manifestation of some ancestral wrongdoing and the family, as a whole, often loses status and opportunities. This serves to explain, at least in part, the complex origins of Japan's reserved attitudes about emotional illness.

In view of the relative youthfulness of the profession as a whole, psychiatric occupational therapists find themselves with predictable problems. A theme raised with some frequency by psychiatrists, but less often by therapists themselves, is the need for therapists to exercise more assertiveness and authority with regard to role definition and collaboration in team decision making. This is a familiar refrain for us as well, but it represents special barriers in Japan. Professional relationships, like all social interaction, are strongly influenced by what Benedict calls a "meticulously explicit map of behavior." (1, p 73) Etiquette and wisdom mandates not telling someone to his/her face that he/she has made a mistake, or that one has committed what might be perceived as a professional error. Similarly, there is characteristic defensiveness about "not knowing" and therefore not publicly acknowledging mistakes. The give and take many American therapists strive for and enjoy in interdisciplinary team meetings represents a formidable challenge to Japanese concepts of one's proper place, particularly for Japanese women.

The number of therapists practicing in psychiatry is significantly less than those practicing in other
specialties. This, and a paucity of research and theory, contribute to a lack of understanding of the field by mental health agencies and administrators who control funding and program design.

In spite of the aforementioned dilemmas, Japanese therapists have some singularly important leverage with which to develop and deliver their services: the meaning and value of activities within their culture. The strength of Japan's traditional commitment to self-expression through activity is evident in the importance artistic and esthetic skills play in daily life as well as in religious practice. While American therapists have long viewed the route to adaptation as a graded, sequential individualized approach in which purposeful, goal-directed activities are used for organized, controlled stimulation of adaptive behavior (10), our culture tends to consider involvement in painting, crafts, poetry, gardening, flower arranging, and music as mere hobbies. Many of our patients associate such activities with play and childhood and view participation as confirmation of their damaged self-concept. To the Japanese, however, such involvements are valued as 'shumi' (taste), "which helps the individual establish identity and commonly becomes increasingly important to them as they grow old." (2, p 151) The therapeutic potential of activities in Japan is further strengthened by the respect given to artists and craftsmen designated as National Living Treasures. Schools of craftsmen are routinely acquired is of particular interest in considering the nature of the therapeutic relationship and our belief in "learning by doing."

The traditional skills are learned not so much by analysis and verbal explanation as by personal transmission from master to disciple through example and imitation. The teacher-disciple bond is a very important one, and this fits in with the whole group orientation of the Japanese, but of equal importance is the fact that learning is more an intuitive than a rational process. The individual is supposed to learn to merge with the skill until his mastery of it has become effortless. Acquiring a skill is essentially an act of will—of self control and self discipline. (2, p 151)

It is important, of course, to recognize the powerful role Japan's homogeneity plays in making meaningful activity selection accessible in both a personal and sociocultural context. Nonetheless, the impressive respectability of activity in Japan stimulates irresistible fantasies of the emergence of a similar devotion in our own country. Greater cultivation of "shumi," self-identity and self-expression through the process of "doing," might serve to establish a valuable balance with the more verbal methods that dominate our culture in general, and American psychiatry in particular.

A resolution emanating from our Tokyo Conference spoke of many things, among them the hope that rehabilitation professionals will acknowledge the need for social action, not only to deepen knowledge in our own field, but also to increase public understanding of the potential of the disabled. Our 16 days in Japan were all too brief, but they did establish roots that can and should be nurtured by more exchange, and a greater understanding of the needs of our patients and of the substance and style of our culture-specific treatment approaches. What makes so complex an effort feasible and worthwhile?

Inherent in the rehabilitation process is an optimism and persistence reflected in the belief that assets and liabilities can be harnessed and mobilized in the interest of adaptation. In keeping with this tradition we know that we need not view the boundaries that appear to demarcate traditional psychiatric treatment and rehabilitation as barriers, but as frontiers to be expanded. Are we willing to go beyond where we are now to develop our research and educational capacities, to plan for more and better interdisciplinary services for the chronically mentally disabled? The answer may well lie in how strongly each of us believes that the patient is more than his illness. (11, p 12)

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