



Negotiating States of Mind

The Transformation of Psychiatric Knowledge
in Imperial Germany and Meiji Japan

Helena Jaskov

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Introduction

Medical concepts come and go, but they leave their traces on the lives of people. Investigating this past knowledge within its historical context can reveal modes of thinking that seem no longer thinkable or believable in the present. It allows us to reconstruct how historical actors understood their world and how they shaped it in accordance with what they knew and believed. Present-centered approaches can aspire to explain where historical actors “erred” and “foundered,” but they fail to understand how that “erroneous knowledge” had force over those peoples’ actions and meaning for their lives. The doctors’ decisions, the patients’ despair and hopes of recovery, the judges’ verdicts, the marginalization of the patients’ families—none of this was dependent on our present-day knowledge.

This book is about the reasons, circumstances, and consequences of *melancholia*’s gradual displacement as a medical category. My scope is the world of psychiatry in early-twentieth-century Germany and Japan, with short side trips to other European nations as well as Russia and the United States. To adequately represent the diverse voices and multilingual nature of this topic, I am using source material and research literature in German, English, French, Russian, and Japanese.¹ My analysis revolves around the years 1880–1915, mainly centered around the Russo-Japanese War (1904–05), and as a consequence mostly focuses on male health. I follow the medical concept of melancholia through entangled levels of external determinants, theoretical assumptions, personal preferences, and macro-historical developments that eventually lead to its disintegration. Through melancholia, I tell the story of an elite group of physicians who practiced a relatively new branch of medicine, variously called “alienism” or “psychiatry,” and occasionally got involved with the theory and practice of experimental psychology.² In Japan, the discipline of psychiatry was referred to as *seishinbyō gaku* 精神病学, a neologism literally meaning

1 My background in both Classical Chinese and Japanese studies greatly facilitated my ability to deal with Japanese sources from this period. The language used in these texts is very distinct from Modern Japanese, and the occasional reference to Chinese classics was a stylistic move that was not at all alien to the medical professionals of this era. In addition to this, their proficiency in German and the ubiquity of the German language make these sources a linguistic challenge with very period-specific characteristics. I believe that a multilingual approach is the only way to do justice to this rich material. It is also crucial to be able to adequately discuss medical terminology and the problem of translation faced by contemporary social actors. On the significance of the German language for Japanese psychiatry, see page 18 below as well as the discussion at the beginning of section 1.2.

2 The use of this language is reflected in the way that associations, specialized journals, and conferences were named at the time. Consider titles such as *The Alienist and Neurologist* (published in the United

“the study of the diseases of the mind.”³ During this period, practitioners of psychiatry could also be expected to teach and practice neurology and pathology (knowing how to dissect a brain) and forensic psychiatry (testifying in court or providing expert opinion on a medical case); to engage with related philosophical topics (musing about the relationship between body and soul); or to discuss social and racial issues (arguing about the predisposition to illness of certain social or ethnic groups).⁴

In this study, I relate how these practitioners became professionals within a framework of international scholarly constellations and nation-specific institutions. I point out the ruptures (and continuities) that defined their world and analyze how they positioned themselves in the contested space between competing schools of thought. However, I also tell the story of the field of psychiatry as a discourse that was all but isolated from the tensions that governed the rest of the world. I present my protagonists’ deep involvement in the Russo-Japanese War and explain their varying approaches to making sense of the miserable bunch of mental health patients that returned from the battlefields in Manchuria. I relate how they saw the world through different eyes and how they put their experiences into different words. Lastly, I sketch the lessons that were drawn from the shattering experience of the war and lay out their influence on future developments in psychiatry. My source material therefore includes patient records, late-nineteenth- and early-twentieth-century articles in psychiatric journals in the languages mentioned above, and textbooks on psychiatry. I believe that it is essential to engage with the original sources in order to

States, St. Louis, 1880–1920) or *The American Journal of Insanity* (United States, Baltimore, 1844–1921), which was renamed *The American Journal of Psychiatry* in 1921. In French, there is for example the *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, etc. Many of these terms are today considered offensive but were in common use at the time. The German-language journal *Der Irrenfreund* [literally: “The Madman’s Friend”] (Germany, Heilbronn, 1859–1902) is a similar case in point. On the use of the term “alienist,” see also footnote 3 on page 28. See also Emil Kraepelin’s handwritten dedication to Kure Shūzō (on page 47), in which he refers to his own profession as “Irrenarzt” [Eng.: “mad-doctor” or “alienist”].

3 This era saw a lot of re-shaping of concepts and disciplines as a result of engaging with ideas from the West. The Japanese term for psychiatry emerged in this context and was also used interchangeably to denote “psychopathology” in Japanese medical journals. It often appeared in contrast with “neurology” (*shinkeibyō gaku* 神経病學), which is “the study of the diseases of the nerves,” or “neuropathology.” However, the word for mind (*seishin* 精神) in *seishinbyō gaku* is naturally a difficult one, as it can mean very different things in different cultures and contexts. It is not the same word for mind used in the Japanese term for psychology (*shinri gaku* 心理學, i.e. “the study of the mind”) and could also be used to refer to “spirit” in other constellations (Shin’ichi Yoshinaga, “The Birth of Japanese Mind Cure Methods,” in *Religion and Psychotherapy in Modern Japan*, ed. Christopher Harding, Routledge Contemporary Japan Series 54 [London: Routledge, 2015], 76). On Japanese debates concerning the import of foreign categories, see Gerard Clinton Godart, ““Philosophy” or “religion”? The Confrontation with Foreign Categories in Late Nineteenth Century Japan,” *Journal of the History of Ideas* 69, no. 1 (2008): 71–91; Jason Ānanda Josephson, *The Invention of Religion in Japan* (Chicago: The University of Chicago Press, 2012); Hans Martin Krämer, *Shimaji Mokurai and the Reconception of Religion and the Secular in Modern Japan* (Honolulu: University of Hawai’i Press, 2015).

4 On related disciplines, see footnote 32 on page 34 for more detail.

be able to see and understand the framework within which historical actors operate. For this reason, this book contains many direct quotes and close-reading sections. Ideally, this approach will prove instrumental in bringing these past mentalities, beliefs, and ways of thinking closer to today's readers and contribute to our understanding of how psychiatry as a discipline evolved and was shaped by those ideas.

I see my study mainly as a contribution to global intellectual history with a strong focus on the social context in which concepts were relevant to historical actors. Some concepts live longer than others, and there are many factors that can affect a concept's lifespan. Unicorns, phlogiston, and the ether were once considered scientific objects worthy of observation and inquiry but were eventually all "banished from the realm of the real."⁵ In the world of science, the degree of compatibility of a scientific object, or "epistemic thing," with an existing or changing experimental system can significantly affect its fate and trajectory.⁶ All objects are embedded in local, material, and practical networks throughout their life-cycle.⁷ Practical pressures, such as legal, actuarial, or administrative considerations, can render one concept salient at the expense of another. Constant stability of any kind is a rare phenomenon in the world of concepts, and some well-established category can ultimately dissolve because the emergence of a new metaphysics and a new sensibility has loosened its coherence.⁸

When concepts die, there is usually no obituary, and no studies are devoted to documenting and commemorating their passing.⁹ It is the creation of new concepts, the genesis of new ideas, the emergence of new modes of thinking that occupies peoples' minds and fills most of the pages of conceptual histories. I began this project as an investigation into the circumstances of melancholia's demise, and while I struggled to unravel the disappearance of a disease concept I found myself without suitable narrative models to rely on. As for the evidence, it all turned out to be less dramatic than I expected. Melancholia had to go in order for hospital administration to run more smoothly, for psychiatry to finally gain the image of a respected discipline grounded in scientific methods, and for insanity to become predictable, calculable, and more easily detectable. The changes in society, medical theory, and practice were so enormous that there no longer seemed to be a place for melancholia. It seemed that modern societies required modern concepts, and

5 Lorraine Daston, "The Coming into Being of Scientific Objects," in *Biographies of Scientific Objects*, ed. Lorraine Daston (Chicago: University of Chicago Press, 2000), 13.

6 Hans-Jörg Rheinberger, "Cytoplasmic Particles: The Trajectory of a Scientific Object," in Daston, *Biographies of Scientific Objects*, 276.

7 Bruno Latour, "On the Partial Existence of Existing and Non existing Objects," in Daston, *Biographies of Scientific Objects*, 250.

8 Lorraine Daston, "Preternatural Philosophy," in Daston, *Biographies of Scientific Objects*, 37.

9 Lorraine Daston's study on the disintegration of the category of preternatural philosophy is one notable exception.

Imperial Germany (1871–1918) and Meiji Japan (1868–1912) were definitely among those nations that strove to be modern.¹⁰

There are, of course, different ways in which you can write the story of a concept. At the beginning of my quest, I became fascinated with a book that I discovered while working through all sorts of secondary literature that was vaguely melancholia-related. I fell in love with Kobayashi Toshiaki's 小林敏明 (1948–) *Melancholie und Zeit*, a fascinating treatise on the patient's altered perception of time when afflicted with melancholia.¹¹ This philosophical study, which draws on existing works combining phenomenology and psychopathology, presents a theory of the self that aims to explain key symptoms in melancholia and schizophrenia as disruptions of the basic structure of self-experience. In his study, Kobayashi introduces the work of Japanese psychiatrist Kimura Bin 木村敏 (1931–2021), who conceptualized the living self as the result of the interplay of two different aspects of the self. According to Kimura's theory, the first self—the perceiving, acting aspect of the self—generates projections of itself into the world. These projections become objectified versions of self, which constitute the second self as an object of consciousness. The perceiving self then actively reviews and reintegrates these projections, thereby renewing itself in the process. Kimura assumed that, in melancholia and schizophrenia, this dynamic process of self-renewal was fundamentally disrupted and that this disruption was also connected to an altered perception of the flow of time.¹²

As fascinating as these ideas seemed to me at the time, I eventually came to realize that they would have no bearing on my historical study. I saw no purpose in searching for proof of Kimura's theories in late-nineteenth-century Japanese sources. My sources revealed hardly any insights into the patients' perception of self or of time, mostly because their testimonies usually only survived in doctors' records, who in turn were little concerned with such matters. This is not at all surprising, considering the period under inves-

10 Akira Kudō, Nobuo Tajima, and Erich Pauer, eds., *Japan and Germany: Two Latecomers on the World Stage, 1890–1945*, 3 vols. (Leiden: Brill, 2009). Although it seems appropriate to mention Plessner's book (for reasons of precedence) on the subject of the “delayed nation,” this 1930s study is problematic for its later role in the *Sonderweg* narrative and the author's controversial hypothesis that German philosophy was responsible for what happened in Germany after 1933 (Helmuth Plessner, *Die verspätete Nation: Über die politische Verführbarkeit bürgerlichen Geistes* [The Delayed Nation: On the Susceptibility of the Bourgeois Spirit to Political Seduction], 2., erw. Aufl. [Stuttgart: Kohlhammer, 1959]).

Similar modernization trends have been observed in the case of the Ottoman Empire. On non-Western modernity, and especially on the connection between Japan and the Middle East, see Renée Worringer, *Ottomans Imagining Japan: East, Middle East, and Non-Western Modernity at the Turn of the Twentieth Century* (New York: Palgrave Macmillan, 2014). On psychiatry, modernity, and the Middle East, see also the references in footnote 37.

11 Toshiaki Kobayashi, *Melancholie und Zeit* [Melancholia and Time] (Basel: Stroemfeld, 1998).

12 This is as simplified a version of Kimura's theory as I am able to formulate. Kimura was inspired by a great number of philosophers, including Edmund Husserl (1859–1938), Henri Bergson (1859–1941), Nishida Kitarō 西田幾多郎 (1870–1945), Martin Heidegger (1889–1976), and Jacques Derrida (1930–2004).

tigation when phenomenological psychology was not yet an established mode of thinking and writing about mental illness.

I was less concerned with using concepts and ideas from the late twentieth century as a lens to investigate descriptions of medical phenomena from the late nineteenth century. Attuned to the dangers of assuming that psychological concepts are universal across time and culture through my reading of medical anthropologists such as Arthur Kleinman and Margaret Lock, I was aware that my approach would narrow and focus my historical analysis.¹³ Being a historian (and not an anthropologist), this seemed like a legitimate method if it would bring me closer to understanding the world of ideas that governed my nineteenth-century Japanese doctors. After all, they did indeed assume that the medical categories they used were universally valid when trying to make sense of their patients' suffering. It is not my place to judge their assumptions in light of the medical anthropology of the 1970s and 1980s.¹⁴ Nor was I totally convinced that the idea of diagnoses being socially constructed was a useful way to understand past (or even present) medical experiences.¹⁵ Even less that another study was urgently needed to draw attention to the fact that socially constructed diagnoses were a phenomenon that could also be encountered in Japan, thus adding yet more evidence to the social construction narrative. My sources just did not yield more insights when examined and scrutinized that way. This detour did not bring me closer to understanding the world in which my Japanese doctors operated, but it helped me to get a more precise idea of what kind of book I wanted to write, albeit by process of elimination.

Another book that I quickly realized I did not want to end up writing was "a history of words." Although entertaining and informative, studies that cover the history of "melancholia" from the earliest appearance in Ancient Greek classics to modern times feel too condensed for my taste. For someone who is used to investigating individual concepts in depth, the idea of a book about all kinds of things named melancholia seems as fanciful and absurd as that of, for example, a composite biography of all the people who have

13 Arthur Kleinman and Peter Kunstadter, eds., *Medicine in Chinese Cultures: Comparative Studies of Health Care in Chinese and Other Societies* (Washington: U. S. Department of Health, Education / Welfare, 1975); Arthur Kleinman, "Neurasthenia and Depression: A Study of Somatization and Culture in China," *Culture, Medicine and Psychiatry* 6, no. 2 (1982): 117–190; Arthur Kleinman, *Social Origins of Distress and Disease: Depression, Neuroasthenia and Pain in Modern China* (New Haven: Yale University Press, 1986); Margaret Lock, "Popular Conceptions of Mental Health in Japan," in *Cultural Conceptions of Mental Health and Therapy*, Reprint, ed. Anthony J. Marsella and Geoffrey M. White, *Culture, Illness, and Healing* 4 (1982; Dordrecht: Reidel, 1984), 215–233.

14 Generally speaking, I don't see a problem in applying a modern concept to a historical context. Historians do that all the time. It only becomes problematic when it is done unconsciously. If that happens, you can end up with a study that reads like a strict teacher's grading exercise: historical actors all turn into either precursors or those who were misled by false beliefs, regardless of what counted as accepted knowledge at the time.

15 I'm sharing my skepticism with other scholars, perhaps most poignantly expressed by Ian Hacking (Ian Hacking, *The Social Construction of What?* [Cambridge: Harvard University Press, 1999]).

been named Peter over the last few centuries. Such works follow a word that was used to represent very disparate medical concepts, and they usually don't have the ambition (or space) to delve into the world of ideas in which these different concepts made sense and were believable. They also rarely explain why and how those conceptual changes occurred. Since these aspects are important to me, I knew that a history of words was not what I was aiming for. If you are curious about what kinds of things were named melancholia throughout the ages, you should take a look at Stanley Jackson's *Melancholia and Depression: From Hippocratic Times to Modern Times* or Jennifer Radden's *The Nature of Melancholy: From Aristotle to Kristeva*.¹⁶

But then, one might ask, if there have been so many “melancholias” throughout the ages, what exactly characterized “the melancholia” that is the object of the present study? Since most of this book is concerned with answering exactly this question by reconstructing past medical knowledge, attempting to understand what it meant at the time, and how it eventually changed, I cannot give a fully satisfying answer here. However, I can give you some clues by resorting to the present-day perspective.

When we look at the historical concept of late-nineteenth-century “melancholia” from the perspective of present-day knowledge, we can observe that it would overlap with a wide range of mental disorders. As the “melancholia historian” Jennifer Radden has pointed out, it would not only cover some of the cases that we now subsume under the term depression, but would also have been used to refer to patients suffering from schizophrenia, anxiety psychosis, and persecutory paranoia. Furthermore, “melancholia” may also have referred to mental states that we now describe as obsessions and compulsions, but that are not necessarily given the status of a disease—that are, rather, seen

16 Stanley W. Jackson, *Melancholia and Depression: From Hippocratic Times to Modern Times* (New Haven: Yale University Press, 1986); Jennifer Radden, ed., *The Nature of Melancholy: From Aristotle to Kristeva* (Oxford: Oxford University Press, 2000). There are many more books on the history of melancholy and melancholia focusing on literature, cultural history, social history, art, religion, treatment, etc. This is only a selection of titles: Jean Starobinski, *A history of the treatment of melancholy from earliest times to 1900* (Basel: Geigy, 1962); Raymond Klibansky, Erwin Panofsky, and Fritz Saxl, *Saturn and Melancholy: Studies in the History of Natural Philosophy, Religion and Art* (London: Nelson, 1964); German E. Berrios, “Melancholia and Depression during the 19th Century: A Conceptual History,” *British Journal of Psychiatry*, no. 153 (1988): 298–304; Jacky Bowring, *A Field Guide to Melancholy* (Harpending, Herts: Oldcastle Books, 2008); Jennifer Radden, ed., *Moody Minds Distempered: Essays on Melancholy and Depression* (Oxford: Oxford University Press, 2009); Mathew Bell, *Melancholia: The Western Malady* (Cambridge: Cambridge University Press, 2014). If you are more interested in understanding how the modern concept of depression developed (from today's perspective), you might also find these books helpful: Edward Shorter, *Before Prozac: The Troubled History of Mood Disorders in Psychiatry* (Oxford: Oxford University Press, 2009); Clarc Lawlor, *From Melancholia to Prozac* (Oxford: Oxford University Press, 2012). Okada Yasuo's article on dementia praecox and schizophrenia is written in the same spirit: Okada Yasuo 岡田靖雄, “Nihon ni okeru sōhatsu chikyō—(seishin) bunretsubyō kainen no juyō” 日本における早発癡呆——「(精神) 分裂病」概念の受容 [The Reception of the Concepts of Dementia Praecox and “Schizophrenia” in Japan], *Nihon ishigaku zasshi* 42, no. 1 (1995): 3–17.

as symptoms. And finally, it is also possible that a patient who may have been diagnosed with “melancholia” in the past would not be considered mentally ill nowadays, because our understanding for what passes for normal behavior has changed considerably over time.¹⁷

There are several reasons why I chose to focus on concepts from the late nineteenth and early twentieth centuries, and one of them has to do with my interest in how knowledge is applied and leveraged, rather than what could be called pure “intellectual history” or “historical semantics.” Although I did come across some interesting finds of premodern melancholia concepts based on humoral theory in Japanese medical texts, those texts were mostly translations of European treatises.¹⁸ I didn’t find any evidence that these translations had any impact on diagnosing or treating that version of (black-bile) melancholia in Japan.¹⁹ This avenue seemed to lead me onto the path of pure philology, where I would spend my time burrowed into historical dictionaries, trying to make sense of obscure translation words that were long out of use or were only ever used in that specific text alone, never to have any bearing on the life of Japanese doctors, patients, or their families.²⁰ This prospect had no appeal to me. And although I still ended up musing about

17 Jennifer Radden, “Shared Descriptions: What Can Be Concluded?,” *Philosophy, Psychiatry, & Psychology* 20, no. 2 (2013): 157.

18 See, for example, Udagawa Genzui 宇田川玄随, *Naika sen'yo* 内科撰要 [Collection of References in Internal Medicine] (Muromachi 室町: Suharaya ichibee 須原屋市兵衛, 1796–97) or Komori Touu 小森桃塙, *Byōin seigi* 病因精義 [Commentary on the Causes of Diseases] (Kyōto 京都, 1827), which both have sections on “melancholia.” Such translations were created in the context of so-called Dutch-learning (*rangaku* 蘭學) by specialized Japanese scholars. The medical texts within this corpus are seen as part of a distinct medical school called Dutch medicine (*ranpō* 蘭方). On *ranpō*, see footnote 38 on page 37. On “humoral theory,” see the following footnote.

19 The word “melancholia” originally means “black bile” in Greek. In Ancient Greek medicine, black bile (along with yellow bile, blood, and phlegm) was one of the four humors considered vital for human health. An excess or deficiency in one of the humors was interpreted as a sign of illness. At a later stage, the four humors were also associated with the four corresponding temperaments (phlegmatic, choleric, sanguine, and melancholic). Melancholia was the illness associated with an excess of black bile and was characterized (among other things) by excessive fear and sadness (Raymond Klibansky, Erwin Panofsky, and Fritz Saxl, *Saturn und Melancholie: Studien zur Geschichte der Naturphilosophie und Medizin, der Religion und der Kunst* [Frankfurt am Main: Suhrkamp, 1990], 39–54).

20 In point of fact, I did pursue that avenue for some time. My original thesis featured a chapter that attempted to build a bridge between traditional Chinese medicine and twentieth-century Japanese psychiatry through the link of language. It is true that many of the newly coined Japanese terms for psychiatric concepts were built from components that had a long history in the context of traditional Chinese (and Japanese) medicine. However, the evidence that these old meanings still had some relevance in their new twentieth-century guises was very scarce. Eventually, I decided to abandon that project because it did not align with the rest of the book. For those who would like to explore this topic, I would recommend starting with Kuriyama Shigehisa’s excellent article on the problem of matching Eastern and Western medical concepts (Shigehisa Kuriyama, “Translation and the History of Japanese Irritability,” in *Traduire, Transposer, Naturaliser: La formation d’une langue scientifique moderne hors des frontières de l’Europe au XIXe siècle*, ed. Pascal Crozet and Annick Horiuchi [Paris: L’Harmattan, 2004], 27–41).

obscure translation words that were long out of use, I decided that I would rather spend my time puzzling over words that had tangible effects on the lives of people. My choice to focus on medical military case files from the Russo-Japanese War and to consider the impact of medical concepts on the military's decisions to grant disability pensions was guided by that sentiment.

Although the story that I unfold in this book takes place at the beginning of the bilateral scientific exchange between Imperial Germany (and beyond) and Meiji Japan, it is not primarily a story about knowledge transfer in the field of psychiatry. The focus of this study is not to show how and to what extent Japanese psychiatry was influenced by German (as well as Austrian, Swiss, French, Russian, American, etc.) psychiatry, otherwise I would have structured my text quite differently and eventually would have written a very different book. Since this is not a story about knowledge transfer, I am not concerned with offering a perfectly balanced narrative of scientific exchange between Imperial Germany and Meiji Japan. Nevertheless, I have made an honest attempt to take a close look at both sides and to identify the flow of information, people, and ideas in both directions. It is not surprising that during the foundational period of Japanese psychiatry, there is little evidence of a symmetrical, balanced knowledge exchange between East and West. The perspective changes if you extend the time-frame or if you broaden the field to include the discipline of neurology and even more so if you take a look at the scientific exchange within medicine as a whole.²¹ However, as long as Japanese scientific contributions (as important as they are in their own right) did not affect the evolution of the medical concepts investigated in this study, they have no place in this book.

Another fruitful angle is to look at “emotion studies” (Paolo Santangelo and Ulrike Middendorf, eds., *From Skin to Heart: Perceptions of Emotions and Bodily Sensations in Traditional Chinese Culture* [Wiesbaden: Harrassowitz, 2006]; Yanhua Zhang, *Transforming Emotions with Chinese Medicine: An Ethnographic Account from Contemporary China* [Albany: State University of New York Press, 2007]; Angelika Messner, “Aspects of Emotion in Late Imperial China: Editor’s Introduction to the Thematic Section,” *Asiatische Studien* 66, no. 4 [2012]: 893–913; Volker Scheid, “Constraint 鬱 as a Window on Approaches to Emotion-Related Disorders in East Asian Medicine,” *Culture, Medicine, and Psychiatry* 37 [2013]: 2–7; Volker Scheid, “Depression, Constraint, and the Liver: (Dis)assembling the Treatment of Emotion-Related Disorders in Chinese Medicine,” *Culture, Medicine, and Psychiatry* 37 [2013]: 30–58). More general accounts can be found in Emily Baum, *The Invention of Madness: State, Society, and the Insane in Modern China* (Chicago: The University of Chicago Press, 2018) and Hsiu-fen Chen, “Pre-modern Madness,” in *Routledge Handbook of Chinese Medicine*, ed. Vivienne Lo, Michael Stanley-Baker, and Dolly Yang (London: Routledge, 2022), 230–244. For a literature-focused angle, there are, for example, Wolfgang Kubin, ed., *Symbols of Anguish: In Search of Melancholy in China* (Berlin: Peter Lang, 2001) and Tudor Vladescu, “Redefining Macau Melancholy through Pushkin and Chekhov,” *Chinese Cross Currents* 7, no. 1 (2010): 56–59.

²¹ If you are interested in this kind of literature, you might want to take a look at Harmen Beukers, *Red-bair Medicine: Dutch-Japanese Medical Relations* (Amsterdam: Rodopi, 1991); Ernst Kraas, ed., *300 Jahre deutsch-japanische Beziehungen in der Medizin* [300 Years of German-Japanese Relations in Medicine] (Tokyo: Springer, 1992).

I also challenge established narratives that paint the development of psychiatry in Imperial Germany and the contribution of the now-famous German psychiatrist Emil Kraepelin (1856–1926) all too straightforwardly in the shining colors of scientific progress. I revisit the conceptual changes that were introduced by this historical figure in redefining mental disorders and contest the common view that the disappearance of melancholia and the simultaneous emergence of *manic-depressive insanity* was the result of a synthetic process. By evoking the image of a “synthesis” and focusing on the conditions of creation, the emergence of the category *manic-depressive* is invariably described as a process of “lumping mood disorders together” in secondary literature.²² However, this narrative does not capture the transformative processes that were at work when the category of melancholia was abandoned. Focusing instead on the conditions of possibility of a mode of thinking disappearing, I not only offer a new conceptual history of the last days of melancholia, but I also propose a new interpretation of the social changes that accompanied this transformation. Whereas I am indebted, of course, to the works of Michel Foucault (but no less so to other writers such as, for example, Georges Canguilhem, Carlo Ginzburg, or Steven Shapin),²³ I do not believe that all works that deal with related topics ought to be written in the same way, nor do I see my study primarily as an extension of Foucault’s work to a geographically different area.²⁴

My interest lies in investigating what destabilizes concepts and how these disruptions affect people.²⁵ The Japanese psychiatrists, who are the protagonists of this study, have an important part to play in this transformative process. Their roles within the global academic network and as mental health experts in the Russo-Japanese War are ideally suited to illustrating the conceptual changes, which I analyze, in action. They all belong to the same group of mental health professionals who received most of their medical training

22 See, for example, Edward Shorter, *What Psychiatry Left Out of the DSM-5: Historical Mental Disorders Today* (New York: Routledge, 2015), 167; Jennifer Radden, “Lumps and Bumps: Kantian Faculty Psychology, Phrenology, and Twentieth-Century Psychiatric Classification,” in Radden, *Moody Minds Distempered*, 131.

23 Among the works that inspired me most are: Georges Canguilhem, *The Normal and the Pathological* (New York: Zone Books, 1991); Carlo Ginzburg, *The Cheese and the Worms: The Cosmos of a Sixteenth-Century Miller*, trans. John Tedeschi and Anne Tedeschi (Baltimore: The Johns Hopkins University Press, 1992); Steven Shapin, *Never Pure: Historical Studies of Science as if it Was Produced by People with Bodies, Situated in Time, Space, Culture, and Society, and Struggling for Credibility and Authority* (Baltimore: Johns Hopkins Univ. Press, 2010).

24 That said, I should perhaps clarify that my distancing from Foucault’s work has less to do with radically disagreeing with any of his hypotheses about the nature and social function of psychiatry as expressed in his influential studies (Michel Foucault, *Histoire de la folie à l’âge classique* [Paris: Gallimard, 1972]; Michel Foucault, *Surveiller et punir: naissance de la prison* [Paris: Gallimard, 1975]). My issue lies with works that pose as “Foucault-inspired” while retelling a simplified story of psychiatry as a tool for social control and applying that blueprint narrative to all sorts of historical periods and cultures without adding much to the original argument. This is not an approach to history writing that I embrace.

25 In this pursuit, Foucault’s writings (especially those that deal with historical epistemology, such as Michel Foucault, *L’archéologie du savoir* [Paris: Gallimard, 1969]), have indeed been inspiring.

in the newly established university structures that emerged in the wake of Meiji Japan's modernization and Westernization efforts. Because they were pioneers in their domain, they shouldered most of the burden of translating and popularizing the foreign concepts in their home country. It was on their shoulders that the next generation of psychiatrists and psychologists would later develop fascinating and creative approaches to mental health that were more eclectic and more hybrid in nature, integrating both Eastern and Western knowledge to a much greater extent.²⁶ It is, perhaps, for this perceived lack in creativity and "Japaneseness" that the scientific output of this group of pioneers is considerably understudied.

Nowadays, most scholars who investigate this period from the vantage points of anthropology, cultural history, social history, or gender studies rarely give university-trained psychiatrists the full attention they deserve. To some degree, this was a very fruitful shift in focus, based on the conviction that other groups of actors offer a more comprehensive insight for understanding the phenomenon of mental illness, in Japan and elsewhere. And, indeed, there is no denying the great benefits of diversifying the source base and enriching our histories by including the perspective of drug sellers, traditional healers, patients, family members, law enforcers, or the media. Nonetheless, I take issue with how these supposedly different perspectives are framed in relation to the "expert knowledge" associated with my chosen group of university-trained psychiatrists.

The framing that you encounter in many studies usually takes the form of a contrasting narrative. However, because the focus is primarily on other actors (drug sellers, traditional healers, etc.), the university-trained psychiatrists appear as particularly shallow characters who essentially serve as convenient targets for all sorts of (postmodern) criticism that has become socially acceptable, especially since the 1960s anti-psychiatry movement.²⁷ In a nutshell, university-trained psychiatrists are portrayed as mindless agents of an oppressive and control-obsessed state who have fully internalized the idea that all forms of mental illness should be understood as brain disease and, therefore, represent a dehumanized form of psychiatry.²⁸ Against this bleak background, the true heroes of the

26 For some examples of distinctly hybrid approaches, see the collection of articles in Harding, *Religion and Psychotherapy in Modern Japan*.

27 Key texts by psychiatrists associated with the movement are: Thomas Szasz, *The Myth of Mental Illness* (New York: Harper & Row, 1961); David G. Cooper, *Psychiatry and Anti-psychiatry* (London: Tavistock Publications, 1971). The critical works of Michel Foucault (already mentioned above), Erving Goffman, and Gilles Deleuze have also considerably contributed to the anti-psychiatry debate.

28 Among the works in which this narrative prevails are Hyōdō Akiko 兵頭晶子, *Seishinbyō no Nihon kindai: tsuku shinshin kara yamu shinshin e* 精神病の日本近代：憑く心身から病む心身へ [Mental Illness and Japanese Modernity: From the Possessed Mind-Body to the Diseased Mind-Body] (Tōkyō: Seikyūsha, 2008); Yu-chuan Wu, "A Disorder of *Ki*: Alternative Treatments for Neurasthenia in Japan, 1890–1945" (PhD diss., University College London, 2012); Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress* (Princeton: Princeton University Press, 2012); Keiko Daidoji, "Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients and Doctors," *Culture, Medicine, and Psychiatry* 37 (2013): 59–80; Satō Masahiro 佐藤雅浩, *Seishin shikkan*

story can shine even brighter as they are painted as a force of resistance that stands for a more social and humane vision of psychiatry—one that acknowledges individual suffering and the diverse social causes that can lead to mental impairment. Because the knowledge that university-trained psychiatrists represent mostly originates from the West, there is also room for additional critique that exploits the East–West dichotomy. As a result, we encounter narratives that fail to step out of the nation-state framework by contrasting a simplified and essentialized view of Western knowledge with a dynamic and vivid portrayal of a supposedly different and exotic indigenous knowledge. While it is important to acknowledge that such a dichotomy was emphasized by contemporary scholars and social actors for various political reasons, it is inappropriate to simply parrot that view when you are the historian who is supposed to provide an analysis of the past. In that context, I find it extremely problematic to identify “expert knowledge” with some kind of “Western mode of thinking” while ascribing a unique “Japaneseness” to the views expressed by patients. *Nowhere in the world* did patients agree with their doctors on issues of mental illness, and it is a mistake to believe that the Japanese case is exceptional in this respect. The patient–doctor relationship and the divide between expert knowledge and lay knowledge that usually characterizes it is a fascinating topic, but it does not do justice to the history of Japanese psychiatry to interpret the divide in terms of a reductionist “Asia and the West” dichotomy. I am offering a new perspective on the institutionalization of psychiatry in Meiji Japan by examining this development within a larger framework that considers the dynamics of global conceptual changes and the role of institutional, administrative, and experimental practices.

Another common narrative, which I find unproductive and misleading, makes use of the concept of “unitary psychosis” as a logical prehistory to Kraepelin’s dichotomy of *dementia praecox* and *manic-depressive insanity*. In this simplified history of the evolution of psychiatric categories, it is assumed that before Kraepelin single-handedly introduced disease specificity as a guiding principle for establishing disease boundaries, the psychiatric community was governed by a shared belief in a single unitary psychosis.²⁹ This

gensetsu no rekishi shakaigaku: Kokoro no yamai wa naze ryūkō suru no ka 精神疾患言説の歴史社会学：「心の病」はなぜ流行するのか [A Historical and Sociological Analysis of the Discursive Practice of Mental Illness: Why Did a Particular “Mental Sickness” Become Prevalent in a Certain Period?] (Tōkyō: Shin’yōsha, 2013); Francesca Di Marco, *Suicide in Twentieth Century Japan* (Abingdon: Routledge, 2016). A good counterexample is the recent work of Yumi Kim, which generally gives a more nuanced picture of university-trained psychiatrists: Yumi Kim, “Seeing Cages: Home Confinement in Early Twentieth-Century Japan,” *The Journal of Asian Studies* 77, no. 3 (2018): 654; H. Yumi Kim, *Madden in the Family: Women, Care, and Illness in Japan* (Oxford: Oxford University Press, 2022), 41.

- 29 It is, in fact, very hard to identify adherents of the unitary psychosis doctrine. First, because unitary psychosis was not an actor’s category most of the time, and historical actors rarely made their views explicit enough; second, because, even if they did, historical actors tended to change their views or express contradicting ideas (German E. Berrios and Michael Dominic Beer, “Unitary Psychosis Concept: The Origin and History of Psychiatric Disorders,” ed. German E. Berrios and Roy Porter [London: Athlone Press, 1995], 313).

term, a rendition of the German *Einheitspsychose*, can refer to a variety of views which have in common “the assertion that there is only one psychosis.”³⁰ Adherents of that doctrine believe that all forms of mental illness are just different manifestations of the same underlying disease. The reason why this meta-concept (not an actor’s category in Imperial Germany or Meiji Japan) does not appear in this book is that it plays no role (not even implicitly) in the sayings and writings of the protagonists in my study for the period under investigation. By the 1860s, after Karl Ludwig Kahlbaum (1828–1899) had published his influential book on classification, the concept of unitary psychosis had largely lost its appeal.³¹ This timing is also the reason why it did not find its way into Japanese psychiatric discourse (as far as I was able to ascertain) at the time when Western-style psychiatry formally took shape in Japan in the 1880s. Apart from its absence from my protagonists’ texts, I also find the unitary psychosis narrative of little use when making a historical argument about the evolution of psychiatric concepts. In this study, I identify very different forces that led to the conceptual changes which heralded melancholia’s disintegration. I further argue that those forces did not hinge on the belief of whether there was only one single psychosis or many, or whether diseases should be differentiated along the affective–cognitive divide (as Radden’s and Shorter’s reading suggests).

By thoroughly engaging with the conceptual and institutional developments that shaped the transformation of psychiatric knowledge in Imperial Germany, I critically reassess Kraepelin’s contribution to psychiatric nosology and provide a comprehensive analysis of the Japanese psychiatrists’ involvement in this knowledge production. Secondary literature that deals with Kraepelin’s historical significance is usually strongly influenced by the authors’ own convictions and reflects their affiliation with the history of medicine or social history. As a result, the historical perception of Kraepelin and his contributions to nosology is divided, as both the proponents of a biologicistic psychiatry and those of social psychiatry have portrayed him as the founding father of their respective factions. This curious circumstance may in part be due to psychiatry’s shifting relationships with other neighboring disciplines. While the 1950s and 1960s were marked by a fraternization with psychology and a fascination with psychoanalysis, the anti-psychiatry movements and scandals of the 1970s (especially the Rosenhan experiment) heavily damaged the discipline’s credibility and have opened the path for a decisively more biologicistic

30 Berrios and Beer, “Unitary Psychosis Concept,” 313.

31 Ludwig Kahlbaum, *Die Gruppierung der psychischen Krankheiten und die Eintheilung der Seelenstörungen: Entwurf einer historisch-kritischen Darstellung der bisherigen Eintheilungen und Versuch zur Anbahnung einer empirisch-wissenschaftlichen Grundlage der Psychiatrie als klinischer Disciplin* [The Grouping of Mental Diseases and the Classification of Mind Disturbances: Outline of a historico-critical Account of Previous Classifications and Attempt at an Initiation of an Empirical and Scientific Basis for Psychiatry as a Clinical Discipline] (Danzig: A. W. Kafemann, 1863). Even Wilhelm Griesinger 1817–1868, who is commonly assumed to have been one of the main proponents of the unitary psychosis concept, had expressed very different views in his later writings and was explicitly agreeing with Kahlbaum’s work (Berrios and Beer, “Unitary Psychosis Concept,” 321).

approach since the 1980s. The new, so-called neo-Kraepelinian era was characterized by a turn towards the natural sciences, heralding an alliance with neurology and especially with psychopharmacology.³²

The ambiguity with regard to Kraepelin's assessment is in turn reflected in studies dealing with the history of psychiatry in Japan. This scholarship usually relies on English-language secondary literature to investigate the relationship between German and Japanese psychiatry in the nineteenth century. Thus, given the disagreement regarding Kraepelin's legacy in secondary sources, it is not surprising that in two recent publications on mental illness in Japan, the reader is confronted with contradictory statements. While Junko Kitanaka depicts Japanese psychiatry as closely following Kraepelin's neurobiological approach, with the Japanese experts eventually adopting his view that all forms of mental illness were seen as hereditary-based "brain disease," Hayang Kim instead presents the Japanese as clinging to the "biological model of psychiatry" *despite* Kraepelin's presumed rejection of this particular approach.³³ These narratives, developed based on a distant reading of German psychiatric history, fail to acknowledge that there might be a middle ground between a materialist and a social constructionist approach to mental illness (both for past and present actors).³⁴ At the same time, they cannot conceive of a history of Japanese psychiatry where the Japanese actively participate in the remapping of madness by retracing the boundaries of diseases with the very same quantitative methods for which Kraepelin has been enshrined as the "father of modern psychiatry."³⁵

Moving the focus to Japan allows me to address hitherto-unexplored aspects of these conceptual changes. Indeed, some of the most important structural determinants come to the fore more clearly at the periphery of the global psychiatric community than in its contemporary centers in Europe. I argue that the impact of institutional structures on the vanishing of melancholia can nowhere be better observed than in Japan. In the early years of Japanese psychiatry, virtually all of the resources and support of the state were channeled to Japan's flagship institution, Tokyo Imperial University. Since it was

32 This periodization mainly reflects the development in the United States as outlined in Andrew Scull, "Contending Professions: Sciences of the Brain and Mind in the United States 1850–2013," *Science in Context* 28, no. 1 (2015): 134.

33 Kitanaka, *Depression in Japan*, 17, 35; Hayang Sook Kim, "Sick at Heart: Mental Illness in Modern Japan" (PhD diss., Columbia University, 2015), 17. Kitanaka gives Radden and Hoff as a reference for her interpretation of Kraepelin's assessment (Radden, *The Nature of Melancholy*; Paul Hoff, *Emil Kraepelin und die Psychiatrie als klinische Wissenschaft: Ein Beitrag zum Selbstverständnis psychiatrischer Forschung* [Emil Kraepelin and Psychiatry as Clinical Science: A Contribution to the Self-Image of Psychiatric Research] [Berlin: Springer-Verlag, 1994]). Kim's inspirations remain more obscure, but popular secondary literature that propagates this particular view is equally abundant. See, for example, Andrew Scull, *Madness: A Very Short Introduction* (Oxford: Oxford University Press, 2011), 69.

34 For a convincing vision of a middle ground, see Nikolas Rose, *Our Psychiatric Future: The Politics of Mental Health* (Cambridge, UK: Polity, 2019), 114–115.

35 The phrase can be found in many works; my quote is from Radden, *The Nature of Melancholy*, 206.

the focus of the governmental efforts to establish a unified and unambiguously “modern psychiatry,” Tokyo became the sole and uncontested center of psychiatric research and teaching.³⁶ This is not to say that institutional hierarchies were not also powerful factors in other countries, but especially when new methods of conceptualizing mental illness were being negotiated, these forces were especially visible in Japan.³⁷

Additionally, Tokyo Imperial University had the official mandate to popularize the new doctrines amongst all of the Japanese physicians, and so it also became the teaching hub of Japanese psychiatry. According to its commitment to keep up with worldwide developments, its professors turned to foreign, “avant-garde” psychiatrists to assess the global discourse. Since the 1880s, the elite community was constantly involved in translating and annotating medical literature from Vienna, Berlin, and Heidelberg, turning the students of Tokyo Imperial University into experts on German views on mental illness. It should perhaps be noted right away that “German views” on mental illness did not match up with ideas developed exclusively within the borders of the present-day German nation state. On the one hand, Imperial Germany before World War I also comprised parts of present-day Poland and Russia; therefore, some historical actors mentioned in this study, whose career involved positions in Breslau (present-day Wrocław), for example, would also be referred to as “German.” On the other hand, the German language served as an important gateway to European and even worldwide academic debates for my Japanese protagonists. It allowed them to be part of a scientific community that ex-

36 On the history of Japanese medical institutions and medical education, see Ulrich Teichler, *Geschichte und Struktur des japanischen Hochschulwesens* [The History and Structure of Japanese Higher Education] (Stuttgart: Ernst Klett Verlag, 1975); Hermann H. Vianden, *Die Einführung der deutschen Medizin im Japan der Meiji-Zeit* [The Introduction of German Medicine in Japan during the Meiji-Period], *Düsseldorfer Arbeiten zur Geschichte der Medizin* 59 (Düsseldorf: Triltsch, 1985); Margaret Powell and Masahira Anesaki, *Health Care in Japan* (London: Routledge, 1990); Nakano Minoru 中野実, *Kindai nihon daigaku seido no seiritsu* 近代日本大学制度の成立 (Tōkyō: Yoshikawa Kōbunkan, 2003); Benjamin C. Duke, *The History of Modern Japanese Education: Constructing the National School System, 1872–1890* (New Brunswick: Rutgers University Press, 2009); Hsiu-Jane Chen, “‘Eine strenge Prüfung deutscher Art’: Der Alltag der japanischen Medizinausbildung im Zeitalter der Reform von 1868–1914” [“A Tough Exam in the German Fashion”: Everyday Life in Japanese Medical Training during the Reform Era 1868–1914] (Charité - Universitätsmedizin Berlin, 2010); Kim, Hoi-eun, *Doctors of Empire: Medical and Cultural Encounters between Imperial Germany and Meiji Japan* (Toronto: University of Toronto Press, 2014).

37 There are some interesting parallels when you compare Japan’s case with the history of psychiatry and modernization in the Middle East. For lack of language skills in that part of the world, I was never able to investigate that trail in full. For those interested in the subject, there are some excellent studies available in European languages: see Michael Dols, *Majnun: The Madman in Medieval Islamic Society* (Oxford: Oxford University Press, 1992); Zalashik Rakefet, *Das unselige Erbe: die Geschichte der Psychiatrie in Palästina und Israel* [A Grim Legacy: The History of Psychiatry in Palestine and Israel] (Frankfurt am Main: Campus Verlag, 2012); Sara Scalenghe, *Disability in the Ottoman Arab World, 1500–1800* (New York: Cambridge University Press, 2014); Omnia El Shakry, *The Arabic Freud: Psychoanalysis and Islam in Modern Egypt* (Princeton: Princeton University Press, 2017); Joelle M. Abi-Rached, *ʿAsfūriyyeh: A history of madness, modernity, and war in the Middle East* (Cambridge: The MIT Press, 2020).

tended to the Austrian Empire and the German-speaking part of Switzerland, as well as some Baltic countries where German still played an important role in academic and scientific circles. Therefore, “German psychiatry,” as often used in this study, could refer to a pool of knowledge that was filled by a variety of scholars well beyond the limits of even Imperial Germany. Since the Japanese psychiatrists absorbed and condensed theories accessible to them in German with exceptional speed, the development of all major strands of late-nineteenth-century psychiatry from German-speaking countries is preserved in their statistical reports, their clinical lectures, and their teaching material.³⁸

The displacement of melancholia in Japan is a valuable indicator of the efforts of the Japanese government to adjust to changing conceptions of global scientific thought and practice. Whereas melancholia had once been imported as a rare intellectual commodity in the cross-cultural occupation with Dutch medicine in the eighteenth century, it quickly rose to prominence when the government began to promote state medicine and psychiatric institutions. In the 1880s, the participation of Japan in the globe-spanning enterprise of “scientific progress” was also marked by the introduction of asylums in major cities. The high numbers of melancholic patients in the Tokyo Metropolitan Asylum bore witness to the leading power-holders’ ambition to make a place for themselves among the more “progressive” nations.

However, towards the end of the nineteenth century, the situation began to change dramatically. Almost overnight, the perception of melancholia was reversed, and suddenly it was the disappearance of melancholia from Japanese asylums that came to symbolize scientific progress and enlightenment. Nonetheless, melancholia did not immediately vanish from academic discourse everywhere but remained an active part of scientific thought in some institutions for several years to come. Most evidently, it persisted outside of the direct zone of influence of the Tokyo academic community and thenceforth became a source of dispute between the metropolitan modernizers and other medical practitioners throughout the rest of Japan.

Lastly, my research fills a gap in historical studies on war-related mental illness, which usually ignore the Russo-Japanese War and often omit mentioning the Japanese perspective at all.³⁹ I will refrain from making any attempt to identify “PTSD,” “shell shock,” or any other form of “psychological trauma” in sources that were written before these concepts had emerged and were consciously used.⁴⁰ Focusing instead on the actor’s cate-

38 On the institutional background and Japanese psychiatry’s tradition with German language, see especially section 1.2.

39 See, for example, the chapter on war syndromes in Dan G. Blazer, *The Age of Melancholy: Major Depression and its Social Origins* (New York: Routledge, 2005), 117–133, which only discusses wars with American participation, or the introduction in Mark S. Micale and Paul Lerner, eds., *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870–1930* (Cambridge: Cambridge University Press, 2001), where the absence of the Russo-Japanese War is admitted, but Japan (or Asia, for that matter) is not even mentioned.

40 There are some notable works where this subject is treated and from which I have borrowed biographical

gories, I will discuss etiologies of mental disorders whenever these issues were problematized by the contemporary authors themselves. It goes without saying that my focus on melancholia prevents me from making general claims about any and all kinds of mental illness witnessed in the Russo-Japanese War. Hopefully, the rich material on *neurasthenia* and *hysteria* that was produced by military doctors on both sides will someday be incorporated into general works in the history of psychiatry as well.⁴¹

Due to the outbreak of the Russo-Japanese War, the Japanese historical documents on melancholia offer unique insights into the disappearance of the concept from psychiatric practice. Just when melancholia was on the brink of disappearance, the Japanese psychiatrists were entrusted with the care of hundreds of mental health patients returning from the battlefields in Manchuria. As a practical result of military administration, most of these patients passed through several medical centers of psychiatric care along the way home to their divisions. Each of these medical centers was a self-contained repository of psychiatric knowledge that became integrated into the centralized system of the military. While the category of melancholia was still in use in some of them, others had already discarded it, but they were now all incorporated into the military machine.

As the patients passed through the different stations, they became objects of inquiry for military doctors, Red Cross attendants, and local and metropolitan psychiatrists. Each examiner produced his own individual medical report that was then continuously passed on, transformed, and re-scripted as the patients moved along the nodes of the military

and bibliographical data for my own research: Catherine Merridale, "The Collective Mind: Trauma and Shell-Shock in Twentieth-Century Russia," *Journal of Contemporary History* 35, no. 1 (2000): 39–55; Paul Wanke, *Russian/Soviet Military Psychiatry 1904–1945* (London: Frank Cass, 2005); Jacqueline Lee Friedlander, "Psychiatrists and Crisis in Russia, 1880–1917" (PhD diss., University of California, 2007); Irina Sirotkina, "Rossijskie psichiatri na pervoj mirovoj vojne" [Russian Psychiatrists in World War One], in *Nauka, tehnika i obščestvo Rossii i Germanii vo vremja Pervoj mirovoj vojny*, ed. Ėduard Kolčinskij and Dietrich Beyrau (St. Petersburg: Nestor-Istorija, 2007), 326–344; Irina Sirotkina, "The Politics of Etiology: Shell Shock in the Russian Army 1914–1918," in *Madness and the Mad in Russian Culture*, ed. Angela Brintlinger and Ilya Vinitsky (Toronto: University of Toronto Press, 2007), 117–129; Jan Plamper, "Soldiers and Emotion in Early Twentieth-Century Russian Military Psychology," *Slavic Review* 68, no. 2 (2009): 259–283; Satō Masahiro, *Seishin shikkan gensetsu no rekishi shakaigaku* Nakamura Eri 中村江里, "Sensō to otoko no 'hisuteri': Jūgonen sensō to Nihongun heishi no 'otokorashisa'" 戦争と男の「ヒステリー」：十五年戦争と日本軍兵士の「男らしさ」[War and Male Hysteria: The Fifteen Years' War [1931–1945] and Japanese Army Soldiers' Masculinity], *Rikkyō daigaku jendā fōramu nenpō* 16 (2015): 33–48.

- 41 Apart from those previously cited, such general works are Marijke Gijswijt-Hofstra and Roy Porter, eds., *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001); Mark S. Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge: Harvard University Press, 2008); Andrew Scull, *Hysteria: The Biography* (Oxford: Oxford University Press, 2009). The subject of mental illness in the Russo-Japanese War has of course been sketchily treated in general works on Russian and Japanese psychiatry, respectively, but the "national style narrative" adopted by the authors has rendered these texts largely incompatible with my own research. For a critical discussion of "national styles" in the sciences, see, for example, Nathan Reingold, "The Peculiarities of the Americans or Are There National Styles in the Sciences?," *Science in Context* 4, no. 2 (2008).

network. The patient records were woven from the fabric of the knowledge that the examiners had at their disposal from their individual careers and at their respective sites of activity. From today's perspective, these records are unique testimonies to widely differing medical and diagnostic practices that mirror the diversity of psychiatric knowledge. Despite this heterogeneity, a significant number of the case histories were still connected by the individual human experiences and stories from which they were abstracted. It is this circumstance that permits that they now be used to assemble composite pictures of the psychiatrists' multi-perspective observations. Indeed, once the records are matched, analyzed, and compared, they constitute an invaluable source for our understanding of the changes that led to the disappearance of melancholia from psychiatric practice.

The overall structure of the book is divided into two parts. The first part concentrates on the academic structures and struggles that surrounded the concept of melancholia. It has as its scene the lecture halls, laboratories, and academic institutions of Meiji Japan and Imperial Germany and relies on academic publications, conference papers, research reports, textbooks, institutional yearbooks, and lecture notes as its primary sources. It focuses on the position of melancholia as a global academic concept and showcases the multi-leveled connections that linked Japanese psychiatry to its German counterpart.

The second part deals with issues surrounding war and mental illness. It has as its scene the front line of the Russo-Japanese War, the line of communication hospitals in the rear, and the hospitals on the Japanese mainland. Its sources are the medical reports of Russian and Japanese psychiatrists who applied the diagnostic category of melancholia to their patients or discussed the term in their writings. It focuses on the use of the category in practice and establishes the scope and meaning of the term based on its use in medical case records produced in the wake of the war. It complements the theoretical accounts on melancholia in textbooks and academic disputes discussed in the preceding part.

Although most chapters touch on all topics to a varying degree, each argues for a specific set of points, and the source materials are weighted accordingly.

Chapter 1 plunges right into a pivotal debate that touched upon issues such as the essence and purpose of psychiatry and sketches the rifts and ruptures it created within the global psychiatric community. First, it situates the concept of melancholia within that worldwide debate; second, within the Japanese educational setting; and third, within the personal affinities of three of the book's protagonists, namely, Kure Shūzō 呉秀三 (1865–1932), Araki Sōtarō 荒木蒼太郎 (1869–1932), and Kadowaki Masae 門脇眞枝 (1872–1925). It narrates the “rifts” that ran through the world of psychiatry and contrasts the different settings, institutions, and personal preferences that constituted the framework within which the vanishing of melancholia took place.

Chapter 2 takes a step back in time and reconstructs the emergence of the so-called “great dichotomy” in psychiatric classification, a new system of classifying mental illness that introduced the concepts of *dementia praecox* and *manic-depressive insanity* as the two main categories into which the majority of mental patients could be divided and

which had a disruptive effect on melancholia and other well-established medical concepts. Within a comparative framework, the chapter traces the institutional roots of this development and focuses on the relationship between risk-management-driven hospital administration and concept formation in Imperial Germany and Meiji Japan. By linking these developments to the psychiatrists' efforts to present asylums as sites of psychiatric modernity, this chapter also addresses issues of professional identity, rivalry, and competition. Lastly, the chapter revisits the conceptual origins of the great dichotomy by taking a closer look at textbook production in Germany and Japan and analyzes the metaphorical language that lay at the heart of its foundation.

Chapter 3 investigates the rhetoric of "scientific progress" that accompanied the emergence of the new classification system and significantly contributed to its popularity. It sheds light on the introduction of experimental practices into the psychiatric clinic and analyzes the implications of these new methods for diagnosing, theorizing, and teaching. Sketching the origins of the new number-producing techniques, the chapter offers an analysis of the theoretical foundations behind the experimental methods. It exposes the black-boxing effect of the metrical operations and investigates the assumptions and judgments implicit in the different experimental settings, the execution of the tests, and the evaluation of the results. The chapter further shows the impact of metric fixation on the clinical gaze and links it to the shift towards a mechanistic model of mental disorders. By showing how these "modern" views translated into teaching, the chapter closes with a juxtaposition of patient demonstrations in Heidelberg and Tokyo and points to the fast dissemination of the new concepts and teaching formats.

Chapter 4 discusses critical reactions to Kraepelin's nosology and its unquestioned adaptation by Kure Shūzō from Tokyo Imperial University. Here, I return to the Japanese contributions to the global debate that I sketched in chapter 1 and analyze the alternative classifications put forward by Araki Sōtarō and Kadowaki Masae in more detail. I point out their allegiance to a rival influential school of thought and illustrate their creative engagement with associationist theory. I carve out the conceptual differences between the various classification systems and clarify melancholia's differing places within them. I also introduce Matsubara Saburō 松原三郎 (1877–1936), the fourth Japanese protagonist, whose professional career and interest in experimental methods brought him to the United States and who independently devised his own original definition of melancholia by harnessing these new techniques.

The second part opens with Chapter 5. It introduces the reader to the Japanese Army's mental health provision during the Russo-Japanese War and reconstructs the system of evacuation routes and the attached hospital network. It highlights the production and rewriting processes of the patient records that were passed through that system. It also gives a detailed account of the changed modes of observation and writing that had developed in the years since Kure's return to Japan. By (re-)constructing a series of events that led to one soldier's divergent diagnoses as a mentally ill person, I highlight the power of

words and illustrate the practical implications of the nosological changes that I analyzed in the first part.

Chapter 6 expands the engagement with soldiers' case histories but moves the lens to the plurality of "new" symptoms and diseases that replaced the older concepts of mania and melancholia. Similar to chapter 5, it emphasizes the power of narrative structures in case histories, but it goes well beyond the individual case study in that it uncovers regularized modes of judgment. By doing so, it establishes a practical lexicon and a comprehensive inventory of diagnostic schemes that dominated the perception of madness in the first war fought with "modern" and "scientific" mental health care in its medical arsenal.

Lastly, chapter 7 presents a wide-angle picture of the Russo-Japanese War. It zooms out from the level of individual soldiers and looks at the war as a madness-triggering phenomenon in its own right. It presents three psychiatrists' conflicting views on the etiological role of the war and looks into the argumentative strategies they employed to bolster their respective positions on questions of responsibility and liability. In this chapter, I pick up on the idea of risk management rationality, already identified as an important force in the creation of prognosis-oriented psychiatry in chapter 2, and interpret the Japanese Army's eager adaptation of Kraepelin's classification as a pragmatic choice that facilitated the handling of compensation claims and minimized financial risks.

Part I

Academic Debates, Teaching, and Research

1 Rifts and Alliances in Academic Psychiatry

In April 1905, an academic dispute on melancholia and other controversial medical categories unfolded in the lecture hall of Tokyo Imperial University. What appeared to be an argument about names and terms was in fact an instantiation of a conflict rooted in a fundamental disagreement about the principles and methods of psychiatric practice. The scene of this academic dispute was the early-twentieth-century lecture theater, a university classroom that had equivalents in many other parts of the world and whose leading actors shared many views on scientific thought and practice. As an established site of knowledge of twentieth-century education and learning, the university classroom offered Japanese psychiatrists a fitting stage on which to negotiate their individual ideas within the framework of global knowledge systems.

The contributions presented at the Tokyo Conference of 1905 and at other conferences around the globe show that these local disputes were deeply enmeshed in global debates that were often characterized by factional struggles within the psychiatric world. They also reveal the German preeminence on the academic psychiatric scene that was central to the disputes on melancholia and other medical categories. These controversies were linked to universalist claims about the scientific foundations of psychiatry and the ultimate aim of psychiatric practice, and they did not fail to find an echo in the international psychiatric community. In Japan, these debates were shaped by the extreme asymmetry that characterized Japanese medical and educational institutions in the Meiji period (1868–1912). However, they were also influenced by the personal and institutional ties of the individual actors to other psychiatric communities outside of Japan.

1.1 Global Debates

In Japan as in many other parts of the world, the roots of these classificatory disputes can be traced back to the controversial textbook *Psychiatrie: Ein Lehrbuch für Studierende und Aerzte*, published by the German psychiatrist Emil Kraepelin from Heidelberg. By introducing the new disease categories *dementia praecox* (in the fifth textbook edition, 1896) and *manic-depressive illness* (in the sixth textbook edition, 1899), Kraepelin had challenged the validity of other illness concepts such as *mania*, *melancholia*, *paranoia*,

and *secondary dementia*.¹ The changes were presented as a new vision of “clinical psychiatry,” where prognosis and outcome were the new guiding principles of the classification of mental disorders. This was one of the more drastic attempts at reforming psychiatric categories at the time and has continued to attract researchers’ attention to this day.² Psychiatrists from all over Europe and beyond did not fail to react to these changes, articulating their views in numerous articles and monographs and voicing their approval or discontent in meetings held by psychiatric societies.

In Germany, Kraepelin’s new classification had first been publicly discussed at the annual meeting of the Association of German Alienists that took place in Heidelberg in 1896.³ On this occasion, director of the Berlin Charité Hospital and chief secretary of the society Friedrich Jolly (1844–1904) criticized Kraepelin’s talk on “Goals and Methods of Clinical Psychiatry,” with which the latter had intended to lay the foundations for a “modern psychiatry.”⁴ Jolly expressed his concerns about Kraepelin’s utilitarian approach to disease classification and criticized his method “to draw conclusions about the diagnosis on the basis of prognosis.”⁵ This struggle resurfaced again three years later at a conference in Munich in 1899 and deepened the rift between the “Berlin School” and the “Heidelberg School.”⁶ This time, Jolly criticized Kraepelin’s basic classification princi-

1 Emil Kraepelin, *Psychiatrie: Ein Lehrbuch für Studierende und Aerzte* [Psychiatry: A Textbook for Students and Doctors], 5th ed. (Leipzig: Verlag von Johann Ambrosius Barth, 1896); Emil Kraepelin, *Psychiatrie: Ein Lehrbuch für Studierende und Aerzte* [Psychiatry: A Textbook for Students and Doctors], 6th ed., 2 vols. (Leipzig: Verlag von Johann Ambrosius Barth, 1899).

2 To name but some of the most relevant publications, see Helmut Hildebrandt, “Der psychologische Versuch in der Psychiatrie: Was wurde aus Kraepelins (1895) Programm?” [The Psychological Experiment in Psychiatry: What Became of Kraepelin’s (1895) Project?], *Psychologie und Geschichte* 5 (1993): 5–30; Volker Roelcke, “Laborwissenschaft und Psychiatrie: Prämissen und Implikationen bei Emil Kraepelins Neuformulierung der psychiatrischen Krankheitslehre” [Laboratory Sciences and Psychiatry: Premises and Implications of Emil Kraepelin’s Reformulation of Psychiatric Nosology], in *Strategien der Kausalität: Konzepte der Krankheitsverursachung im 19. und 20. Jahrhundert*, ed. Christoph Gradmann and Thomas Schlich, *Neuere Medizin- und Wissenschaftsgeschichte. Quellen und Studien*, 5 (Pfaffenweiler: Centaurus, 1999), 93–116; Eric Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca: Cornell University Press, 2003); Katharina Trede et al., “Manic-Depressive Illness: Evolution in Kraepelin’s Textbook, 1883–1926,” *Harvard Review of Psychiatry* 13 (2005): 155–178; David Healy et al., “Historical Overview: Kraepelin’s Impact on Psychiatry,” *European Archives of Psychiatry and Clinical Neuroscience* 258 (2008): 18–24.

3 Please note that “alienist” is the general historical term for people who deal with “alienism,” i.e. psychiatry. It does not specifically refer to psychiatrists who testify in a court of law.

4 Emil Kraepelin, “Ziele und Wege der klinischen Psychiatrie” [Aims and Means of Clinical Psychiatry], *Allgemeine Zeitschrift für Psychiatrie* 53, no. 5 (1897): 840–844.

5 Gustav Aschaffenburg, Heinrich Laehr, and Ernst Beyer, “Jahressitzung des Vereins der deutschen Irrenärzte am 18. und 19. September 1896 in Heidelberg” [Annual Meeting of the Association of German Alienists in Heidelberg on September 18–19, 1896], *Allgemeine Zeitschrift für Psychiatrie* 53, no. 5 (1897): 845.

6 Here, I follow the account of Schmidt-Degenhard, who referred to Jolly as the “spokesman of the Berlin School” (Schmidt-Degenhard, *Melancholie und Depression: Zur Problemgeschichte der depressiven Er-*



Figure 1.1: “Psychiatrists of Europe!” cartoon, 1896

ples of dividing mental disorders into curable and incurable forms, with which the latter had fragmented the concept of melancholia.⁷

The conflict between Kraepelin and the Berlin School was also visualized in a contemporary cartoon that was created on the occasion of the Heidelberg Conference of 1896 (see Figure 1.1).⁸ In this drawing, he was portrayed as an isolated outsider and innovative

krankungen seit Beginn des 19. Jahrhunderts [Melancholia and Depression: A Critical History of Depressive Disorders Since the Early 19th Century] [Stuttgart: Kohlhammer, 1983], 92). See also Jolly’s critical assessment of Kraepelin’s fifth edition in Friedrich Jolly, review of *Psychiatrie: Ein Lehrbuch für Studierende und Aerzte*, 5th, completely revised edition by Emil Kraepelin, *Archiv für Psychiatrie und Nervenkrankheiten* 28 (1896): 1003–1006.

⁷ Emil Kraepelin, “Die klinische Stellung der Melancholie” [The Clinical Status of Melancholia], *Monatsschrift für Psychiatrie und Neurologie* 6, no. 5 (1899): 325–335; Ludwig Mann, “Bericht über die Sitzungen der Abtheilung für Neurologie und Psychiatrie der 71. Versammlung deutscher Naturforscher und Aerzte zu München vom 17.–23. September 1899” [Report on the Sessions of the Department of Neurology and Psychiatry at the 71. Meeting of German Natural Scientists and Physicians in Munich on September 17–23, 1899], *Centralblatt für Nervenheilkunde und Psychiatrie* 22 (1899): 584.

⁸ Although the authorship of this cartoon (and an accompanying satirical poem) is sometimes attributed to Kraepelin himself, its exact provenance remains unknown. It reflects the self-perception of Kraepelin and his Heidelberg followers vis-à-vis their rivals and was certainly published with Kraepelin’s approval. The model for this picture was a painting by Herman Knackfuß (1848–1915) titled “Völker Europas, wahret eure heiligsten Güter” [Peoples of Europe, Guard Your Dearest Goods]. It is an allegorical painting depicting the united Nations of Europe protecting Christianity against Buddhism. This cartoon was originally published in the comic-newspaper (Bierzeitung) *Neue Zeitschrift für Metapsychiatrie* [New Journal for Metapsychiatry] circulated on the occasion of the Heidelberg Conference of 1896 (Emil Krae-

reformer within the German-speaking psychiatric community. Under the slogan “Psychiatrists of Europe! Guard your Dearest Diagnoses!” his main antagonists were depicted as being led by the spirit of Carl Westphal (1833–1890), the late director of the neuropsychiatric clinic of the Charité Hospital, who was represented as a guardian angel. Behind him, the current Charité director Friedrich Jolly and the future director Theodor Ziehen (1862–1950) are shown to have closed ranks with other famous European psychiatrists such as Richard von Krafft-Ebing (1840–1902), from Vienna, and Carl Wernicke (1848–1905), from Breslau (present-day Wrocław).⁹

As opposed to his adversaries’ depiction as a confederation of guardians of European psychiatric traditions, Kraepelin was presented as an enlightened reformer and visionary. The cartoon showed Kraepelin’s rivals’ fallacious beliefs by depicting Jolly, Ziehen, and their followers as standing under a cross showing the slogan *In hoc symptomate vinces* [In this symptom thou shalt conquer], an alteration of the phrase *In hoc signo vinces* [In this sign thou shalt conquer]. This motto is a reference to the legend of the Battle of the Milvian Bridge, in which Constantine the Great is said to have had a vision of a cross bearing this inscription before he led his armies to victory against his rival Maxentius.¹⁰ Building on this analogy, the imagery seems to imply that Kraepelin’s academic rivals were clinging to beliefs that were based on visions and superstitions. Kraepelin identified these false beliefs with an adherence to the “symptomatic method” of classifying mental disorders that he saw in opposition to his own “clinical method.”¹¹

Until the 1920s, Kraepelin would continue to actively propagate his vision of a “clinical psychiatry” with the dichotomous division of curable and incurable diseases.¹² But, as we shall see in more detail below, the underlying factional disputes did not only dominate the contemporaneous German discourse but also found a strong echo in Japan and other parts of the world. In fact, the discussions at the Tokyo Conference can be con-

pelin, *Kraepelin in Heidelberg (1891–1903)*, ed. Wolfgang Burmair, Eric Engstrom, and Matthias Weber [München: Belleville, 2005], 27). The image in Figure 1.1 is from a copy of the journal preserved at the Max-Planck-Institute for Psychiatry in Munich (MPIP HA K 31/12).

9 For more details on the cartoon and the identification of individual figures, see Kraepelin, *Kraepelin in Heidelberg (1891–1903)*, 30.

10 On Constantine’s vision, see Raymond van Dam, *Remembering Constantine at the Milvian Bridge* (Cambridge: Cambridge University Press, 2011), 2–5.

11 This interpretation of Kraepelin’s use of the slogan *In hoc symptomate vinces* is offered by Wübben, who used this picture in her introduction; see Yvonne Wübben, “Mikrotom der Klinik: Der Aufstieg des Lehrbuchs in der Psychiatrie (um 1890)” [The Microtome of the Clinic: The Ascendence of the Textbook in Psychiatry (around 1890)], in *Krankheit schreiben: Aufzeichnungsverfahren in Medizin und Literatur*, ed. Yvonne Wübben (Göttingen: Wallstein-Verlag, 2013), 155–156.

12 Towards the end of his life, Kraepelin was no longer convinced that every disease could be attributed to a specific disease process and even admitted that it was impossible to clearly distinguish manic-depressive insanity and dementia praecox (Talya Greene, “The Kraepelinian Dichotomy: The Twin Pillars Crumbling?,” *History of Psychiatry* 18, no. 3 [2007]: 362–363). See also German E. Berrios, Rogelio Luque, and José M. Villagrán, “Schizophrenia: A Conceptual History,” *International Journal of Psychology and Psychological Therapy* 3, no. 2 (2003): 134.

sidered to have been part of a global academic dispute within an international scientific community. Indeed, psychiatric societies in Russia, Belgium, and the United States were also divided on the matter of Kraepelin's new disease categories. In the following, I will sketch the debates at the conferences in Moscow (1902), Brussels (1903), and New York (1904) that preceded the Tokyo Conference and highlight common argumentative strategies. As in the Japanese case, debates about the concepts of melancholia and dementia praecox dominated the discussions on classification.

At a meeting of the Moscow Society of Neuropathologists and Psychiatrists in October 1902, the presentation of a study on melancholia by Sergej Alekseevič Suchanov (1867–1915) and Pëtr Borisovič Gannuškin (1875–1933) caused heated debates about the usage of this disease term and the assessment of Kraepelin's newest (1899) classification.¹³ The speakers presented a statistical study on melancholic patients in the Moscow Clinic for Nervous Diseases of Moscow University and proposed some theses on the nature of melancholia and its relationship with dementia praecox that were met with hostility from the audience.¹⁴ While some members of the conference criticized the speakers for having ignored “the basic principles of a scientific classification” by blindly following some of Kraepelin's innovations, others in turn attacked them for their ignorance of Kraepelin's views.¹⁵

Aleksandr Nikolaevič Bernštejn (1870–1922) was an especially fervent supporter of the Kraepelin school. He declared that he categorically disagreed with the speakers that there could be any overlap between dementia praecox and circular insanity (i.e. alternating states of exaltation and depression).¹⁶ On a similar occasion in a meeting in January, he had already complained that none of the conference members had a thorough understanding of “Kraepelin's disease,” by which he meant dementia praecox.¹⁷ At this meeting,

13 Sergej Alekseevič Suchanov, “Protokoly Obščestva nevropatologov i psichiatrov pri Moskovskom Universitetě: Zasedanie 11 oktjabrja 1902 goda” [Proceedings of the Moscow Society of Neuropathologists and Psychiatrists: Meeting of October 11, 1902], *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 2, no. 6 (1902): 125–134.

14 Sergej Alekseevič Suchanov and Pëtr Borisovič Gannuškin, “K učeniju o melancholii” [On the Teaching of Melancholia], *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 2, no. 6 (1902): 1170–1187. For a short history of the clinic, see Alla A. Vein, “The Moscow Clinic for Nervous Diseases: Walking Along the Portraits,” *Journal of the History of the Neurosciences* 16 (2007): 42–57.

15 A few years later, Suchanov changed his mind and became a follower of the Kraepelin school and the new classification method. See especially Sergej Alekseevič Suchanov, “O sovremennoj klassifikacii duševnykh bolëznej” [On the Modern Classification of Mental Disorders], *Sovremennaja psichiatrija*, 1907, 241–246. Suchanov's call for a “modern” classification method and the Japanese reception of his work on the Russo-Japanese War will be discussed in chapter 7.

16 Suchanov, “Protokoly Obščestva nevropatologov i psichiatrov pri Moskovskom Universitetě,” 134.

17 Sergej Alekseevič Suchanov, “Seksija nervnykh i duševnykh bolëznej VIII-go s'ëzda Obščestva russkich vračej v pamjat' N. I. Pirogova: Zasedanie 4-go janvarja” [Section of Mental and Nervous Diseases of the VIII. Conference of the Pirogov Society of Russian Physicians: Meeting of January 4, 1902], *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 2, nos. 1–2 (1902): 266.

Bernštejn was one of five different speakers who gave a talk on dementia praecox.¹⁸ One of the more critical voices was the talk by Vladimir Petrovič Serbskij (1858–1917), the director of the Moscow Clinic for Nervous Diseases, who attacked Kraepelin’s classification principles and questioned the consistency of his dementia praecox description.¹⁹ The meeting was concluded with the general impression of Vladimir Michajlovič Bechterev (1857–1927) that most of his Russian colleagues took a critical stance towards Kraepelin’s new disease category.

A similar debate arose in Brussels, where the Conference of Alienists and Neurologists from France and French-speaking Countries took place in August 1903.²⁰ After the presentation of a study on “Catatonia and Stupor” by Arthur Claus (1861–1932), a pro-Kraepelin psychiatrist from Antwerp, another discussion about Kraepelin’s new disease categories ensued.²¹ Several concerns were voiced, such as the inappropriateness of the designation “dementia praecox,” skepticism about its status as a disease (as opposed to a syndrome), and doubts about Kraepelin’s conception of manic-depressive insanity.²² The most severe criticism came from Gilbert Ballet (1853–1917), who questioned Kraepelin’s very principles for establishing new medical categories.²³ Ballet admonished that

18 On the early reception of Kraepelin’s textbooks by Suchanov and Bernštejn, see also Maike Rotzoll and Frank Grüner, “Emil Kraepelin and German Psychiatry in Multicultural Dorpat/Tartu, 1886–1891,” *Trames* 20, no. 4 (2016): 364.

19 In his talk, which later appeared in print, he mocked Kraepelin’s dementia that could apparently also proceed without dementia, and made the criticism that there was no uniting element in Kraepelin’s characterization of the disease. (Vladimir Petrovič Serbskij, “K voprosu o rannem slaboumii (Dementia praecox)” [On Premature Mental Enfeeblement (Dementia Praecox)], *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 2, nos. 1–2 [1902]: 40). His article was also translated into French in three installments (Vladimir Petrovič Serbskij [Serbsky, Wladimir], “Contribution à l’étude de la démence précoce I,” *Annales médico-psychologiques* 18 [November–December 1903]: 379–388; Vladimir Petrovič Serbskij [Serbsky, Wladimir], “Contribution à l’étude de la démence précoce II: Suite,” *Annales médico-psychologiques* 19 [January–February 1904]: 19–34; Vladimir Petrovič Serbskij [Serbsky, Wladimir], “Contribution à l’étude de la démence précoce III: Suite et fin,” *Annales médico-psychologiques* 19 [March–April 1904]: 188–203). In this form, it was also noted by the French-speaking psychiatric community and has been discussed by Garrabé as belonging to the anti-Kraepelinian francophone school (Jean Garrabé, *Histoire de la schizophrénie* [Paris: Seghers, 1992], 46–53).

20 The aforementioned Russian psychiatrist Suchanov was also present at this conference (J. Crocq, ed., *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française: XIIIe session*, Comptes rendus, vol. 2, tenue à Bruxelles, du 1er au 8 Août 1903, Congrès des médecins aliénistes et neurologistes de France et des pays de langue française, August 1–8, 1903 [Paris and Bruxelles: Masson et Cie / Henri Lamertin, 1903], 16).

21 Arthur Claus, “Catatonie et stupeur,” in *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française: XIIIe session*, Rapports, ed. J. Crocq, vol. 1, tenue à Bruxelles, du 1er au 8 Août 1903, Congrès des médecins aliénistes et neurologistes de France et des pays de langue française, August 1–8, 1903 (Paris and Bruxelles: Masson et Cie / Henri Lamertin, 1903), 5–131.

22 Crocq, *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, 58, 69–70, 89.

23 Gilbert Ballet, ed., *Traité de pathologie mentale* (Paris: Octave Doin, 1903). For a more detailed discussion

the theory of dementia praecox had been accepted too easily and without having been thoroughly subjected to critical examination. He suggested that, instead of relying on general statistics, the existence of this new disease form could only be proven by long-term observations of a series of similar and well-studied cases.²⁴

It is important to note that in the Russian and French communities, the anti-Kraepelin faction relied on a different rhetoric than their German colleagues. In fact, they did not fight out the dispute along the Berlin–Heidelberg rift but instead referred to French-speaking authorities, namely, Jean-Étienne Esquirol (1772–1840), Bénédict Augustin Morel (1809–1873), and Valentin Magnan (1835–1916). This focus on a supposedly entirely independent French tradition stands in stark contrast to those centers that formally mirrored the inner-German factional dispute, i.e. the United States and especially Japan.

At a meeting of the New York Neurological Society in October 1904, the new (1899) version of the concept of dementia praecox was attacked by Adolf Meyer (1866–1950), who had himself introduced the term in the United States in 1896.²⁵ He and several other speakers complained that Kraepelin had abandoned the theory of degeneration that characterized his early version of the dementia praecox concept.²⁶ Other speakers, such as Allen Ross Diefendorf (1871–1943), who had made a translation of Kraepelin’s new textbook, in turn defended the new classification.²⁷

At another meeting in November 1904, the concept of *manic-depressive insanity* proved controversial as well in a discussion on “the Classification of the Melancholias.”²⁸ Meyer proposed replacing the term “melancholia” with “depression,” noting that the former referred to some inaccessible knowledge of the past.²⁹ Other speakers also expressed their “decided belief” in the new term, while Moses Allen Starr (1854–1932) stated that he had no sympathy for it and saw no reason to protest against the classification

of this conference, see Ian Dowbiggin, “Back to the Future: Valentin Magnan, French Psychiatry, and the Classification of Mental Diseases, 1885–1925,” *Social History of Medicine* 9, no. 3 (1996): 398–399. For a general discussion of the reception of Kraepelin’s new classification in France, see Berrios and Porter, *A History of Clinical Psychiatry*, 285.

24 Gaston Deny, “Congrès Français des Médecins Aliénistes et Neurologistes: Treizième session tenue à Bruxelles du 1^{er} au 7 août 1903,” *La Semaine Médicale* 23, no. 31 (1903): 254–255.

25 Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox* (Cambridge: Harvard University Press, 2011), 10.

26 “New York Neurological Society: Society Proceedings, October 4, 1904,” *The Journal of Nervous and Mental Disease* 32, no. 1 (1905): 38–39.

27 Allen Ross Diefendorf, *Clinical Psychiatry: A Text-Book for Students and Physicians*, abstracted and adapted from the sixth German edition of Kraepelin’s “Lehrbuch der Psychiatrie.” (New York: Macmillan Company, 1904). On a large scale, Noll found that there was little evidence of any significant resistance to the adoption of Kraepelin’s classification in American asylums (Noll, *American Madness*, 97).

28 “Society Proceedings, November 1, 1904: A Discussion on the Classification of the Melancholias,” *The Journal of Nervous and Mental Disease* 32, no. 2 (1905): 112–120.

29 “Society Proceedings, November 1, 1904,” 113–114. On Adolf Meyer’s views, see also Jackson, *Melancholia and Depression*, 6, 195–202 and especially Susan D. Lamb, *Pathologist of the Mind: Adolf Meyer and the Origins of American Psychiatry* (Baltimore: John Hopkins University Press, 2014).

proposed by Krafft-Ebing. Starr evoked the idea of cultural specificity and argued that manic-depressive insanity did not coincide with the clinical experience in America.³⁰ This line of argument was not only used by the anti-Kraepelin faction. Diefendorf stated in the preface to his translation of Kraepelin's textbook that he had abbreviated the descriptions of some psychoses that were of "less importance to the American physician," suggesting that other diseases, such as *acquired neurasthenia*, were more common in the United States.³¹

This brief survey of international conference debates provided a panoramic view of the sometimes hefty discussions that Kraepelin's new textbook caused within psychiatric societies around the globe. By moving from the provincial town of Heidelberg to the metropolis of Munich and to the capitals of Russia and Belgium, and lastly to New York, several shared concerns came to light, including topics such as the discussion of the appropriateness of disease names, the idea of the cultural specificity of diseases, and general questions about the purpose of classificatory systems. All of these concerns and struggles were in no way alien to Japan but had become a source of dissent in Tokyo as well. Here, the newly founded Japanese Society for Neurology (*Nihon shinkei gakkai* 日本神経學會) offered Japanese psychiatrists a platform to position themselves within this global debate.³²

30 "Society Proceedings, November 1, 1904," 113–114.

31 Diefendorf, *Clinical Psychiatry*, V.

32 Alongside the Japanese name, the society was also known by its German name, *Japanische neurologische Gesellschaft*. Its proceedings were published in the journal *Shinkeigaku zasshi* 神経學雜誌, launched in the same year (1902), which also had a German-language edition called *Neurologia*. Although the name of the society and the journal might suggest that the content was limited to neurology, this was not the case (Masaaki Matsushita, "History of Neuropathology in Japan," *Neuropathology* 20 [2000]: S2–S6). This journal was the main platform for publications on psychiatric matters in Japan and also covered a variety of related fields (such as psychology, physiology, therapy, and anthropology). See, for example, the reviews section in the table of contents of issue 4, volume 1 (1902) of the *Shinkeigaku zasshi*. It covered reviews from foreign journals in the fields of anatomy (*kaibō gaku* 解剖學), physiology (*seiri gaku* 生理學), psychology (*shinri gaku* 心理學), pathological anatomy (*byōrikaibō gaku* 病理解剖學), neuropathology (*shinkeibyō gaku* 神經病學), psychopathology (*seishinbyō gaku* 精神病學), therapy (*chiryō* 治療), forensic medicine (*hōi gaku* 法醫學), educational psychology and pathology (*kyōiku shinri oyobi byōri gaku* 教育心理及病理學), sociology (*shakai gaku* 社會學), anthropology (*jinrui gaku* 人類學), and zoology (*dōbutsu gaku* 動物學). (In this particular issue, the Japanese table of contents has the term "criminal anthropology" (*keiji jinrui gaku* 刑事人類學), while the German table of contents simply has "anthropology.") In 1935, both the society and the journal were renamed to clearly indicate the great importance of psychiatry. From this year, the society was known as the Japanese Society for Psychiatry and Neurology (*Nihon seishin shinkei gakkai* 日本精神神経學會) and the journal as *Seishin shinkeigaku zasshi* 精神神経學雜誌, with a parallel title in Latin, *Psychiatria et neurologia Japonica*. On the choice of the journal's name, see Matsushita Masaaki 松下正明, "'Nihon shinkei gakkai' to zasshi 'Shinkeigaku zasshi' no rekishiteki igi" 「日本神経学会」と雑誌「神経学雑誌」の歴史的意義 [The Historical Significance of the "Japanese Society for Neurology" and the Journal "Shinkeigaku zasshi"], *Seishin Shinkeigaku zasshi* 精神神経学雑誌 105, no. 6 (2003): 710.



Figure 1.2: Lecture hall at Tokyo Imperial University in 1906

When Araki Sōtarō presented his views on the classification of mental disorders in the auditorium of Tokyo Imperial University on April 2, 1905 (see Figure 1.2), he found himself wedged between the pro- and anti-Kraepelin factions.³³ His friend and former college-mate Kure Shūzō, who had founded the Japanese Society for Neurology in 1902, was acting director of the psychiatry department of the university and had become the leader of the pro-Kraepelin faction. When Araki discussed concepts such as melancholia and *mania* as *affective insanity*, both of which Kure had chosen to relegate to the “pre-scientific” age of Japanese psychiatry, he overtly took the side of the oppositional camp. On his side of the rift, he found himself in the company of the former department director Katayama Kuniyoshi 片山国嘉 (1855–1931) and his loyal assistant Kadowaki Masae.³⁴

33 Araki Sōtarō 荒木蒼太郎, “Kyōshitsu no ruibetsu” 狂疾ノ類別 [Classification of Mental Disorders], *Shinkeigaku zasshi* 4, no. 5 (1905): 33–34. The image in Figure 1.2 shows the lecture hall of the Department of Pathology at Tokyo Imperial University in 1906. The Tokyo Conference was actually taking place in the auditorium of the Faculty of Law. The room was very similar in appearance to the auditorium of the pathologists and clearly resembled lecture halls in Imperial Germany. This semblance testifies that the adaptation of the German medical system in Japan also extended to architectural elements, facilitating the adaptation of certain teaching practices such as the “patient demonstration” lecture format discussed in more detail in section 3.2 of chapter 3. The images are preserved in the Archive of the Medical Library of the University of Tokyo.

34 Alternative readings for Kadowaki’s first name are “Sakae” and “Shinshi.”

Kadowaki was discussant for Araki's talk and eagerly presented his own views on the classification of mental disorders in a flamboyant display of approval.³⁵ Although he admitted that he had consulted the newest edition of Kraepelin's textbook, he declared that he considered Theodor Ziehen's classification system to be the conceptually clearest. He therefore took the side of the "Berlin School," although he did not phrase his allegiance in factional terms.³⁶ Kadowaki justified his choice by pointing out that Ziehen's way of classifying mental disorders was in accordance with clinical experience. On the same level, he challenged Kraepelin's dementia praecox by suggesting effective overlaps between this concept and circular insanity, which he had termed *circular dementia* and claimed to have personally witnessed. Lastly, he also raised the question of the appropriateness of disease names and argued that all forms of *dementia* should be referred to with a Japanese term that unambiguously indicated irreversibility.³⁷

In retrospect, it should be noted that neither Kadowaki's nor Araki's ideas were really taken seriously in Tokyo. In fact, they had no lasting effect on the course that psychiatry would take in Japan over the next decades. This was not necessarily due to a lack of theoretical insight or practical aptness on their part but, rather, to wholly extraneous reasons. Indeed, the Japanese debate was characterized by a profoundly hierarchical structure that is difficult to assess historically and that has remained invisible in the account so far. As in the American case, the ideological trenches between the opposing actors were dug along the lines of competing German schools, and their roots lay in the historico-institutional development of Japanese psychiatry.

1.2 Japanese Educational Institutions

In 1905, the field of psychiatry in Japan was dominated by the Medical Faculty of the Tokyo Imperial University, where teaching and research were oriented towards the German-speaking scientific community. The strong German influence and the exceptional standing of this institution had their origins in two converging developments initiated by the Japanese government in the second half of the nineteenth century. The first was related to medical reforms started in 1869 and the second to the establishment

35 Kadowaki Masae 門脇眞枝, discussion following Araki Sōtarō's talk on Classification, *Shinkeigaku zasshi* 4, no. 5 (1905): 34–36.

36 Kadowaki Masae, 35.

37 German was the language of reference in all these talks. In the written version of Kadowaki's contribution, Japanese phonetic script indicates the use of German terms such as めらんこりい (*Melancholie* [Eng.: melancholia]), いんてりげんつでふゑくとぶしこーぜ (*Intelligenzdefektpsychose* [Eng.: psychosis with defect of intelligence]) or でんめるつーすたんど (*Dämmerzustand* [Eng.: dreamy state]). Kadowaki would return to the difficult topic of translation several years later and criticize Kure's terminology and choice of appropriate translation words in a dedicated article (Kadowaki Masae 門脇眞枝, "Seishinbyōgakujō no yakugo ni tsuite" 精神病学上ノ譯語ニ就テ [On the Translation of Psychiatric Terms], *Shinkeigaku zasshi* 10, no. 1 [1911]: 19–21).

of a higher education system in 1877. On behalf of the government, the Dutch-trained (*ranpō* 蘭方) physicians Sagara Chian 相良知安 (1836–1906) and Iwasa Jun 岩佐純 (1835–1912) had elaborated a reform program that amounted to an adoption of the German medical system in Japan in the first half of 1869.³⁸ They suggested that the Japanese government should employ German doctors, change the medical administration's legislation in accordance with the German system, and henceforth send Japanese medical students to Germany for their training.³⁹ After a largely nonacademic struggle with a faction that favored British medicine, their proposal was accepted, and two German military doctors were appointed as lecturers at the newly founded Tokyo Medical School (*Tōkyō Igakkō* 東京醫學校).⁴⁰

At the same time, Tanaka Fujimaro 田中不二麿 (1845–1909) and his North American adviser David Murray (1830–1905) pursued their plans to modernize the Japanese education system based on the American model. Following their initiative, Japan's first ever university, the Tokyo University (*Tōkyō daigaku* 東京大學), was created in 1877 by merging the Tokyo Medical School with the Tokyo School for Western Sciences (*Tōkyō kaisei gakkō* 東京開成學校). The new institution structurally resembled American universities and incorporated the faculty of medicine from the former and the faculties of law, literature, and science from the latter. As it inherited characteristics from both of its forebears, English remained the language of instruction in the non-medical departments, whereas the medical faculty maintained its tradition with the German language.⁴¹ In 1897, it was rechristened Tokyo Imperial University (*Tōkyō teikoku daigaku* 東京帝國大學), and, despite various internal changes, the focus on Germany within the medical faculty remained largely unchallenged throughout the pre-war period.⁴²

Within the educational landscape of the Meiji period (1868–1912), Tokyo Imperial University and its predecessor institutions were clearly at the top of the hierarchy. In the early years of the university, the medical students had to attend a preparatory school (*yobimon* 豫備門) which provided education in elementary science (mathematics, chemistry, physics, and others) as well as German language training.⁴³ After 1886, this function was

38 In the Tokugawa period (1603–1868), a limited group of Japanese scholars engaged with what they perceived as “Western sciences” and started to study Dutch books on medicine and technology obtained from merchants in Deshima, a man-made island near Nagasaki. In this period, the Japanese government tried to limit Japan's exchanges with unwelcome foreigners, confining it to this port and restricting trade to Dutch merchants. On the practice and significance of Dutch-learning in Japan, see Ellen Gardner Nakamura, *Practical Pursuits: Takano Chōei, Takahashi Keisaku, and Western Medicine in Nineteenth-Century Japan* (Cambridge: Harvard University Press, 2005).

39 Vianden, *Die Einführung der deutschen Medizin im Japan der Meiji-Zeit*, 46–51.

40 Kim, Hoi-eun, *Doctors of Empire*, 20–23.

41 Duke, *The History of Modern Japanese Education*, 230–231.

42 Between 1886 and 1897, the university was simply called Imperial University (*teikoku daigaku* 帝國大學), as it was the only one in the country. It was only when a second institution of this kind was established in Kyoto in 1897 that “Tokyo” was added to the name to distinguish between the two imperial universities.

43 Kim, Hoi-eun, *Doctors of Empire*, 39, 46–46.

relegated to the higher middle schools (*kōtō chūgakkō* 高等中學校), which were soon renamed “high schools” (*kōtō gakkō* 高等學校) and represented the regular track that led to university-level education.⁴⁴ These regional schools were usually directed by graduates of Tokyo Imperial University, which served to reinforce this institution’s standing and prestige.

At the time when the speakers of the Tokyo Conference had started their medical careers, Tokyo Imperial University had been the only institution in Japan where psychiatry was taught. Sakaki Hajime 榊俣 (1857–1897), the first Japanese professor of psychiatry, had taken up his office in 1886, and many members of the Japanese Society for Neurology who attended the conference of 1905 were his former students.⁴⁵ In fact, so were the three that are most relevant to my discussion below: Araki Sōtarō, whom we have already encountered at the beginning of the story; Kure Shūzō, Sakaki’s successor to the chair of psychiatry in Tokyo; and Kadowaki Masae, the discussant for the section of Araki’s talk on classifications.

All three had studied at Sakaki’s department of psychiatry and obtained practical training at the Tokyo Metropolitan Asylum at Sugamo (*Tōkyō fu Sugamo byōin* 東京府巢鴨病院), which served as the teaching hospital of the university. However, they had entered the university via different tracks, and their future careers were to be heavily influenced by their personal backgrounds. Araki was born to a family of practitioners of Chinese medicine (*kanpō* 漢方) in the town of Mabi 真備町 in Okayama domain 岡山藩.⁴⁶ In 1889, he graduated from the medical department of the Third Higher Middle School (*daisan kōtō chūgakkō igakubu* 第三高等中學校醫學部) in Okayama and thereafter entered the Medical Faculty of Tokyo Imperial University as an “elective,” or “limited status student” (*senkasei* 選科生) in 1890.⁴⁷ According to the regulations of the university, medical students from the higher middle schools (and a few other medical schools) were allowed to enroll at the university through the venue of “limited status” to specialize in a subject of their choice.⁴⁸ Originally, Araki had chosen ophthalmology and surgery as his

44 Teichler, *Geschichte und Struktur des japanischen Hochschulwesens*, 62.

45 The German doctor Erwin von Bälz (1849–1913) is considered to be the first to have taught psychiatry in Japan. According to his diary, he gave the first lecture on psychiatry in the summer term of 1879 (Erwin von Bälz, *Erwin Bälz: Das Leben eines deutschen Arztes im erwachenden Japan*, Tagebücher, Briefe, Berichte [Erwin Bälz: A German Physician’s Life in Wakening Japan. Diaries, Letters, Reports], ed. Erwin Toku Bälz [Stuttgart: Engelhorn, 1937], 50–51). The Kyoto Imperial University was the second (1897) and the Tōhoku Imperial University the third (1907) to be established.

46 In 1871, the system of feudal domains (*han* 藩) was replaced with the system of prefectures (*ken* 県). Araki and Kure were both born before this change, and their respective places of origin are therefore given according to the former system.

47 Araki’s name first appeared in the list of enrolled *senka* students in the directory of Tokyo University for the academic year of 1890 Teikoku daigaku 帝國大學, ed., *Teikoku daigaku ichiran: Meiji 23–24 nen* 帝國大學一覽：明治 23–24 年 [Directory to the Imperial University: 1890–1891] (Tōkyō: Teikoku daigaku, 1890), 289. On the regulations for *senka* students in 1890, see Teikoku daigaku, 44–46.

48 The *senka* or “limited status” track had originally been created in 1878 to accommodate students of di-

subject matters, but he switched to psychiatry in 1891.⁴⁹ In these years, Sakaki's psychiatry department was mostly filled with people who—like Araki—had obtained their medical degree outside of the university or had taken a shortened study course.⁵⁰ As there was a shortage of Tokyo graduates, it is not surprising that Araki eventually became assistant (*joshu* 助手) at the Tokyo Medical Faculty in December 1892 and thereby joined the medical staff (*iin* 醫員) at the Sugamo hospital, where he first met Kure Shūzō.⁵¹ Araki was a good student, and after having completed his studies in Tokyo, he returned to his native prefecture of Okayama to assume the position of professor of psychiatry at the Medical Department of the Third Higher School (*daisan kōtō gakkō* 第三高等學校) in 1895.⁵²

verse backgrounds. When applying to faculties other than the medical, such students were required to pass an entrance exam devised by the professors of the subjects they had elected to study. The *senka* students were usually not entitled to a university degree and were denied the privileges of “regular students” (*seikasei* 正科生). It is known that some students experienced their “limited status” as a humiliation, as was the case for the eminent Japanese philosopher Nishida Kitarō, who did not finish the Fourth Higher Middle School in Kanazawa and was therefore “forced” to enroll as a *senka* student at Tokyo Imperial University in 1891 (Michiko Yusa, *Zen & Philosophy: An Intellectual Biography of Nishida Kitarō* [Honolulu: University of Hawai'i Press, 2002], 30).

- 49 Teikoku daigaku 帝國大學, ed., *Teikoku daigaku ichiran: Meiji 24–25 nen* 帝國大學一覽：明治 24–25 年 [Directory to the Imperial University: 1891–1892] (Tōkyō: Teikoku daigaku, 1891), 300. According to the university regulations, it was actually not allowed for *senka* students to change their subject before finishing the one previously chosen (Teikoku daigaku, 51), but as Araki's case shows, this rule could be evaded.
- 50 Among the fourteen students who became assistants under Sakaki between 1889 and 1897, there were three university graduates (including Kure), four higher middle school graduates (including Araki), three short-term-study graduates, Kadowaki with his private school degree, and three students whose medical school degree is unknown (they certainly were not university graduates); see Okada Yasuo 岡田靖雄, *Shisetsu Matsuzawa byōinshi 1879–1980 私説松沢病院史 1879–1980* [A Private History of the Matsuzawa Hospital 1879–1980] (Tōkyō: Iwasaki Gakujutsu Shuppansha, 1981), 161–162. Until 1889, the Tokyo University offered “short-term-study” or “commuter courses” (*bekka* 別科) which comprised three years of study instead of the regular five years. The standards were lower in these courses and the students were not required to have knowledge of German or English as they were usually taught by the Japanese assistants. They were not entitled to wear the school uniform and were not required to stay in school dormitories like the regular students. Apparently, these differences could lead to conflicts between the *bekka* and the regular students, who referred to the former group as “insects” (H.-J. Chen, “‘Eine strenge Prüfung deutscher Art,’” 25–27; Kim, Hoi-eun, *Doctors of Empire*, 44–45).
- 51 Okada Yasuo 岡田靖雄, *Kure Shūzō sono shōgai to gyōseki* 呉秀三その生涯と業績 [The Life and Works of Kure Shūzō] (Kyōto: Shinbunkaku shuppan, 1982), 181.
- 52 Kashida Gorō 榎田五郎, *Nihon ni okeru seishinbyōgaku no nichijō* 日本ニ於ケル精神病学ノ日乗 [A Chronology of Psychiatry in Japan] (Tōkyō: Kashida Gorō, 1928), 23. This is the same school from which Araki had graduated in 1889. In 1894, the Third Higher Middle School was renamed into “Third Higher School.” In 1901, the Medical Department of this school became an independent institution under the name of Okayama Medical College (*Okayama igaku senmon gakkō* 岡山醫學專門學校) and attained the status of a university in 1922 as Okayama Medical University (*Okayama ika daigaku* 岡山醫科大學). Nowadays, it is part of Okayama University (*Okayama daigaku* 岡山大学), see “Okayama han igakkan - Okayama ika daigaku: Shirarezaru senkushatachi” 岡山藩医学館・岡山医科大学：

Unlike Araki, Kure had received his complete medical education at Tokyo Imperial University, from which he graduated in 1890. His father was a *ranpō*-physician from the Hiroshima domain 廣島藩, and his family had intimate connections with the Sakaki family.⁵³ Kure became an assistant at the Medical Faculty in 1891, advanced to the position of assistant professor (*jokyōju* 助教授) in 1896, and became a full professor in 1901. As mentioned above, there were few university graduates who specialized in psychiatry under Sakaki's professorship. In fact, among the medical students graduating from Tokyo Imperial University, there had only been eight psychiatrists in twenty years (1880–1900).⁵⁴ As students from schools other than Tokyo Imperial University were not eligible for the position of professor at that institution in the first place, there had accordingly been few candidates for Sakaki's succession after his young death at age thirty-nine in 1897. In fact, Kure's only real rival had been Funaoka Einosuke 舟岡英之助 (1861–1929), who had finished his studies one year earlier than Kure; but ever since Sakaki had explicitly declared his preference for Kure as assistant professor in March 1896, the issue of his succession had basically been settled.⁵⁵ After Sakaki's death, the Japanese Ministry of Education (*Monbushō* 文部省) granted Kure a three-year research scholarship in Europe to prepare him for his future position as professor.

It was during Kure's stay in Europe that the third protagonist, Kadowaki, received most of his medical education at Tokyo Imperial University. Kadowaki was the son of a Shinto priest from Daikonjima 大根島, a small island in Shimane prefecture 島根県 in the south-west of Japan.⁵⁶ Before he enrolled at the university, he had studied medicine at the Saisei Gakusha 濟生學舎, a private medical school established in 1876, which served as a preparatory school (cram school) for the medical practitioners' examinations.⁵⁷ This career option was usually chosen by people who intended to open a private clinic and to

知られざる先駆者たち [Medical School of the Okayama Domain - Okayama Medical University: Unknown Pioneers], *Ichō namiki: Okayama daigaku kōhō* 50 (2009): 3–4.

53 Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 1–10. On the connection between the Kure and the Sakaki family, see Okada Yasuo, 173–174. On *ranpō* (Dutch-medicine) see footnote 38 on page 37.

54 Okada Yasuo, 277.

55 The fact that by 1896 Kure had produced more publications than Funaoka might have influenced Sakaki's judgment (Okada Yasuo, 209).

56 Ide Saburō 井手佐武郎, “Kure Shūzō to Kadowaki Sakae: Kasanete chihō to iu kotoba, boke to iu kotoba” 呉秀三と門脇眞枝：重ねて痴呆という言葉、呆けという言葉 [Kure Shūzō and Kadowaki Masae: Once Again about the Terms Chihō and Boke], *Nihon iji shinpō*, no. 3603 (1993): 58.

57 Powell and Anesaki, *Health Care in Japan*, 30. Since 1874, everyone who wished to obtain a medical license had to pass an examination that required knowledge in chemistry, physiology, surgery, anatomy and other disciplines included in Western curricula (H.-J. Chen, “Eine strenge Prüfung deutscher Art,” 24). Naturally, such a radical legislative change provoked the indignation of some of the 23,015 practitioners of traditional Chinese medicine who constituted the majority (80.2%) of the profession in 1873. The history of their resistance and their struggle for survival has been explored in Christian Oberländer, *Zwischen Tradition und Moderne: Die Bewegung für den Fortbestand der Kanpō-Medizin in Japan* [Between Tradition and Modernity: The Movement for the Survival of Kanpō-Medicine in Japan] (Stuttgart: Franz Steiner Verlag, 1995).

become practicing physicians without aspirations to a civil service position. The academic standard at the Saisei Gakusha was relatively high, especially since some of the classes were taught by assistants of the Medical Faculty of Tokyo Imperial University. In fact, Kure himself had been teaching physiology at this institution since 1893, and it seems very likely that Kadowaki and Kure would have met there for the first time.⁵⁸ Having obtained his medical license, Kadowaki enrolled as a *senka* student at the Tokyo Medical Faculty in 1896.⁵⁹ He chose psychiatry as his specialization, but his studies were interrupted by the death of Sakaki in February 1897. When Kadowaki became assistant at the faculty in August 1897, Kure had already embarked on his journey to Europe, and the chair of psychiatry was temporarily filled by Katayama Kuniyoshi, a forensic specialist. As a matter of fact, both Sakaki and Katayama had been trained in forensic medicine as well as psychiatry, as their position originally required that they should teach both subjects.⁶⁰ However, when the chair for forensic medicine had been established at Tokyo Imperial University in 1889, the teaching responsibilities had been split up and Katayama had become the first Japanese professor of forensic medicine.⁶¹

Kadowaki remained at the faculty for the whole period of Katayama's reign and even published a textbook on psychiatry that was based on his teacher's lectures.⁶² It was shortly before Kure returned from Europe in October 1901 that Kadowaki completed his training and became director of the newly established private asylum Ōji Mental Hospital (*Ōji seishin byōin* 王子精神病院) in a suburb of Tokyo City.⁶³ During his later career, he served as hospital director of several private asylums in the Tokyo region. In

58 Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 189.

59 Teikoku daigaku 帝國大學, ed., *Teikoku daigaku ichiran: Meiji 29–30 nen* 帝國大學一覽：明治 29–30 年 [Directory to the Imperial University: 1896–1897] (Tōkyō: Teikoku daigaku, 1896), 358. On the *senka*-track see footnote 48 on page 39.

60 After graduating from the Tokyo University in 1879, Katayama was sent to Germany and Austria for further training (1884–1888). Among his German teachers was the Berlin psychiatrist Carl Westphal, who was then director of the Charité Hospital (Kure Shūzō 呉秀三, *Wagakuni ni okeru seishinbyō ni kansuru saikin no shisetsu* 我邦ニ於ケル精神病ニ関スル最近ノ施設 [Recent Psychiatric Institutions in Japan] [Tōkyō: Tōkyō igakkai jimusho, 1912], 21–22).

61 Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 221–222.

62 Kadowaki Masae 門脇眞枝, *Seishinbyōgaku* 精神病學 [Psychiatry] (Tōkyō: Hakubunkan, 1902).

63 This hospital was established by an innkeeper who had no medical qualifications but profited from the Mental Patients' Custody Act of 1900, which allowed the confinement of mental patients in privately-run asylums at public cost (Akihito Suzuki, "A Brain Hospital in Tōkyō and Its Private and Public Patients, 1926–45," *History of Psychiatry* 14, no. 3 [2003]: 340–346). The hospital was later renamed Ōji Brain Hospital (*Ōji naōbyōin* 王子脳病院) (Okada Yasuo 岡田靖雄, *Nihon seishinka iryōshi* 日本精神科医療史 [The History of Psychiatry in Japan] [Tōkyō: Igaku shoin, 2002], 157). In 1908, it passed into the hands of the innkeeper's adopted son Komine Shigeyuki 小峯茂之 (1883–1942), who had made a medical career very similar to that of Kadowaki, studying first at the Saisei Gakusha and gaining some practical training at the Sugamo hospital (Akihito Suzuki, "The State, Family, and the Insane in Japan, 1900–1945," in *The Confinement of the Insane: International Perspectives, 1800–1965*, ed. Roy Porter and David Wright [Cambridge: Cambridge University Press, 2003], 221).

1905, he was director of the Tokyo Mental Hospital (*Tōkyō seishin byōin* 東京精神病院), to whose patient population he applied his classification of mental disorders presented at the Tokyo Conference.⁶⁴

All in all, the medical careers of the three protagonists are perfectly suited to illustrating the pyramidal structure of medical education in Meiji Japan. At the top of the structure was the Medical Faculty of Tokyo Imperial University, which was followed by national and regional medical schools, such as the Third Higher Middle School in Okayama. The private schools, represented here by the Saisei Gakusha, were at the bottom of the pyramid.⁶⁵ This hierarchy had direct consequences for the income and future position of graduates. Thus, Kure, the Tokyo graduate, became professor at the university, whereas Araki, from a national medical school, became professor at that institutional level, and Kadowaki, with his private school degree, became director of a private clinic. Although this hierarchical structure was not entirely set in stone, the most prestigious positions were usually filled by the Tokyo graduates in practice. This becomes even clearer when one examines the careers of those students who studied psychiatry under Sakaki, Katayama, and Kure and later became professors (*kyōju* 教授) at the various medical schools of Japan (see Figure 1.3, from which Kadowaki is conspicuously absent).⁶⁶

64 This hospital was established in 1901 and renamed Hoyōin 保養院 in 1906 (Kure Shūzō, *Wagakuni ni okeru seishinbyō ni kansuru saikin no shisetsu* III). On Kadowaki's statistical report on this hospital's population see Kadowaki Masae 門脇眞枝, "Meiji sanjū nana nen Kōshinzuka Tōkyō seishin byōin ni okeru chiryō tōkei gaiyō" 明治三十七年庚申塚東京精神病院ニ於ケル治療統計概要 [Summary of the Statistical Results on Medical Treatment in the Tōkyō Mental Hospital in Kōshinzuka for the year 1904], *Shinkeigaku zasshi* 4, no. 2 (1905): 117–120.

65 Powell and Anesaki have suggested in 1990 that this basic structure prevailed unchanged into the present (Powell and Anesaki, *Health Care in Japan*, 30–31). Although a private school, the Saisei Gakusha, predecessor of the Nippon Medical School, had a good reputation, and some of its graduates attained high-ranking positions in civil service. However, it was more important as a training center for medical practitioners and is supposed to have trained half of the practicing physicians of the Meiji period (Oberländer, *Zwischen Tradition und Moderne*, 65).

66 This figure is adapted from Okada Yasuo, *Nihon seishinka iryōshi* 169. It also contains information on two disciples of Shimamura Shun'ichi 島邨俊一 (1862–1924), who became professors of psychiatry at the future Kyoto Prefectural University of Medicine (Kyoto Pref.). However, only the disciples of the three Tokyo professors (Sakaki, Katayama, and Kure) are relevant for my discussion in this chapter. The names of the disciples are generally arranged by order of graduation (Shimamura in 1887, Ōnishi in 1888, Kure in 1890 etc.). The information in brackets refers to their later place of employment. As in the original table by Okada, the names of the schools are given in abbreviated form: Tokyo, Kyoto, and Tōhoku stand for the respective Imperial Universities; Keiō, Jikei, and Nippon Med. refer to the three private Japanese schools which became universities in 1920, 1921, and 1926 respectively. The remaining names indicate the locations of the medical schools, but can refer to different kinds of institutions, as their status used to change over the years. For the institutional changes of the Okayama Medical School see also footnote 52 on page 40.

In my opinion, Katayama's influence is somewhat misrepresented, as both Miyake Koichi 三宅鑛一 (1876–1954) and Kitabayashi Sadamichi were in fact also students of Katayama. Moreover, Kitabayashi continued his academic relationship with Katayama long after Kure replaced him as professor, see

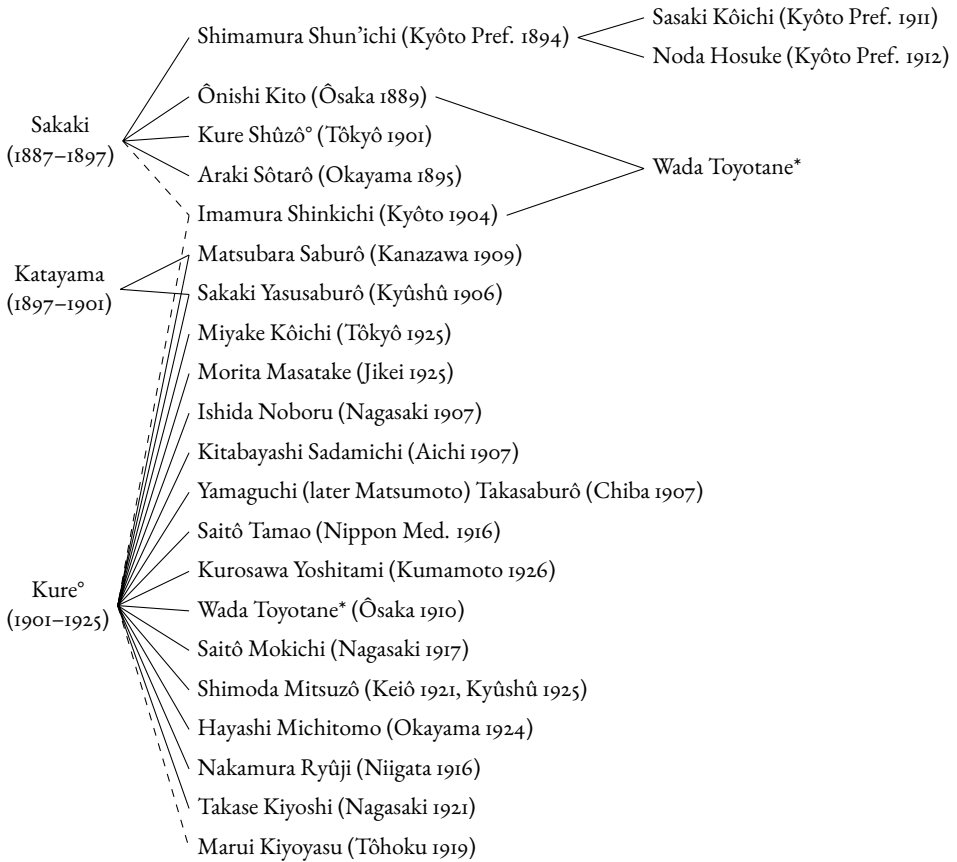


Figure 1.3: Teacher–student relationships in early Japanese psychiatry

A closer look at their educational background shows that, among the twenty-one students who became professors of psychiatry between 1887 and 1925, seventeen had a Tokyo University degree. The remaining four comprised two graduates of national higher middle schools, Araki and Matsubara Saburō, and two graduates of prefectural schools, Kitabayashi Sadamichi 北林貞道 (1872–1948) and Wada Toyotane 和田豊種 (1880–1967).⁶⁷ These four were able to get faculty positions at the national and prefectural schools of Okayama, Kanazawa, Ōsaka, and Aichi, but after the University Ordinance of 1918, all of these schools were successively transformed into universities, and their positions were endangered.⁶⁸ All four had studied in Europe or the United States after their graduation, but in addition to that, Wada and Matsubara had also submitted doctoral theses to Tokyo Imperial University and were thus able to keep their positions after the institutional changes.⁶⁹ Kitabayashi and Araki, on the other hand, lost their positions when their institutions were upgraded to universities. Kitabayashi was discharged from office in 1931 (aged fifty-nine) and thereafter opened his own hospital.⁷⁰ Araki had to retire in March 1923 (aged fifty-four) after the establishment of Okayama Medical University, whereupon he moved to Tokyo to spend the rest of his life studying classical Chinese texts (*kangaku o kenkyū* 漢學を研究).⁷¹

Katayama Kuniyoshi 片山國嘉 and Kitabayashi Sadamichi 北林貞道, “Utsukyōsha bōsatsu hikoku jiken kantei” 鬱狂者謀殺被告事件鑑定 [Medical Evaluation of a Melancholic Accused of Murder], *Chūō igakkai zasshi* 66–67 (1906): 23–34.

67 In the figure, Wada’s name appears twice to show that he was a pupil of Kure, but also had two other teachers. One of them was Imamura Shinkichi 今村新吉 (1874–1946). The broken line over his name indicates a limited influence from Sakaki and Kure. Imamura did not specialize in psychiatry while he was in Tokyo, but developed an interest in the subject when he was studying abroad. The same applies to Marui Kiyoyasu 丸井清泰 (1886–1953), who left for Europe shortly after his graduation in 1913 and became professor at Tōhoku University directly after his return to Japan (Okada Yasuo, *Nihon seishinka iryōshi* 169). On Wada’s medical career see Iseki Kurō 井関九郎, ed., *Igaku Hakushi (Hakushi of Medicine)*, vol. 2, bk. 1 of *Dai Nihon hakushiroku - Who’s Who Hakushi in Great Japan 1888–1922: Biographical Dictionary*, with which is incorporated Doctorate Hakushi or Professor Doctorship Who’s Who and Who was Who Learned in All in Japan (Tōkyō: Hattensha shuppanbu, 1926), 168 (English); 157 (Japanese).

68 On the University Ordinance of 1918 and its effects see Teichler, *Geschichte und Struktur des japanischen Hochschulwesens*, 100–118.

69 On Matsubara see Terahata Kisaku 寺畑喜朔, “Matsubara Saburō kyōju to beikoku ryūgaku” 松原三郎教授と米国学 [Professor Matsubara Saburō Studies Abroad in the United States], *Hokuriku Eigakushi kenkyū* 5, no. 6 (1992): 17.

70 Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 303.

71 Araki’s resignation is announced in “Zappō” 雑報 [Miscellaneous News], *Okayama igakkai zasshi* 35, no. 399 (1923): 267. His later engagement with Chinese Studies is mentioned in his short obituary in “Zappō” 雑報 [Miscellaneous News], *Okayama igakkai zasshi* 44, no. 3 (1932): 702. In the academic year of 1922, Araki was one of three professors without a university degree (Okayama ika daigaku 岡山醫科大學, ed., *Okayama ika daigaku ichiran: Ji Taishō 11 nen shi 12 nen* 岡山醫科大學一覽：自大正11年至12年 [Directory to the Okayama Medical University: From 1922 to 1923] [Okayama: Okayama ika daigaku, 1922], 90–91). By 1924, Hayashi Michitomo 林道倫 (1885–1973) had assumed Araki’s position

Apart from the lower social status and uncertain career prospects that came with a medical degree from a national or private school, it also entailed a considerably lower income as compared to university degree holders. At the time when Araki, Kure, and Kadowaki were assistants at the Tokyo Medical Faculty and worked at the Sugamo Mental Hospital, their monthly allowances differed according to the school from which they had graduated. Tokyo graduates received 20 *yen* per month, higher middle school graduates 15 *yen*, and those from other schools earned even less. This being the case, Kadowaki may have earned something between 12 and 15 *yen*.⁷²

The hierarchy of the medical system was also reflected in the income of the graduates upon entering civil or private service. After having finished his training, Araki was the first to find employment. His yearly income as professor at the Third Higher School in Okayama was 500 *yen*.⁷³ Kure and Kadowaki both started working in 1901. Kure's yearly income as professor was set at 1,000 *yen*,⁷⁴ while Kadowaki's first job as director of the Ōji Mental Hospital turned out to be a generally unstable source of income. Indeed, Kadowaki's salary was dependent on the number of patients admitted to the hospital, but in its early years this private establishment was still struggling to attract enough patients to be profitable. Theoretically, he would earn a yearly income of between 480 and 600 *yen*: when there were more than twenty patients, Kadowaki was to receive 50 *yen* per month, but when there were fewer than twenty, he was only to receive 40 *yen*. However, as the hospital owner was constantly in financial trouble, he regularly fell behind with the wages, and eventually Kadowaki resigned.⁷⁵

and there were no longer any professors without a university degree (Okayama ika daigaku 岡山醫科大學, ed., *Okayama ika daigaku ichiran: Ji Taishō 13 nen shi 14 nen* 岡山醫科大學一覽: 自大正 13 年至 14 年 [Directory to the Okayama Medical University: From 1924 to 1925] [Okayama: Okayama ika daigaku, 1924], 46–54).

72 On the monthly allowance of Sugamo assistants see Okada Yasuo, *Shisetsu Matsuzawa byōinshi 1879–1980* 143, 272, 276, 284; Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 177. The difference also becomes apparent when the end-of-the-year bonus (*nenmatsu irō* 年末慰勞) that the Sugamo employees received in December 1897 is compared: The Tokyo graduate (Funaoka Einosuke) received 30 *yen*, the national school graduates 27 *yen*, and Kadowaki was given only 14 *yen* (Okada Yasuo, *Shisetsu Matsuzawa byōinshi 1879–1980* 198).

73 “Zappō” 雑報 [Miscellaneous News], *Okayama igakkai zasshi* 7, no. 63 (1895): 130.

74 Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 269.

75 “Jinrui no saidai ankokukai fūten byōin: Ōji seishinbōin” 人類の最大暗黒界癲癲病院: 王子精神病院 [The Darkest Place of Mankind—The Madhouse: The Ōji Mental Hospital], *Yomiuri Shimbun*, May 26–June 1, 1903, Sunday, May 31, p. 6. In March and June of 1903, the popular daily newspaper *Yomiuri shinbun* published a series of sensational reports on seven mental hospitals in the Tokyo region. The description of the Ōji Mental Hospital was spiced up with gossip about the hospital's “incompetent staff” and its “penny-pinching owner.” Kadowaki was characterized as a lazy, greedy, and arrogant man who had been fired from the Sugamo hospital for being idle, but was then lured into the Ōji Hospital with the promise of a leading position and a lucrative salary. A few issues later, the newspaper withdrew (*torikeshi* 取り消し) the statements concerning Kadowaki's person (“Jinrui no saidai ankokukai fūten byōin: Tōkyō seishinbyōin” 人類の最大暗黒界癲癲病院: 東京精神病院 [The Darkest Place of

1.3 Individual Paths

Although Kure, Araki, and Kadowaki had all studied psychiatry at the Tokyo Medical Faculty under Sakaki, their professional perspectives evolved as they ventured to explore new theories and methods on their individual paths. After his time with Sakaki, Kure's most important formative phase was his four-year-long experience in European clinics and universities. Indeed, five months after his teacher's death, the Ministry of Education decreed that Kure should receive a scholarship to continue his studies in Germany and Austria for another three years, and his scholarship was later extended for another year in November 1899.⁷⁶

Kure first went to Vienna to attend seminars by Krafft-Ebing, whose textbook was familiar to him from the lectures of his late teacher.⁷⁷ Besides, his personal preferences were also clearly oriented towards Vienna and Berlin at this time. In point of fact, in a talk delivered two years before his departure to Europe, he had declared that, of the various theoretical approaches to psychiatry, he favored the methods of Krafft-Ebing and Jolly.⁷⁸ However, Kure did not develop a lasting professional relationship with Krafft-Ebing during his time in Austria, and he hardly ever mentioned him in his later writings.⁷⁹ About a year after his arrival in Vienna, he received written permission from the Ministry

Mankind—The Madhouse: The Tōkyō Mental Hospital], *Yomiuri Shimbun*, June 2–5, 1903, Wednesday, June 3, p. 4). However, the financial struggles of the Ōji Hospital seem to have had a solid factual base.

76 Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 445, 446.

77 During his time as assistant, Kure had compiled a textbook that reflected Sakaki's teachings and showed a close resemblance to Krafft-Ebing's work. Kure Shūzō 呉秀三, *Seishinbyōgaku shūyō* 精神病学集要 [The Essentials of Psychiatry], vol. 1 (Tokyo: Shimamura Risuke, 1894); Kure Shūzō 呉秀三, *Seishinbyōgaku shūyō* 精神病学集要 [The Essentials of Psychiatry], vol. 2 (Tokyo: Shimamura Risuke, 1895). This and other Japanese textbooks will be discussed in more detail in the next chapter.

78 Kure Shūzō 呉秀三, "Seishinbyō no bunruihō" 精神病の分類法 [Classification Systems of Mental Diseases], *Saisei gakusha iji shinpō* 31 (1895): 628.

79 Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 232. Okada speculates that Kure probably did not really get the chance to establish a personal relationship with Krafft-Ebing because the latter was already a famous psychiatrist and was therefore always surrounded by many other students. Apart from that, it also seems that Kure's German-language skills were not sufficiently developed to grasp all the details of a clinical lecture during his first year in Europe. During his time in Vienna Kure did establish a lasting personal and academic relationship with Heinrich Obersteiner (1847–1922) whose neurological institute he preferred to Krafft-Ebing's seminars (H.-J. Chen, "Eine strenge Prüfung deutscher Art," 113). On the Tokyo–Vienna connection, see also Bernhard Leitner, "Psychiatrie und Neurologie zwischen Wien und Tokyo: Zur Rolle eines transnationalen Netzwerkes in der Entwicklung der akademischen Medizin in Japan circa 1900" [Psychiatry and Neurology between Vienna and Tokyo: On the Role of a Transnational Network in the Development of Academic Medicine in Japan circa 1900], in *Strukturen und Netzwerke: Medizin und Wissenschaft in Wien 1848–1955*, ed. Daniela Angetter et al. (Göttingen: V&R unipress, 2018), 533–554.

of Education to continue his studies in Heidelberg.⁸⁰ This seems to suggest that, unlike his visits to Vienna and Berlin, the stay in Heidelberg had not been part of his initial plan.⁸¹

Before departing for Heidelberg, Kure announced his visit to Kraepelin in a formal letter of introduction written in March 1899.⁸² He explained that he was planning to spend the next summer term in Heidelberg and asked for Kraepelin's support and guidance. As will become clear from the discussion in section 2.2 and section 3.2, Kraepelin must have exerted a truly tremendous influence on Kure during the latter's stay in the German Southwest, as the Japanese professor would come to push Kraepelin's novel ideas in Tokyo's classrooms and hospital wards later on. As we have already seen in section 1.1, Kraepelin had been actively propagating his vision of a "modern psychiatry" since the Heidelberg Conference of 1896, and his missionary attitude is also reflected in a handwritten note that Kure would keep for the rest of his life.

During his stay in Europe (and later in the US), Kure had collected dedications from the various scholars that he had met. Whereas most people contented themselves with wishing him good luck for the future or quoting lines from Goethe and Shakespeare, Kraepelin used this social medium to advertise his "modern psychiatry" project. His dedication reads:⁸³

Daß wir unsere Kranken heilen, wird man von uns Irrenärzten vielleicht immer nur in sehr bescheidenem Umfange erwarten dürfen; was wir aber leisten können und sollen, ist die Vorhersage des Verlaufes und des Ausganges der Krankheit.

Perhaps, we alienists can only be expected to heal our patients to a very limited degree, but what we can and must be able to do, is to predict the course and the outcome of the illness.

Heidelberg, 20. May 1900

Kraepelin

The focus on prognosis, which Kraepelin proclaimed as the psychiatrist's true and ultimate duty, must certainly have been appealing to clinic directors like Kure for its practical utility in hospital administration. Additionally, the new classification was presented as the result of careful observation and unbiased scientific accuracy, which was also expressed in the label "clinical psychiatry."⁸⁴ However, it would be wrong to say that Kure

⁸⁰ Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 446.

⁸¹ The Japanese students receiving a scholarship from the Ministry of Education were free to choose their place of study, but they had to submit applications to ask for an extension or to make changes (H.-J. Chen, "Eine strenge Prüfung deutscher Art," 108).

⁸² The content of this letter is reproduced in Kraepelin, *Kraepelin in Heidelberg (1891–1903)*, 293.

⁸³ Kure's original collection of dedications is in the possession of the Medical Library of Tokyo University. The transcription is my own. I deliberately translate Kraepelin's "Irrenarzt" [literally: "mad-doctor"] with "alienist" as this was the more common term in the English speaking world at the time.

⁸⁴ The justifications for these claims have repeatedly been questioned. See especially Matthias Weber and

had been overexposed to one particular school during his stay in Europe. In September 1899, for instance, Kure had participated in the conference of the German Society of Natural Scientists and Physicians held in Munich, where he was able to personally witness the dispute between the Heidelberg and Berlin Schools.⁸⁵ Whatever the specific reasons that convinced him to become a follower of the Heidelberg School, his privileged position as professor of psychiatry at Tokyo University for a duration of more than twenty years definitely empowered him to steer Japanese psychiatry in this direction.

While Kure was digesting his new impressions and experiences in southern Germany, Katayama Kuniyoshi was reshaping psychiatric teaching at Tokyo Imperial University. Instead of using the textbook favored by his colleague Sakaki, of which Kure had compiled an adapted translation in Japanese, Katayama chose to base his lectures on the textbook of Theodor Ziehen.⁸⁶ Although Ziehen was one of the best known psychiatrists of his time on an international level, he has been largely neglected by medical historians.⁸⁷ This may at least partly be owed to the fact that he was strongly opposed to some of the ideas of Kraepelin and Sigmund Freud (1856–1939), who have subsequently become the focus of historical research in psychiatry.⁸⁸ Ziehen not only rejected Kraepelin's classification but also harshly criticized his attempts in experimental psychology, which was his own favorite field of research.⁸⁹ After having worked under Otto Binswanger (1852–1929) at the University of Jena for fourteen years, Ziehen received several appointments as professor of psychiatry and eventually became the director of the psychiatric clinic at the Berlin Charité Hospital in 1903. It should be no surprise that Ziehen was depicted as belonging to the Berlin faction in the aforementioned cartoon (see Figure 1.1), as both his academic views and his institutional ties aligned him with those whom Kraepelin regarded as his professional adversaries.

Kadowaki's medical education at Tokyo Imperial University mostly coincided with Katayama's teaching period (1897–1901). Because of this, he learned psychiatry through the works of Theodor Ziehen and eventually compiled a textbook that reflected his men-

Eric Engstrom, "Kraepelin's 'Diagnostic Cards': The Confluence of Clinical Research and Preconceived Categories," *History of Psychiatry* 8 (31 1997): 375–385; E. Engstrom, *Clinical Psychiatry in Imperial Germany*, 144–146.

85 Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 446. See also my discussion on page 29 at the beginning of this chapter.

86 Theodor Ziehen, *Psychiatrie für Ärzte und Studierende* [Psychiatry for Doctors and Students] (Berlin: Friedrich Wreden, 1894).

87 Ulrich Herberhold, "Theodor Ziehen: Ein Psychiater der Jahrhundertwende und sein Beitrag zur Kinderpsychiatrie" [Theodor Ziehen: A Psychiatrist of the Turn of the Century and His Contribution to Child Psychiatry] (PhD diss., Albert-Ludwigs-Universität Freiburg, 1977), 1.

88 Christopher Baethge, Ira Glovinsky, and Baldessarini Ross J., "Manic-Depressive Illness in Children: An Early Twentieth-Century View by Theodor Ziehen (1862–1950)," *History of Psychiatry* 15, no. 2 (2004): 201–226.

89 Theodor Ziehen, review of *Psychologische Arbeiten*, vol. 1, issue 1 by Emil Kraepelin, *Zeitschrift für Psychologie und Physiologie der Sinnesorgane* 10 (1896): 247–252.

tor's lectures and can be considered an adaptation of the first edition of Ziehen's textbook.⁹⁰ However, only nine days after Kadowaki had left Tokyo University, Kure returned to the institution as its next professor, and his newly imported ideas almost immediately superseded Katayama's legacy. By introducing Kraepelin's textbook as the new reference work in psychiatric education, he ensured that his department and future generations of psychiatrists graduating from Tokyo came under the influence of the Heidelberg School.

Araki, the third and last of the Japanese protagonists, left Tokyo Imperial University several years before either Katayama or Kure introduced their respective reforms. There is little evidence that he stayed in contact with the Tokyo psychiatric community apart from the fact that he was part of the editorial board of the *Shinkeigaku zasshi*, the journal of the Japanese Society for Neurology. However, a few insights into his life and his relationship with Kure can be gathered from a short text entitled "Farewell to See Off the Frugal Minister Araki upon his Return to Okayama" (*Song Huangmu [Araki] Yue Qing gui Gangshan [Okayama] xu* 送荒木約卿歸岡山序) that was included as a preface in Araki's 1906 textbook on psychiatry.⁹¹ It had originally been composed by Kure on the occasion of Araki's departure from Tokyo in 1895 and was written in Classical Chinese prose style. Following the conventions of the genre, Kure did not only sign as Kure Shūzō, but prepended his colorful pen name "The Hermit from the Fragrant Creek" (*Fang Xi Yinsbi* 芳溪隱士). In this text, Araki was characterized as having the appearance of an "eccentric from antiquity" (*zhuangmao qi guren* 狀貌奇古人), and Kure admitted that he "did not seek his company" (*wei you yu zhi* 未有與之) at first. Nonetheless, he recalled that they later became "intimate friends for many years" (*shen jiao younian* 深交有年) after Araki had joined the team of medical faculty assistants. Generally speaking, the text is full of praise for Araki's outstanding personality and brilliant mind, which is rather typical for the genre. However, his eccentricity and a certain fascination for the old are referred to repeatedly and seem to have made a lasting impression on Kure. Araki's devotion to Classical Chinese literature towards the end of his life also reveals a certain fondness for classical learning.

From Kure's professional perspective, Araki represented a school that was different from both Kraepelin's and Ziehen's teachings. In 1912, he summarily wrote about the

⁹⁰ Kadowaki Masae, *Seishinbyōgaku*.

⁹¹ Araki Sōtarō 荒木蒼太郎, *Seishin byōri hyōshaku* 精神病理氷釋 [On the Pathology of Mental Illness] (Tōkyō: Tohōdō, 1906). Since the preface is written in Classical Chinese prose style, I follow Chinese standards for the transliteration and only supply the Japanese reading where necessary.

For reasons that are not entirely clear, the text would be relegated to the lesser position of a postscript in the 1911 edition of his textbook, see Araki Sōtarō 荒木蒼太郎, *Seishinbyōgaku sūki* 精神病学枢機 [Essentials of Psychiatry] (Tōkyō: Tohōdō, 1911). One might conjecture that this reflects a change in their personal relationship after they had parted ways professionally, compare section 1.1 and the following chapters.

different psychiatric schools that existed in Japan.⁹² In that short passage, he categorized Araki and his 1906 textbook on psychiatry as a separate school (*beppa* 別派) that had allegedly been inspired by the teachings of the German psychiatrist Robert Sommer (1864–1937).⁹³ However, there is no evidence that Araki should have been noticeably influenced by Sommer while he was working on his textbook in 1905, and the similarities between his work and Sommer’s were definitely rather scant during that period. Admittedly, Araki did later come to share an interest in physiological experiments with Sommer as he worked with him at his clinic in Giessen in the Summer and Winter Terms of 1907–08.⁹⁴ It would even be fair to say that his research in Giessen and afterwards in Göttingen reveals an outright fascination with mathematical representations of physiological phenomena.⁹⁵ The attractions of these particular sites of research and their relation to the emerging field of experimental psychology will be the subject of chapter 3. Whatever Araki’s motives were for choosing to visit these institutions, it should be noted that his studies on harmonic analysis were perceived as an important contribution to applied mathematics, which is a remarkable accomplishment for a scholar who had originally been trained in medicine.⁹⁶

92 Kure Shūzō, *Wagakuni ni okeru seishinbyō ni kansuru saikin no shisetsu* 2–5.

93 Kure Shūzō, 4. Sommer was famous for his textbooks on diagnostics and examination methods. He was one of the founders of the German Society for Experimental Psychology (1904) and had invented his own apparatuses, such as the “Reflexmultiplikator” (Robert Sommer, *Lehrbuch der psychopathologischen Untersuchungsmethoden* [Textbook on Examination Methods in Psychopathology] [Berlin: Urban & Schwarzenberg, 1899], 26). On Sommer’s engagement with psychology see also Mitchell Ash, “Academic Politics in the History of Science: Experimental Psychology in Germany, 1879–1941,” *Central European History* 13, no. 3 (1980): 266; Jan-Peters Janssen, “Der Psychiater Robert Sommer (1864–1937): Förderer des Universitätssports und der Psychologie” [The Psychiatrist Robert Sommer (1864–1937): Patron of University Sports and Psychology], in *Jahrbuch 2010 der Deutschen Gesellschaft für Geschichte der Sportwissenschaft e. V.* Ed. Jürgen Court, Arno Müller, and Wolfram Pyta (Berlin: LIT, 2011), 145–176.

94 Universitäts-Sekretariat, ed., *Personalbestand der Grossherzoglich Hessischen Ludwigs-Universität zu Giessen* [Personnel of the Grand-Ducal Hessian Ludwig-University in Giessen] (Giessen: Von Münchow’sche Hof- und Universitätsdruckerei, Otto Kindt, 1907), 37. Araki left Japan on February 9, 1907 (“Ihō: Gakuji” 彙報：學事 [Miscellaneous News: Study Affairs], *Kanpo* [Tōkyō], February 13, 1907, no. 7084, 333). He arrived in Germany on March 10 and gave his temporary address as: Hillebrandstr. No. 2/1, Giessen, Germany (“Zappō” 雑報 [Miscellaneous News], *Okayama igakkai zasshi* 17, no. 208 [1907]: 327).

95 See especially his works on the patellar reflex: Araki Sōtarō 荒木蒼太郎 [Araky, S.], “Beiträge zur harmonischen Kurvenanalyse” [Notes on Harmonic Analysis], *Zeitschrift für Allgemeine Physiologie* 8 (1907): 405–421; Araki Sōtarō 荒木蒼太郎 [Araky, S.], *Studien über Kniereflexkurven* [Studies on Knee Reflex Curves] (München: Kastner & Callwey, 1908); Araki Sōtarō 荒木蒼太郎 [Araky, S.], “Zur Muskelmechanik” [On Muscle Mechanics], *Okayama igakkai zasshi* 21, no. 221 (1909): 1–6; Araki Sōtarō 荒木蒼太郎, “Shitsugai hansha kyokusen no kenkyū” 膝蓋反射曲線ノ研究 [Studies on Knee Reflex Curves], *Okayama igakkai zasshi* 22, no. 245 (1910): 21–32.

96 Araki Sōtarō 荒木蒼太郎, *Chōwa kaiseiki* 調和解析 [Harmonical Analysis] (Okayama, 1914). This treatise is a Japanese adaptation of his earlier work on knee reflex curves published in Germany. Shortly after its publication, it was reviewed in an internationally renowned mathematical journal (Hayashi Tsurioichi 林鶴一, review of *Chōwa kaiseiki* (*shōroku tanpyō*) 調和解析 (抄録短評) [Harmonical Analysis] by

Nonetheless, Kure's retrospective assessment seems to have been based mainly on the importance that he ascribed to Araki's studies in Europe, not on a close (or even distant) reading of his 1906 text. Indeed, neither did his interpretation do justice to the originality of Araki's textbook, nor did he successfully grasp its theoretical scope. If anything, Kure's judgment is more telling about his own method of appropriating theories and ideas than it is an adequate analysis of Araki's approach to psychiatry, as will become clear in the following chapter.

This chapter has shown that Japanese psychiatry was global psychiatry. It was global in the triple sense that it was deeply rooted in worldwide psychiatric trends, was able to produce an academic discourse in very much the same way as any of the so-called "Western" countries, and reinforced the center at the periphery by its active appropriation and validation of medical theories on mental illness in the Japanese setting. On the national scale, the imported knowledge was solidified within a newly created institutional structure. However, the institutional situation in Japan at the turn of the twentieth century created a situation where one person wielded most of the discursive power. This discursive hegemony was successively in the hands of a select group of professors of psychiatry at Tokyo Imperial University. At the time I am most interested in, it channeled all available resources into the hands of Kure Shūzō, whose long reign attempted to shape Japanese psychiatry into a faithful copy of Kraepelinian psychiatry where melancholia had been relegated to the mythical age of non-scientific objects.

In the following chapter, I will provide a glimpse into the challenges that Kure faced with his Westernization project and show that, despite his efforts, the Japanese copy was not so accurate a reproduction as Kure had envisioned for his home country. The travel notes of a visiting colleague who toured Japanese psychiatric institutions in 1905 will provide a firsthand account of Kure's visions and disappointments for modernizing Japanese psychiatry in this formative period. While alternative Japanese diagnostic practices in which melancholia survived Kure's modernization policies will be discussed in detail in chapter 4, the following chapter will focus on the formation of hegemony with regard to psychiatric concepts and thus take a closer look at Kure's teaching and publishing activities in Tokyo.

Araki Sōtarō, *Tōhoku sūgaku zasshi* 6 [1914]: 57). I thank Harald Kümmerle from the MLU in Halle-Wittenberg for sharing his assessment of Araki's mathematical texts.

2 Asylums as Sites of Psychiatric Modernity

Present-day psychiatric classification is characterized by a curious dichotomy that has preoccupied the profession for a long time. Although the discipline of psychiatry has witnessed many conceptual shifts and reorientations since the nineteenth century, two medical concepts—schizophrenia and manic-depressive disorder—seem to have survived the turbulence and continue to shape psychiatric thinking, research, and practice to a considerable degree. In the 1960s and '70s, the classification was subject to violent attacks spurred by social and political movements that were directed against the institution of psychiatry itself, but even those critics who opposed this dichotomy on empirical grounds in the 1980s were rather pessimistic with regard to the possibilities of changing the system:

The structure remains unchanged not because the rubrics concerned have been shown to represent valid and independent entities, but because no better classification has yet been devised, and because we are aware that if the twin pillars of manic-depressive psychosis and schizophrenia are disturbed before there is anything better to put in their place the roof will come crashing in.¹

This statement suggests that the dichotomy not only appears to be extremely resilient but that it also is of great importance to the discipline of psychiatry and the professional identity of its members. Its emergence can be traced back to the end of the nineteenth century, and although medical historians usually frame this development as a process of synthesis and continued accumulation of knowledge, I will point to the discontinuities inherent in the process and argue that the birth of the dichotomy was simultaneously the death of melancholia, as it was known then. The image of psychiatry as an independent discipline had already been of great concern in the formative years of the dichotomy, and I will narrate the story of its emergence as a struggle for recognition and acceptance marked by institutional changes and conceptual eclecticism. In historiographic writing, the achievement of bringing about disciplinary maturity is closely associated with the nosological

¹ Robert E. Kendell, "Diagnosis and Classification of Functional Psychoses," *British Medical Bulletin* 43, no. 3 (1987): 500.

(i.e. classification-related) work of the German psychiatrist Emil Kraepelin (who has already been introduced as having caused major rifts within the global psychiatric community). By introducing dementia praecox and manic-depressive insanity, Kraepelin is usually credited for having set up the basic nosological templates for the present-day concepts of schizophrenia and affective disorders, thereby having laid the foundations for the great dichotomy.²

In this chapter, I will situate the emergence of the great dichotomy of dementia praecox and manic-depressive insanity popularized by Kraepelin within the constraining framework of German psychiatric institutions and the rationalizing logic of the German welfare system. I will show how the emergence of the former was doubtless influenced by the latter, but also how the conceptual changes played an even more important active role in facilitating developments in psychiatric practice that have become widely accepted ever since, if not become the absolute norm worldwide. I will contrast this place-specific genesis of psychiatric knowledge with contemporary developments in Japan, where the institutional framework was very different but where the new knowledge was adopted nonetheless, not least because of the rhetoric of “scientific progress” that was attached to the discussion of the new classification from the very beginning.

In addition to offering a close reading of German and Japanese sources that document this specific knowledge production, I will also point out the detrimental side-effects of prioritizing the paradigm of manageability by linking the prognosis-oriented development of psychiatric categories of the nineteenth century with the practices of modern risk societies.³ My narrative is structured around the progressive disappearance of the melancholia concept, and I will therefore primarily highlight the destabilizing effects which the new scientific practices had on the older concept of melancholia. The social and institutional conditions in which these conceptual changes occurred, as well as the intellectual framework from which they arose, will not merely serve as historical background but will be examined as both influencing and being influenced by the conceptual developments.

2 Edwin R. Wallace, “Psychiatry and Its Nosology: A Historico-Philosophical Overview,” in *Philosophical Perspectives on Psychiatric Diagnostic Classification*, ed. John Z. Sadler, Osborne P. Wiggins, and Michael A. Schwartz (Baltimore: Johns Hopkins University Press, 1994), 71.

3 For a discussion of risk as a key principle of welfare organization see Hazel Kemshall, *Risk, Social Policy and Welfare* (Buckingham: Open University Press, 2001); Paul Godin, *Risk and Nursing Practice* (Basingstoke: Palgrave, 2006). For a social critique of prognosis-oriented psychiatry and risk-based mental health care see Nikolas Rose, “Governing Risky Individuals: The Role of Psychiatry in New Regimes of Control,” *Psychiatry, Psychology and Law* 5, no. 2 (1998): 177–195; George Szmukler and Nikolas S. Rose, “Risk Assessment in Mental Health Care: Values and Costs,” *Behavioral Sciences & The Law* 31, no. 1 (2013): 125–140; Hervé Guillemain, “Les enjeux sociaux de la médecine prédictive: L’exemple de l’émergence du diagnostic de la démence précoce et de la schizophrénie dans la première moitié du xx^e siècle” [The Social Stake of Predictive Medicine: A Focus on the Development of the Diagnostic of Dementia Praecox and Schizophrenia during the First Half of the xxth Century], *Droit, Santé et Société*, nos. 3–4 (2017): 54–60.

2.1 Institutional Setting and Diagnostic Practice

Throughout the nineteenth century, most “psychiatrists” were referred to as medical superintendents, asylum physicians, or alienists.⁴ These older designations resonate with the main responsibilities and duties of the profession, which for the most part consisted in administering and managing the sometimes enormous patient populations of nineteenth-century psychiatric institutions, so-called asylums. Housing and nourishing the mentally ill were the main concerns of asylum superintendents, who had to cope with overcrowded facilities and limited resources. These unfavorable conditions certainly enforced the general tendency that the risk management strategy of the asylum era was mostly limited to containment and incarceration rather than treatment and integration.⁵ The historical phenomenon of large scale-confinement in Western Europe and the United States is usually seen as a byproduct of modernization processes.⁶ It indicates the growing involvement of nation states in controlling and monitoring the mental and physical health of their citizens while effectively managing the poor and the unemployed through institutional means in the name of national welfare and scientific progress. These negative systemic effects (i.e. the marginalization of the lower social classes) associated with the early forms of institutionalized mental health provision seem to be a characteristic of the “asylum era.”

However, when we turn our gaze to Japan with these European and American conditions in mind, it would seem that there was no corresponding “asylum era” in the period that is most strongly associated with modernization and the emergence of the Japanese nation state. The Meiji period (1868–1912) saw no huge numbers of patients confined in large madhouses managed under the administration of local or national governments. Looking further back in Japanese history, it is quite clear that in the Edo period (1603–1867), mental health provision was very different from the situation described above, and it appears that conditions did not change drastically after public welfare reforms were initiated in the Meiji period.⁷ Considering that attitudes towards what was perceived as “mental illness” were not stable within this large time-frame, it is difficult to give a general

4 Wallace, “Psychiatry and Its Nosology,” 28.

5 Kemshall, *Risk, Social Policy and Welfare*, 90; Tony Ryan, “Risk Management and People with Mental Health Problems,” in *Good Practice in Risk Assessment and Risk Management: Protection, Rights and Responsibilities*, ed. Hazel Kemshall and Jacki Pritchard (London: Jessica Kingsley Publishers, 1996), 101. Ryan and Kemshall argue that different historical periods were characterized by different risk management strategies towards mental health. Thus, they suggest that while, for example, in the Middle Ages the dominant approach was “expulsion,” the late twentieth century with its shift towards community care (especially in the US context) was characterized by an “integration” strategy.

6 A key study with a global approach to “understand the rise of the asylum within the wider context of social and economic change of nations undergoing modernization” is the edited volume by Roy Porter and David Wright which also features articles on the history of the asylum in Japan, Argentina, India, and Nigeria (Porter and Wright, *The Confinement of the Insane*, i).

7 Akihito Suzuki, “The State, Family, and the Insane in Japan, 1900–1945,” in *The Confinement of the In-*

account of mental health provision in Japan.⁸ Generally speaking, however, attitudes toward mental illness seems to have been very similar to what Roy Porter has observed for seventeenth- and eighteenth-century England. Being “an extremely broad sociocultural category,” madness could be seen as “medical, or moral, or religious, or, indeed, Satanic. It could be sited in the mind or the soul, in the brain or the body.”⁹ Apart from “Satanic” (which carries strong Christian connotations and which could perhaps be rendered as “demonic” in the Japanese context), most of these statements would also hold true for Edo and early Meiji Japan.¹⁰

These attitudes toward madness largely defined the management strategies of the public authorities with regard to the insane. Especially in the case of violent madmen and madwomen, insanity was strongly associated with dangerous animals on the loose. Accordingly, the police of the city of Tokyo regarded such cases as belonging into a similar category as unrestrained oxen, horses, and rabid dogs.¹¹ In urban areas, prisons and poorhouses served to accommodate the “unruly” and the “troublesome,” but it was also common to put “lunatics” or “violent offenders” in a cage (*sashiko* 指籠) in their own house after obtaining permission from local authorities.¹² In the absence of an existing network of asylums, the latter custom of incarceration at home was effectively codified by the Meiji government in the form of the “Mental Patients’ Custody Act” of 1900. In practice, the act legalized the old tradition of home custody while also formally granting rights to the patients by criminalizing wrongful or unjust confinement.¹³ However, with this legal step, the Meiji government effectively expanded their reach into controlling and defining the meaning of madness in Japanese society. By criminalizing unjust

sane: International Perspectives, 1800–1965, ed. Roy Porter and David Wright (Cambridge: Cambridge University Press, 2003), 198.

8 Some works where this has been attempted include Genshiro Hiruta, “Japanese Psychiatry in the Edo Period (1600–1868),” ed. Allan Beveridge, *History of Psychiatry* 13 (2002): 131–151; Okada Yasuo, *Nihon seishinka iryōshi* Watarai Yoshiichi 度会好一, *Meiji no seishin isetsu: Shinkeibyō, shinkeisuijaku, kamigakari* 明治の精神異説：神経病、神経衰弱、神がかり [Conflicting Views on the Mind during the Meiji Era: Nervous Disorder, Neurasthenia, and Possessed by the Gods] (Tōkyō: Iwanami shoten 岩波書店, 2003); Hyōdō Akiko, *Seishinbyō no Nihon kindai* Kanekawa Hideo 金川英雄, *Nihon no seishin iryōshi: Meiji kara Shōwa shoki made* 日本の精神医：療史-明治から昭和初期まで [History of Psychiatry in Japan: From the Meiji-Era to the Early Shōwa-Era] (Tōkyō: Seikyūsha, 2012); Wolfgang Michel-Zaitz, *Traditionelle Medizin in Japan: Von der Frühzeit bis zur Gegenwart* [Traditional Medicine in Japan: From Antiquity to the Present] (München: Kiener, 2017).

9 Roy Porter, *Mind-Forg’d Manacles: A History of Madness in England from the Restoration to the Regency* (London: Athlone Press, 1987), x.

10 In addition to the works that provide a general account on mental illness in Japan cited above, there is also a lot of specialized literature on the phenomenon of spirit possession in Japan and especially on fox possession. See the references in section 6.2 (Foxes and Electricity) of chapter 6.

11 Okada Yasuo, *Nihon seishinka iryōshi* 130.

12 Suzuki, “The State, Family, and the Insane in Japan, 1900–1945,” 197. On the Japanese practice of putting the mentally ill in cages see also Y. Kim, “Seeing Cages.”

13 Suzuki, “The State, Family, and the Insane in Japan, 1900–1945,” 199.

confinement through national legislation, the authority of distinguishing between sanity and madness was ultimately put into the hands of the emerging centralized nation-state.

Another strand within the Japanese tradition of managing the mentally ill had evolved in close connection with the profit-oriented establishments that sprouted around places of religious healing.¹⁴ These privately-run guesthouses, usually found in proximity to Buddhist shrines, hot springs, or waterfalls, served as prototypes for the private asylums of the late nineteenth and early twentieth centuries, which dominated the institutional landscape of the Meiji welfare system.¹⁵ For the whole of the Meiji period, there existed only one public asylum in all of Japan (the Sugamo Mental Hospital in Tokyo), and the rest of those deemed mentally ill were provided for through private asylums or through home custody. In a national survey conducted between 1910 and 1916, it was found that for an estimated patient population of 140,000–150,000 mental health cases, there were only some 1,000 beds available in public institutions (including the Sugamo Mental Hospital with its 446 beds) and another 4,000 beds provided by 37 privately run hospitals all over Japan. Thus, the large majority of mental patients were found in home custody or remained without any kind of the mental health provision deemed appropriate by academic psychiatrists.¹⁶

Besides exposing the negative effects of the home custody system based on family care, which in some points resembles present-day critiques of community care (brandished as “community neglect” in polemic accounts), the above-mentioned survey explicitly promoted the construction of public asylums.¹⁷ Campaigning to increase the number of public mental health institutions was a direct attempt to shift the balance of mental health provision from the private and family care sectors to the public sector and thus strengthen the position of those working in public mental health institutions. Therefore, it is not surprising that this study was conducted with the help of Kure Shūzō, chair of psychiatry at Tokyo Imperial University and director of the sole public asylum in all of Meiji Japan.

As such, the survey should not be seen as a pure act of philanthropy campaigning for public welfare, but it also ought to be considered for its political potential to safeguard professional interests. With its accusatory rhetoric, it aimed to strengthen the role of university-trained mental health professionals (of which Kure was the lead representa-

¹⁴ Suzuki, 213.

¹⁵ On practices of religious healing, see Akira Hashimoto, “Psychiatry and Religion in Modern Japan: Traditional Temple and Shrine Therapies,” in Harding, *Religion and Psychotherapy in Modern Japan*, 51–75.

¹⁶ Kashida Gorō 榎田五郎 and Kure Shūzō 呉秀三, *Seishinbyōsha shitaku kanchi no jikkō oyobi sono tōkei-teki kansatsu* 精神病患者私宅監置ノ実況及ビ其統計の觀察 [The Situation and Statistical Observation of Home Custody of Mental Patients] (Tōkyō: Naimushō eiseikyoku, 1918), 5. See also the statistical tables on mental health provision in Okada Yasuo, *Nihon seishinka iryōshi* 180–81.

¹⁷ The debate about the negative side of community care (neglect, homelessness, degradation etc.) was intensified by Andrew Scull, *Decarceration: Community Treatment and the Deviant—A Radical View* (New Jersey: Prentice-Hall, 1977), 182. See also Rose, “Governing Risky Individuals,” 182.

tive) as the appropriate authority on madness. Academic practitioners like Kure were a minority in the Meiji period, but through reforms in medical education and the legal system, their position (and, with it, the knowledge which they represented) was successively backed and endorsed by the state. Attempts to monopolize the act of diagnosing through institutional and legal means should, therefore, be seen as an expression of professional rivalry and insecurity.

In a parallel development, the diagnostic classifications (nosologies) of the asylum era partly reflected the predominantly administrative concerns of nineteenth-century mental health provision in Europe and North America.¹⁸ With the prevalence of disease categories such as mania and melancholia, a large proportion of the patient population was conveniently divided into agitated and quiet patients, the medical category thus already indicating the degree of surveillance that was required for the management of those hospitalized. This is not surprising, as all classifications reflect the institutional structure when they are required to be of practical use within that structure.¹⁹ Consequently, one might expect that institutional changes would affect classificatory discourse. In the following, I will briefly trace the transformation of the German mental health care system and link it with the nosological innovations introduced by Kraepelin.

In the second half of the nineteenth century, German psychiatry was undergoing some significant institutional changes that would eventually contribute to an increased popularity and international reputation for German psychiatrists and their theories. Unlike in the French- and English-speaking worlds, where “mad-doctoring remained essentially an administrative specialty,” German practitioners were increasingly engaged with laboratory work and the teaching and research practices of the university.²⁰ In the wake of these changes, two different types of psychiatric institutions gradually emerged, each with its specific tasks and responsibilities. On the one hand there was the research-oriented university clinic, equipped with laboratory instruments and featuring classrooms and lecture theaters for patient demonstrations; and on the other hand there was the state asylum, which was more and more reduced to its custodial function, housing the bulk of the human “research material” necessary for research and teaching. However, this transformation did not play out without conflicts over the rights and privileges of the professionals involved, and it also left its mark on the administrative management of madness and the treatment of patients.

The institutionalization of psychiatry in Meiji Japan, which was modeled after the German system, also witnessed considerable tensions between various groups involved in mental health provision. The conflicts between university psychiatrists, asylum superintendents, and the local government (not to mention Kanpō practitioners) were part and

18 Sadler, Wiggins, and Schwartz, *Philosophical Perspectives on Psychiatric Diagnostic Classification*, 9.

19 Jennifer Radden, “Recent Criticism of Psychiatric Nosology: A Review,” *Philosophy, Psychiatry, & Psychology* 1, no. 3 (1994): 195.

20 Scull, *Madness*, 66–7.

parcel of the welfare system which the Meiji government had imported from Germany in an attempt to modernize the country (see chapter 1). The circumstances surrounding the national mental health survey conducted by Kure had already revealed some of the issues that were at stake in the institutional struggle. More direct insight into the details of the struggle can be gained from the eyewitness report of a traveling psychiatrist who visited Japanese institutions in 1905. Wilhelm Stieda (1875–1920) was a Russian citizen of Baltic-German origin who had been involved in the treatment of mental patients in Manchuria during the Russo-Japanese War (1904–05).²¹ After the war, he decided to make a sight-seeing tour of the psychiatric institutions of Japan and later published his report in Russian and German academic journals.²² He was equipped with letters of recommendation from the psychiatric clinic of Heidelberg University to Professor Kure in Tokyo and to Professor Imamura Shinkichi (1874–1946) in Kyoto, both of whom had studied in Germany and were fluent in the German language, as was expected of mental health professionals of their status.²³

Stieda was full of admiration for the private mental hospitals which he visited in the Kyoto area. He pointed out that they were nothing like the constantly overcrowded facilities he knew from Europe.²⁴ The rooms in the private institutions were spacious, abundant with light and fresh air, and surrounded by gardens. In contrast to these, the Sugamo Mental Hospital in Tokyo, which he visited last, reminded him of a genuine “madhouse,” reminiscent of the older type of hospitals for the insane of Europe.²⁵ Stieda was told by his Japanese colleagues that they were on a crusade against the government in striving to

21 I will come back to Stieda and his experience of mental illness during the war in chapter 7.

22 Wilhelm Stieda, “O psichiatрії v Japonii” [On Psychiatry in Japan], *Obozrēnie psichiatрії, nevrologії i eksperimental’noj psichologii* 11 (April 1906): 260–268. The German version was soon after translated into Japanese: Wilhelm Stieda, “Nihon no seishinbyōgaku” 日本ノ精神病学, trans. s. n., *Shinkeigaku zasshi* 5, no. 7 (1906): 31–44.

23 Stieda, “O psichiatрії v Japonii,” 260. The letters are mentioned in the Russian version of Stieda’s report but not in the German version. There are some other considerable differences between the two versions which will be discussed below. Stieda had also worked in the Heidelberg clinic as assistant physician in 1903–04. See Stieda’s short biography in Isidorus Brennssohn, *Die Ärzte Kurlands vom Beginn der herzoglichen Zeit bis zur Gegenwart: Ein Biographisches Lexikon nebst einer historischen Einleitung über das Medizinalwesen Kurlands* [The Doctors of Courland from Ducal Times to the Present: A Biographical Lexicon along with a Historical Introduction to the Medical System of Courland] (Riga: Verlag von Ernst Plates, 1929), 381.

24 When speaking of Europe, Stieda explicitly considered Russia as being part of European cultural space. In the Russian version of the report (but not in the German) he often made comparisons with his former home institution, the St. Nicholas Psychiatric Hospital in St. Petersburg where he had worked in 1901–1902 (see Brennssohn, 381). In his article on Japan he referred to the St. Petersburg hospital as one representative of “our European public hospitals” (Stieda, “O psichiatрії v Japonii,” 267). In the German version of the article the references to Russia are all omitted, which gives the impression of a “German” view of Japan (Wilhelm Stieda, “Über die Psychiatrie in Japan,” *Centralblatt für Nervenheilkunde und Psychiatrie* 29 [July 1906]: 514–522).

25 Stieda, “O psichiatрії v Japonii,” 265.

preserve the tradition of lunatic colonies and the existing system of family care.²⁶ They assured him that they were against abolishing these existing practices and were “merely” urging the government to reform them by putting these institutions under the direct supervision and control of the experts (i.e. the academic psychiatrists themselves).²⁷ Expressing solidarity with his Japanese colleagues’ quest for expanded epistemic power and total jurisdiction in all areas of mental health provision, Stieda stated that hopefully the Japanese government would pay more attention to the advice and requests of the country’s experts.

As for the institutional and academic setting, even though psychiatry was taught at university, there were no purpose-built university clinics. Consequently, while the municipal hospital of the city of Tokyo (the Sugamo clinic) was used for teaching purposes, the urban administration was reluctant to address the needs of the psychiatrists, making them feel merely “tolerated” and not effectively in charge of the asylum administration.²⁸ They had no control over patient admissions, they complained, and the city was unwilling to support their various “modernization projects” financially. One such example was Kure’s plan to introduce “bed rest” (*shindai ryōbō* 寢臺療法) as a treatment at the Sugamo clinic.²⁹ In practice, it turned out that “bed rest” proved incompatible with the Japanese lifestyle, namely, the custom of sleeping on a futon which is usually put away in the morning. Kure figured that he could enforce “bed rest” with heavy, unmovable European-style beds, but the municipal government saw no sense in purchasing them for the mental hospital, arguing matter-of-factly that everyone else in Japan was using futons, so that there was no reason why mental patients should be accommodated differently. Even after Kure was able to obtain some patient-built wooden bed frames produced in the clinic’s own workshop (an institution deemed to provide “occupation

26 On the lunatic colony in Iwakura Village (near Kyoto) visited by Stieda, see Akira Hashimoto, “The Invention of a ‘Japanese Gheel’: Psychiatric Care from a Historical and Transnational Perspective,” in *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, c. 1800–2000*, ed. Waltraud Ernst and Thomas Mueller (Newcastle: Cambridge Scholars, 2010), 142–171; Akira Hashimoto, “A ‘German World’ Shared Among Doctors: A History of the Relationship between Japanese and German Psychiatry before World War II,” *History of Psychiatry* 24, no. 2 (2013): 180–195. In the latter article, Hashimoto argues (relying solely on Stieda’s German and Japanese publications) for a strong resentment against Russia and all Russians on Stieda’s part which is supposedly grounded in the latter’s heightened identification with German culture. Even though it would not be uncommon to express feelings of racial superiority for ethnic Germans at the time, there is no direct evidence to be found in the sources. My reading is that Stieda carefully considered his target audience when publishing in Russian and German journals respectively.

27 Stieda, “O psichiatrii v Japonii,” 263–4.

28 Stieda, “Über die Psychiatrie in Japan,” 515.

29 Stieda, “Nihon no seishinbyōgaku,” 41.

therapy”), the patients sometimes continued to sabotage the treatment by removing the bed linen from the bed and putting it on the floor next to it.³⁰

A similar problem presented itself with Kure’s idea of introducing “continuous bath treatment” (*jizoku yoku ryōhō* 持續浴療法) at his clinic, which was also prevented by lack of resources and staff.³¹ Apart from the use of strong sedatives, both “bed rest” and “continuous bath treatment” were essential measures when clinic directors like Kure were aiming to enforce a no-restraint policy (i.e. no use of straitjackets or chains). This shift from physical violence and movement restriction, which many nineteenth-century physicians regarded as backward and uncivilized, allowed clinic directors to present themselves as progressive by employing other means of violence that were deemed purely medical, treatment-oriented, and non-violent in nature. However, there seems to have been a disagreement between Kure and the urban administration about the level of psychiatric modernity that was seen as appropriate and necessary for a city asylum.

The modern touch of restraining methods was not a high priority for city authorities, who were quite content to rely on the existing isolation wards of the Sugamo clinic, which Kure tried to abolish. The city governors were less concerned with Kure’s image as a progressive psychiatrist and the Sugamo clinic as a modern institution than with costs and public safety. On the whole, Stieda was only partly convinced of his Japanese colleague’s experiments and ambitions, concluding that a psychiatrist engaged in the construction of his hospital should eventually shape his institution in accordance with the customs and requirements of his people.³² Kure’s struggles with the local authorities of the city of Tokyo not only shed light on different attitudes towards the appropriate management of the insane, but also point to diverging views on how much the national government’s modernization (and Westernization) project should transform Japanese society and everyday life.

A few years before Stieda documented Kure’s conflict with the Tokyo city authorities, the director of the Heidelberg clinic was experiencing his own bureaucratic and administrative fights that would cause repercussions well beyond the boundaries of Imperial Germany. At the time when Kraepelin assumed professorship at the Heidelberg University clinic in 1891, the rivalry between academic clinics and state asylums was still an ongoing process. However, the tensions with regard to jurisdiction over psychiatric patients were

30 Kure tried to counter this behavior by removing the tatami flooring from the rooms with European beds to discourage people of sleeping on the floor (Stieda, “O psichiatrii v Japonii,” 266).

31 Stieda, “Nihon no seishinbyōgaku,” 42. “Continuous bath” therapy was a popular hydrotherapy of the nineteenth and twentieth centuries where the patient was required to spend several hours in a bathtub (sometimes in combination with sedatives) that was filled with constantly warm or cold water. Patients’ negative reactions to this treatment are described in Ingrid von Beyme and Sabine Hohnholz, *Vergissmeinnicht: Psychiatriepatienten und Anstaltsleben um 1900*, Aus Werken der Sammlung Prinzhorn [Forget-me-not: Psychiatry Patients and Asylum Life around 1900] (Berlin and Heidelberg: Springer, 2018), 67–9, 79–90.

32 Stieda, “Über die Psychiatrie in Japan,” 520.

further aggravated when Kraepelin increased the number of admissions at his clinic and thus made the existing overcrowding problem even more urgent.³³ The Heidelberg clinic was part of the mental health care system of the German state of Baden and was responsible for admitting mentally ill patients directly. Two other institutions (the asylums of Emmendingen and Pforzheim) served as long-term hospitalization facilities and accepted patient transfers from Heidelberg to relieve the pressure from the clinic. A necessary condition for effectuating such a transfer was a diagnosis attesting that the patient's affliction was chronic or incurable.³⁴ Diagnosis and hospital management were thus closely linked within the mental health care system in which Kraepelin operated.

These circumstances had led to disputes between the Heidelberg University clinic director and the asylum directors of Emmendingen and Pforzheim over issues of patient transfers. Soon after arriving in Heidelberg, Kraepelin complained to the state ministry that overcrowding at his clinic negatively affected the quality of teaching and research. In 1893, he insisted that transfer regulations should be reformed and that the Heidelberg clinic as a university institution should be granted more autonomy in the management of patient transfers.³⁵ This request was denied by the local authorities with reference to existing regulations of the state of Baden which handled the distribution of patients according to the criterion of curability.

It was in these circumstances that Kraepelin redesigned his classification of mental disorders and proclaimed prognosis to be the true calling of the "modern psychiatrist." At the conference of the Association of German Alienists in 1896 (discussed in chapter 1), he appealed to his colleagues, saying that it was first and foremost the reliability of the prognosis that was crucial for guaranteeing the trust of the public in the discipline of psychiatry, for the reputation of the psychiatrists in court, and for the possibility to teach the subject to students.³⁶ Whereas this line of argument pointed out why prognosis was so important for the image of the psychiatrist and his discipline, it failed to explain why it was correct to assume that diseases with the same prognosis should belong into the same category from an epistemological point of view. In other words, it did not explain why prognosis should be indicative of disease boundaries between naturally occurring disease entities.

Kraepelin's prognosis-oriented approach was criticized by several people in the audience, most notably Friedrich Jolly. He pointed out that prognosis was not a key criterion for disease formation in other branches of medicine, and he saw no logical reason why this should be different for the discipline of psychiatry.³⁷ General practitioners do not,

33 Eric Engstrom, "The Birth of Clinical Psychiatry: Power, Knowledge, and Professionalization in Germany, 1867–1914" (PhD diss., University of North Carolina, 1997), 319–22.

34 E. Engstrom, 347–8.

35 E. Engstrom, 330–3.

36 Kraepelin, "Ziele und Wege der klinischen Psychiatrie," 842.

37 See Jolly's response to Kraepelin's 1896 talk as well as his review of Kraepelin's textbook Aschaffenburg,

in fact, routinely create separate categories for afflictions (such as strokes or pneumonia) depending on whether their patients die, receive permanent damage, or completely recover. Kraepelin never attempted to refute this particular argument, but kept insisting that even though prognosis might not be essential for classifying disease, one could not deny its high practical utility.³⁸ The utilitarian thinking behind the new classification system was rarely expressed so bluntly. Institutional pressures had created a situation in which the unpredictability of mental illness had become a major problem for hospital administration.

In the existing system, predicting the outcome of a disease had not been a high priority. Thus, a patient diagnosed with melancholia could be expected to recover or to get worse, depending on his or her mind's resistance as well as external factors. There was no available system of signs to predict the outcome of a wide range of conditions, and there was no other option than to wait and observe how the condition developed. Accordingly, patient transfers could only be effectuated after a certain period of time, when signs of terminal disease had become manifest in Heidelberg. Dissatisfied with these circumstances and determined to speed up patient transfers from his clinic, Kraepelin determined in 1893 that the prognosis should no longer be made after four weeks of observation but immediately after the first examination of the patient.³⁹ However, in order to be able to make a diagnosis this early, it was necessary to devise new observation criteria for identifying incurable cases before the symptoms of irreversible mental debility were plainly visible. This goal was practically achieved by declaring earlier observation methods and differentiating criteria as erroneous and insignificant and by establishing a new hierarchy of truly "significant signs."

With regard to melancholia, Kraepelin claimed that his new system of "significant signs" allowed him to effectively differentiate between curable melancholia and incurable melancholia at a very early stage. Due to their different outcomes, he believed that the two melancholias actually represented two different kinds of mental illness, such that the curable melancholia should be considered part of manic-depressive insanity and the

Laehr, and Beyer, "Jahressitzung des Vereins der deutschen Irrenärzte am 18. und 19. September 1896 in Heidelberg," 845; Jolly, review of Kraepelin, *Psychiatrie* (5th edition), 1005. A similar critique was voiced following Kraepelin's 1899 talk in Ludwig Mann, "Bericht über die Sitzungen der Abtheilung für Neurologie und Psychiatrie der 71. Versammlung deutscher Naturforscher und Aerzte zu München vom 17.-23. September 1899" [Report on the Sessions of the Department of Neurology and Psychiatry at the 71. Meeting of German Naturalists and Physicians in Munich on September 17-23, 1899], *Centralblatt für Nervenheilkunde und Psychiatrie* 22 (1899): 584. Among Russian-speaking psychiatrists making this particular point see Serbskij, "K voprosu o rannem slaboumii (Dementia praecox)," 37.

38 See Kraepelin's response to his critic's comments in the conferences of 1896 and 1899 Aschaffenburg, Laehr, and Beyer, "Jahressitzung des Vereins der deutschen Irrenärzte am 18. und 19. September 1896 in Heidelberg," 847; Mann, "Bericht über die Sitzungen der Abtheilung für Neurologie und Psychiatrie der 71. Versammlung deutscher Naturforscher und Aerzte zu München vom 17.-23. September 1899," 584.

39 E. Engstrom, "The Birth of Clinical Psychiatry," 343.

incurable melancholia part of dementia praecox. The talk Kraepelin gave at the conference in 1896 and the textbook editions which he subsequently published in 1896 and 1899 served to popularize his new diagnostic scheme of new relevant signs, and it ultimately allowed him to deal with the institutional and administrative constraints at his clinic.

In addition to his more critical colleagues, some patients, asylum superintendents, and local politicians were also skeptical about Kraepelin's prognostic approach and its efficacy. In 1900, a deputy of the Baden Parliament reported in the session of 20 February that he had received serious complaints about the Heidelberg clinic. He drew attention to cases where patients had been transferred to the asylums "in a dilapidated state" (*in einem verwahrlosten Zustand*) and that some had been declared "completely demented" (*ganz blödsinnig*), when in fact they could have been released in a few weeks.⁴⁰ A few months later, the Ministry of the State of Baden accused the Heidelberg clinic of mismanagement in the case of the patient Wilhelmine Koessler. The ministry claimed that the patient had not been deloused prior to transfer to the Pforzheim asylum and that she had been declared incurable but was later declared completely recovered by the local physician. In his official report to the ministry, Kraepelin claimed that the actual cause of the problem was overcrowding at his clinic and that his actions had been justified in the face of the circumstances. During the examination of the patient, his assistant had come to the conclusion that Mrs. Koessler's affliction would presumably last a long time and that her case represented no interest for teaching. Kraepelin further declared that he categorically disagreed with the local physician's verdict and insisted that the patient was indeed incurable from a "scientific" point of view. This latter statement provides some insight into the matter surrounding the problematic label of "incurability."⁴¹

From the point of view of Kraepelin and his supporters, the incurable demented state of the patient (unanimously attested in all dementia praecox cases) usually escaped the untrained gaze of family members and "non-experts." The patients could thus return to their families, resume their work, and go on with their lives, and all the while only the Heidelberg experts were able to perceive the signs of debility: strange behavior, tics, and unmotivated acts (usually unmotivated laughter). The label of debility was also readily applied to patients who expressed indifference and did not show much emotional response. This lack of affect was perceived as a much more serious symptom than it is in present-day psychiatric discourse. The apparent loss of the emotional faculty was not interpreted as a *symptom* of dementia praecox but as its *result*. To nineteenth-century

40 "Badischer Landtag. BN Karlsruhe, 20 Februar. Zweite Kammer" [Landtag of Baden. BN Karlsruhe, February 20. Second Chamber], *Freiburger Zeitung*, February 22, 1900, no. 44, Zweites Blatt.

41 Kraepelin refrained from providing any details substantiating his view on the issue of diagnosis noting that it would require an overly lengthy explanation of a very technical nature. His letter to the ministry is included in Kraepelin, *Kraepelin in Heidelberg (1891–1903)*, 146–148.

observers, it indicated that the acute phase of the disease had already passed, leaving the patient in a state of debility.⁴²

Although the administrative need to use a classification system that was based on prognosis did not exist in Japan, since there existed neither an asylum network nor overcrowding issues, Kraepelin's new nosology still became very popular not only in the Tokyo clinic, where it was first introduced by Kure Shūzō around 1901, but also in many other parts of the world. This popularity may have been due to the fact that the new ideas were cast in a rhetoric of progress and "scientific modernity." Time and again, the claim that the new classification was based on empirical methods and was therefore putting psychiatry on a par with other scientific disciplines was repeated.⁴³ For the early-nineteenth-century physician, a "scientific" approach usually implied some sort of numbers-based evidence. Counting cases was a very convenient way of creating "facts" about the "kinds of people" that were being thus classified.⁴⁴ In particular, it was a combination of statistical record-keeping and measured observation that contributed to the popularity of Kraepelin's work.

The rhetoric of superior nosological aptitude is often reiterated in historiographic writing on Kraepelin and his textbooks. In the same manner in which Kraepelin is sometimes credited for having single-handedly invented our present-day psychiatric categories, he is also repeatedly lauded for having introduced the scientific means which made his discovery possible. This historical perception is closely tied to the myth surrounding Kraepelin's diagnostic cards (*Zählkarten*). Hagiographical accounts of Kraepelin's work tend to stress that it was thanks to these cards that he was able to empirically establish the existence of his new categories. As he had already proclaimed at the conference in 1896, he saw the main task and responsibility of psychiatrists as being to produce reliable prognoses for the diseases they studied; a position that he also propagated in his textbooks. In this talk, he had also claimed that he was able to make a significant contribution to this new direction of prognosis-oriented psychiatry by having observed the mental development of his

42 The ignorance of family members and non-experts is most explicitly mentioned by Gustav Aschaffenburg (1866–1944), Kraepelin's assistant in Heidelberg who originally examined Mrs. Koessler ("29. Versammlung der südwestdeutschen Irrenärzte in Heidelberg in der psychiatrischen Klinik am 26. und 27. November 1898" [29th Meeting of Alienists from South-Western Germany in the Psychiatric Clinic in Heidelberg on November 26–27, 1898], *Allgemeine Zeitschrift für Psychiatrie* 56, nos. 1–2 [1899]: 260). See also Kraepelin's textbook Kraepelin, *Psychiatrie* 5th ed., 426–427, 429–430. The significance of emotional deterioration (*gemüthliche Verblödung*) for the dementia praecox illness is described in "29. Versammlung der südwestdeutschen Irrenärzte in Heidelberg in der psychiatrischen Klinik am 26. und 27. November 1898," 258; Kraepelin, *Psychiatrie* 6th ed., 142–143.

43 Kraepelin, "Ziele und Wege der klinischen Psychiatrie," 840. This rhetoric was picked up by Miyake Kōichi, Kure's successor as the chair for psychiatry at Tokyo University (Miyake Kōichi 三宅鑛一, "Nihon ni okeru hakaki ni hassuru seishinbyō ni tsuite" 日本ニ於ケル破瓜期ニ發スル精神病ニ就テ [On Mental Illness Occurring in Puberty in Japan], *Shinkeigaku zasshi* 6, no. 4 [1907]: 171).

44 Ian Hacking, "Kinds of People: Moving Targets. British Academy Lecture," *Proceedings of the British Academy* (Oxford) 151 (2007): 305–7.

Heidelberg patients over the last five years (1891–1896) and having thereby collected 1,000 cases on diagnostic cards.

He further assured his listeners that the observations he made did not follow the usual habit of the clinical gaze still common among most of his colleagues. Symptoms like “hallucinations (*Sinnestäuschungen*), delusions (*Wahnbildungen*), and alterations in mood (*Stimmungsschwankungen*)” did not really matter for properly differentiating between diseases. It was quite other symptoms, he claimed, such as “flight of ideas (*Ideenflucht*), apprehension (*Auffassungsfähigkeit*), mental orientation (*Orientierung*), motor excitability (*motorische Erregbarkeit*), and inhibition (*Hemmung*)” that were allegedly truly significant (*wesentlich*) for identifying natural disease entities.⁴⁵

The epistemic value and clinical significance of Kraepelin’s original diagnostic cards has been a matter of debate among historians of medicine. Studies based on a re-examination of the existing cards have yielded differing and inconclusive results. According to Kraepelin’s own testimony, he was able to prove the existence of his two basic categories from a long-term observation (five years) of some 1,000 cases. The majority of these cases fell into one of four large categories: 215 cases of dementia paralytica (*Paralyse*), 175 cases of periodic insanity (*periodisches Irresein*), 164 cases of dementia praecox (*Verblödungsprocesse*), and 157 undiagnosed cases. Thus, the great dichotomy was allegedly established on the basis of observing and recording the course and outcome of 164 Heidelberg patients fitting the description of dementia praecox and of 175 patients who would eventually be diagnosed with manic-depressive insanity.

Whether the great dichotomy was, indeed, discovered in this process of recording and observing can no longer be ascertained. Engstrom and Weber expressed some serious doubts, arguing that the majority of Kraepelin’s cards (more than 54%), of which a set of 705 has been preserved in the historical archives of the Max Planck Institute of Psychiatry in Munich, did not contain any information on the course of the illness and that, consequently, Kraepelin could not have come to his conclusions based on the data recorded on the cards. It is also clear that Kraepelin was already working with the dementia praecox diagnosis in 1893, long before the end of the long-term observation period of five years (1891–1896) which supposedly yielded the results when he presented his findings in 1896. All these inconsistencies seem to confirm Engstrom and Weber’s suspicions that the “empirical findings” were based on “preconceived ideas” and that reference to the cards primarily served to enhance the credibility of the prognosis-oriented classification.

Another reason for the approach’s popularity is related to the practical use of prognosis-oriented classification. With Kraepelin’s emphasis on the early recognition of signs, the risk assessment could effectively be concluded with the first examination of the patient, which greatly facilitated hospital management and the distribution of resources. Much like in modern risk societies, the managing of mental health is increasingly governed by a

45 Kraepelin, “Ziele und Wege der klinischen Psychiatrie,” 841.

cost-driven, rather than a needs-driven, rationality. In present-day mental health care, a diagnosis is required to calculate the costs a patient is likely to produce, to estimate health insurance claims, and to predict the time a patient would be absent from work.⁴⁶ In Kraepelin's time, his new diagnostic scheme made mental health care easier to manage, not least because the label of incurability attached to the dementia praecox diagnosis sanctioned the non-treatment of a huge number of patients locked away in long-term hospitalization facilities.

2.2 Textbook Production and Intellectual Borrowing

Apart from the talks and discussions at various conferences (introduced in chapter 1), the main medium to promote Kraepelin's new ideas on psychiatric nosology was his textbook on psychiatry. In the fourth edition of his *Psychiatrie: Ein Lehrbuch für Studierende und Aerzte*, published in 1893, he introduced his first version of dementia praecox, which he then envisioned as an illness of degeneration.⁴⁷ In the fifth edition, in 1896, it was framed as a metabolic disorder, and in 1899 it became an umbrella term for diseases that affected young healthy people and resulted in dementia. It was also in this sixth edition of 1899 that manic-depressive insanity made its first appearance, marking the beginning of the Krepelinian dichotomy. These two categories (dementia praecox and manic-depressive insanity) were presented as naturally occurring disease entities with distinctive characteristics that could be clearly differentiated at an early stage by carefully following Kraepelin's diagnostic recommendations.

The dichotomy laid out in the textbook was supported by various claims, hypotheses, and analogies concerning the nature of the respective disorders and the adequate means for identifying and observing them. In agreement with earlier statements, Kraepelin argued that dementia praecox and manic-depressive insanity predominantly affected young adults and that both were marked by a characteristic course and outcome. While dementia praecox was perceived as the manifestation of a debilitating process that permanently eroded basic mental functions, manic-depressive insanity was allegedly a disease that was recurrent but did not leave the patient mentally disabled. The former was defined as damaging and incurable; the latter as merely temporarily impairing but curable in principle. As we have already seen, the rationality of conceptualizing disease categories on the basis of their curability was closely linked to the institutional system in which this dichotomy was created. Although Kraepelin's textbook of 1899 triggered fierce debates and remained controversial in academic circles, it also enjoyed enormous popularity and was soon translated into foreign languages.

⁴⁶ Rose, *Our Psychiatric Future*, 34.

⁴⁷ Emil Kraepelin, *Psychiatrie: Ein kurzes Lehrbuch für Studierende und Aerzte* [Psychiatry: A Short Textbook for Students and Doctors], 4th ed. (Leipzig: Verlag von Ambrosius Abel, 1893), 435.

In Japan, Kraepelin's dichotomy was first popularized by Kure Shūzō in his lectures at the Sugamo Mental Hospital, and the first rendition of Kraepelin's 1899 textbook in Japanese appeared in the guise of Ishida Noboru's 石田昇 (1875–1949) *New Psychiatry* (*Shinsen seishinbyōgaku* 新撰精神病学), published in 1906. It is a curious peculiarity of Japanese textbook history that, in the early years of psychiatric education at Tokyo University, the textbooks were always compiled by the assistants of the teaching professors. Therefore, the work which is most representative for Kure's teaching and practice is not the one which bears his name but the one that was compiled by his assistant Ishida. Kure's *Essentials of Psychiatry* (*Seishinbyōgaku shuyō* 精神病学集要), on the other hand, was written when Kure himself was still acting as an assistant and reflects the beliefs and theoretical assumptions of his teacher—the first professor of psychiatry at Tokyo University, Sakaki Hajime. The same teacher–student constellation can also be observed with the second psychiatry professor to teach at Tokyo in the short period between Sakaki's and Kure's time. Katayama Kuniyoshi's approach to mental illness can best be learned from studying *Psychiatry* (*Seishinbyōgaku* 精神病学), compiled by his assistant Kadowaki Masae in 1902.⁴⁸ Each of these three textbooks represents an affiliation of the Japanese professor with a school of thought in the German-speaking world, as each of them can be matched with a German psychiatry textbook.

Sakaki, Katayama, and Kure preferred different German textbooks to teach psychiatry at Tokyo University. When their assistants set out to produce Japanese-language teaching material, they created the first translations of these German-language works. The second volume of Kure's *Seishinbyōgaku shuyō* is closely modeled after Richard von Krafft-Ebing's *Lehrbuch der Psychiatrie*.⁴⁹ Kadowaki's *Seishinbyōgaku* is a faithful rendition of Theodor Ziehen's *Psychiatrie für Ärzte und Studierende*, and, as already mentioned, Ishida's *Shinsen seishinbyōgaku* follows Kraepelin's *Psychiatrie* for the better part of the book. However, none of these Japanese renditions are straightforward literal translations. The Japanese authors often chose a significantly different structure, omitted entire paragraphs, added sections from other works, and provided examples and illustrations from their own working context and experience.

48 On early Japanese textbooks on psychiatry, see Okada Yasuo, *Nihon seishinka iryōshi* 187 and Kaneko Junji 金子準二, *Nihon seishin byōgaku shoshi. Meiji hen, Nihon saiban seishin byōgaku shoshi* 日本精神病学書史. 明治篇, 日本裁判精神病学書史 [A Bibliography of Japanese Psychiatry: The Meiji Period, a Bibliography of Forensic Psychiatry] (Tōkyō: Nihon Seishin Byōin Kyōkai, 1965).

49 Richard von Krafft-Ebing, *Lehrbuch der Psychiatrie auf klinischer Grundlage für praktische Ärzte und Studierende* [Textbook on Insanity Based on Clinical Observations for Practitioners and Students of Medicine] (Stuttgart: Verlag von Ferdinand Enke, 1893). The situation is somewhat different in the case of the first volume of Kure's book. This volume provides a more general outline of psychiatry and its auxiliary disciplines. According to the preface, it was based on more than twenty different contemporary works from German, French, and British authors. On the other hand, Kure also heavily relied on Chinese and Japanese medical texts thus continuing the philological tradition of providing glosses for contemporary medical concepts from the classics.

Ishida's *Shinsen seishinbyōgaku* is a prime example of the translation and adaptation process involved in the making of a Japanese textbook. Although at first glance it appears to mostly follow Kraepelin's textbook, the chapters that provide detailed descriptions of the individual diseases are arranged in a different order. Whereas the diseases seem to be arranged according to etiological factors in Kraepelin's book, Ishida presents them in accordance with their relative occurrence in the patient population. Thus, more common diseases, such as dementia praecox (*sōbatsu chikyō* 早發癡狂) and manic-depressive insanity (*sōutsu kyō* 躁鬱狂) are treated at the beginning of the section, and the rarer ones are described at the end. More interestingly, certain paragraphs are not in fact based on Kraepelin's textbook but on Wilhelm Weygandt's (1870–1939) *Atlas und Grundriss der Psychiatrie*, published in 1902. Weygandt, one of Kraepelin's students, had studied the so-called mixed states of manic-depressive insanity that would later become important to Kraepelin's conception of the disease, and although his textbook hardly diverges from his teacher's doctrine, his sections on differential diagnosis are more detailed and more specific than Kraepelin's explanations. This may explain why Ishida chose Weygandt's text for all of his differential diagnosis chapters.⁵⁰

Another feature which comes to the fore in Kure's *Seishinbyōgaku shuyō* is the Japanese writers' attempts to link the medical concepts found in Western books with the medical past of their own country. The first volume of Kure's book contains an introduction to the anatomy and functioning of the brain, offers sections on genetics and degeneration, and familiarizes the student with diagnostic instruments and therapeutic methods. With this kind of content, it seems to be deeply rooted in a categorically materialist approach to the illnesses of the human mind. Yet the short parable presented in the preface of his book presents the whole topic of madness and insanity in a very different light: Kure quotes a passage found in the biography of the famously faithful Chinese official Yuan Can 袁粲 (420–477), recorded in the History of the Southern Dynasties (*Nanshi* 南史).⁵¹ The story features a “well of madness” (*kuang quan* 狂泉) and a wise king who took a very pragmatic stance towards the idea of being mad:

⁵⁰ The observation that Ishida's textbook was based on these two texts has also been made in Okada Yasuo 岡田靖雄, “Ishida Noboru *Shinsen seishinbyōgaku* no daiichiban kara daikuban made—sono naiyō no henshen” 石田昇『新撰精神病学』の第1版から第9版まで—その内容の変遷 [The Changes in the *Shinsen seishinbyōgaku* by Ishida Noboru from the First to the Ninth Edition], *Seishin igakushi kenkyū* 2 (1999): 27–33. In addition to these structural and compilational particularities, Ishida's textbook also features several photographs of mental patients actually treated in the Sugamo clinic, which tacitly reveal some of the differences between the Heidelberg and the Tokyo setting. With relation to melancholia, Kraepelin's book shows the picture of a depressed woman, which correlates with the prevalence of female patients diagnosed with this illness in Heidelberg, whereas Ishida's book contains the photograph of a melancholic man, which reflects the reverse gender distribution for this illness in Japan. This “statistical anomaly” with regard to melancholia and depression apparently prevailed in Japan until the 2000s (Kitanaka, *Depression in Japan*, 129).

⁵¹ The same text can also be found in the Book of Song, which covers the history of the Liu Song (420–479) from the period of the Northern and Southern dynasties (386–589).

One day the king realized that all of his subjects had drunk from the well of madness and had all become insane. Although he was the only truly sane person left in the kingdom, everyone else considered him to be mad and his subjects got increasingly worried about their ruler's health condition. Thus, he too decided to drink from the well of madness and as he became as mad as his people, there was no more difference between their states of mind and harmony was eventually restored in the kingdom.⁵²

With this opening Kure seems to offer a more relativistic view of madness, where insanity is more a matter of perspective rather than of biology; but just as importantly, his quotation from the Chinese Histories places his text within the textualist tradition of his Chinese and Japanese forebears. His "philological approach" becomes even more apparent in his attempt to find fitting translation words for the Western medical concepts that he discusses in his textbook. Some of the Japanese translation words are borrowed from classical Chinese texts such as Zhang Zhongjing's 張仲景 (150–219) *Essential Prescriptions from the Golden Cabinet* (*Jingui yaolüe* 金匱要略) or Xu Shen's 許慎 (c. 58–148) *Explaining Graphs and Analyzing Characters* (*Shuowen jiezi* 說文解字) and thereby establish a link between past and present medical knowledge. The quotations from Chinese materia medica and pharmacopoeia are undoubtedly proof of Kure's profound knowledge of the Chinese classics, but in order to "identify" Western concepts in Chinese classical texts, he also relied on the work of Japanese Dutch-trained physicians active in the not-so-distant Edo period.⁵³ This careful philological work did not necessarily prove that the Western concepts had already existed in Ancient China, but it shows an awareness of different medical traditions, all of which Kure could relate to in his own work.

Neither the tendency to showcase a historical awareness of a distant medical past, nor the practice of borrowing from other authors, was limited to Japanese authors and to Japanese textbook production. On the other side of the globe, hardly any nineteenth-century German psychiatrist could resist the urge to relate their work to Hippocrates (c. 460–c. 370 BC) or Aristotle (384–322 BC), thereby showcasing their educational attainment and erudition.⁵⁴ However, even though Kraepelin framed his nosological scheme as a continuation of traditions which originated in antiquity (i.e. Ancient Greek medicine),

52 Variations of this story are also known outside of China and Japan. Most popular is perhaps the rendition found in Khalil Gibran, *The Madman: His Parables and Poems* (New York: Alfred A. Knopf, 1918).

53 For example, Kure's entry for hypochondria (*shinki-byō* 心氣病) was copied from the "Memoir of Internal Medicine" (*Naika hiroku* 内科秘録) by Honma Sōken 本間棗軒 (1808–1872), a scholar who had studied medicine under the German physician Philipp Franz von Siebold (1796–1866).

54 See, for example, Krafft-Ebing, *Lehrbuch der Psychiatrie*, 35; Emil Kraepelin, *Allgemeine Psychiatrie* [General Psychiatry], vol. 1 of *Psychiatrie: Ein Lehrbuch für Studierende und Aerzte*, 6th ed. (Leipzig: Verlag von Johann Ambrosius Barth, 1899), 1; Georges L. Dreyfus, *Die Melancholie: Ein Zustandsbild des manisch-depressiven Irreseins* [Melancholia: A State of Manic-Depressive Insanity] (Jena: Verlag von Gustav Fischer, 1907), 1–2. Karl Jaspers's (1883–1969) affinity to philosophy is well known, so it is not surprising to find many references to Aristotle in his work (Karl Jaspers, *Philosophie* [Philosophy] [Ber-

he was much more indebted to his French and German contemporaries in terms of his conceptual framework. In his textbook, he acknowledged that the works of the German psychiatrist Ewald Hecker (1843–1909) and his teacher Karl Ludwig Kahlbaum on “hebephrenia” and “catatonia” served as an inspiration for his dementia praecox concept, which Kraepelin had divided into hebephrenic, catatonic, and paranoid forms by 1899. He also mentioned Jean-Pierre Falret’s (1794–1870) *folie circulaire* and Jules Baillarger’s (1809–1890) *folie à double forme* as precursors to his concept of manic-depressive insanity.

Ewald Hecker’s description of hebephrenia provided the blueprint for Kraepelin’s first version of the dementia praecox concept, introduced in the fourth edition. Hecker’s hebephrenia was structured around the idea of a never-ending, exaggerated state of puberty.⁵⁵ He described his young patients as volatile, foolish, and utterly childish: always inclined to philosophize, to rave about magniloquent ideas, or to use obscene language, these patients were unable to concentrate, to pursue a job, or simply to finish what they started; wasting their talents on fatuous endeavors, they followed their silly dreams without ever growing up. In parts, Hecker’s treatise reads like a study on the nature of adolescence and adulthood, and it is tainted by a strong personal dislike for anything not entirely serious and austere.⁵⁶

Hecker argued that the diagnosis of hebephrenia could in many cases be made from examining the patients’ letters alone, and consequently, he engaged in a meticulous analysis of their writing style and noted a curious combination of profanity with stilted language. On the one hand, he pointed out that some of his patients showed an inclination to use coarse language or provincial dialect—that they frequently inserted misplaced foreign words, favored all kinds of jargon, and chose blatant, obscene expressions. On the other hand, they showed a tendency for exuberance, a predilection for sentimental narration, a pseudo-poetic style, and an excess of hollow and inflated phraseology. Hecker was convinced that these stylistic flaws indicated a significant lowering of the patients’ writing style when compared to their actual educational level.⁵⁷

lin: Springer, 1948], 89, 110, 269, 810). Later generations of psychiatrists would continue the tradition of relating their own theories to the ancient classics. A prominent example is Hubert Tellenbach’s (1914–1994) reinterpretation of melancholia presented as an allegedly Aristotelian concept (Hubert Tellenbach, *Melancholie: Zur Problemgeschichte, Typologie, Pathogenese und Klinik* [Melancholia: On Its History, Typology, Pathogenesis and Clinic] [Berlin: Springer, 1961]).

55 Ewald Hecker, “Die Hebeephrenie: Ein Beitrag zur klinischen Psychiatrie” [Hebephrenia: A Contribution to Clinical Psychiatry], *Virchows Archiv für pathologische Anatomie und Physiologie und für klinische Medizin* 52 (1871): 420. In Hecker’s words: Through hebephrenia the “psychological process” of puberty virtually became a “pathological permanence” (Hecker, 400).

56 In fact, Hecker’s concept of hebephrenia seems in turn to have been related to older concepts such as “adolescent dementia” and “adolescent masturbatory insanity” that were originally developed by French degenerationists (Wallace, “Psychiatry and Its Nosology,” 69).

57 Hecker, “Die Hebeephrenie,” 403–405. The connection between literary criticism and psychiatry was examined in Yvonne Wübben, *Verrückte Sprache: Psychiater und Dichter in der Anstalt des 19. Jahrhun-*

Without explicitly incorporating the “arrested puberty” metaphor, Kraepelin copied Hecker’s description of hebephrenia and renamed the condition *dementia praecox*. In Hecker’s version, it already contained many of the elements that would later characterize the whole group of Kraepelin’s *dementia praecox* diseases. For one, Hecker had noted the rapid course of the affliction that quickly progressed towards debility.⁵⁸ Second, he insisted upon the distinction between significant and insignificant signs.⁵⁹ Third, he was very explicit about the very unfavorable prognosis of the disorder, which always resulted in dementia and was essentially incurable.⁶⁰ When Kraepelin restructured his textbook in the sixth edition and moved the chapter containing Hecker’s description of hebephrenia to the general introduction of *dementia praecox*, he transferred these hebephrenia-specific characteristics to all diseases affecting young people and ending in dementia.

Ludwig Kahlbaum’s catatonia was another disease concept hijacked by Kraepelin. In this case, the intellectual borrowing was even more profound than with Hecker’s hebephrenia. Kahlbaum’s catatonia concept was built around the image and mechanics of the “seizure” or “spasm” (*Krampf*).⁶¹ He differentiated between tonic and clonic seizures and explained all physiological and psychological catatonia symptoms as an expression of either tension or contraction.⁶² All of these symptoms would eventually become part of Kraepelin’s *dementia praecox* description, and many would be elevated to the rank of “catatonic signs,” a special class of “significant signs” that was a sure indicator of the *dementia praecox* illness. Kahlbaum’s description included verbigeration (*Verbigeration*), mutism (*Mutacismus*), catalepsy (*Katalepsie*), negativism (*Neigung zu Negationen*), stereotyped movements (*Bewegungsstereotypie*), schnauzkrampf (*Schnauzkrampf*),⁶³ automatic obedience (*Willigkeit*), and unmotivated acts (*unmotiviert Redewiederholung, unmotiviertes Lachen*).⁶⁴ It also contained contrasting de-

derds [Insane Language: Psychiatrists and Poets in the Asylum of the 19th Century] (Konstanz: Konstanz University Press, 2012).

⁵⁸ Hecker, “Die Hebephrenie,” 396.

⁵⁹ Hecker, 400.

⁶⁰ Hecker, 423.

⁶¹ Ludwig Kahlbaum, *Die Katatonie oder das Spannungsirresein: Eine klinische Form psychischer Krankheit* [Catatonia or Melancholia attonita: The Clinical Form of a Mental Disease] (Berlin: August Hirschwald, 1874), 50. Kahlbaum noted that a sequence or alteration of different mental states (mania, melancholia, stupor) was typical for both catatonia and general paresis but that these changes were accompanied by pathological processes in the motor division of the nervous system. While in catatonia, these motor-function anomalies have the nature of the “seizure,” in general paresis their common feature is that of “paralysis.” In contrast to these two disease forms, he described simple or genuine mania (usually leading to recovery) as an illness that could also present different mental states but without the motor-function anomalies (Kahlbaum, 87–88).

⁶² Kahlbaum, 44.

⁶³ This is a technical term where the German-language expression remains still in use. It is used to describe a grimace that resembles pouting.

⁶⁴ Kahlbaum, 39–49.

scriptions to differentiate catatonia from simple mania and melancholia, especially in the field of motor activity, which is affected in both afflictions. Thus, he set apart the catatonic's impulse to talk incessantly (*Redesucht*) from the maniac's urge to entertain his audience.⁶⁵ These and many other examples suggest that the roots of the "Kraepelinian dichotomy" were already contained in Hecker's and Kahlbaum's work, especially when considering that they had also studied circular insanity (*Cyclothymie, cyklisches Irresein*), which they considered to be conceptually different from hebephrenia and catatonia.⁶⁶

Generally speaking, Kraepelin not only copied the description of symptoms but, in some instances, also the rationale and rhetoric attached to the new concepts. He very successfully adopted Hecker's and Kahlbaum's rhetoric of the "clinical method" (*klinische Methode*) with which the two had intended to set apart their classification and observation practice from other schools and practitioners. The clinical method implied a focus on the course of the whole illness (longitudinal approach) instead of a description of individual episodes.⁶⁷ The model for determining what exactly constituted a "disease entity" and how to differentiate significant signs from insignificant ones was the well-established concept of general paresis.⁶⁸ Apart from the classification method, Kraepelin also mimicked their emphasis on the "importance of prognosis," and their insistence that this method allowed differentiation between simple mania and melancholia and those manic and melancholic states that would lead to hebephrenic or catatonic dementia.⁶⁹

In fact, this was exactly the kind of classification that Kraepelin needed to solve his administrative problems at the Heidelberg clinic. By incorporating Hecker's and Kahlbaum's ideas into his new textbook, he justified the clinical practice of early transfers

65 Kahlbaum, 36–37.

66 Ludwig Kahlbaum, "Ueber cyklisches Irresein" [On Cyclical Insanity], *Allgemeine Zeitschrift für Psychiatrie* 40, no. 3 (1884): 405–406; Ewald Hecker, "Die Cyclothemie, eine circuläre Gemüths-erkrankung" [Cyclothymia, a Circular Mood Disorder], *Zeitschrift für praktische Ärzte* 7 (1898): 6–15.

67 Kahlbaum, *Die Katatonie oder das Spannungsirresein*, V.

68 Hecker, "Die Hebephrenie," 395; Kahlbaum, *Die Katatonie oder das Spannungsirresein*, VII; Ewald Hecker, "Zur klinischen Diagnostik und Prognostik der psychischen Krankheiten" [On Clinical Diagnosis and Prognosis of Mental Diseases], *Allgemeine Zeitschrift für Psychiatrie* 33, nos. 5–6 (1877): 33; Emil Kraepelin, *Klinische Psychiatrie* [Clinical Psychiatry], vol. 2 of *Psychiatrie: Ein Lehrbuch für Studierende und Aerzte*, 6th ed. (Leipzig: Verlag von Johann Ambrosius Barth, 1899), 427. If symptoms such as "hallucinations" or "alterations in mood" were present in general paresis but not defining it, these symptoms were consequently disqualified from being considered pathognomonic (disease defining) for any other disease. Despite historical depictions of Kraepelin successfully singling out acoustic hallucinations as the defining feature of what later became schizophrenia, neither Kraepelin nor Hecker (from whom he borrowed the description) actually considered hallucinations to be of much importance. Hecker explicitly noted that acoustic hallucinations had "no pathognomonic significance" for hebephrenia (Hecker, "Die Hebephrenie," 406) and Kraepelin would later repeat this line of thought (Kraepelin, "Ziele und Wege der klinischen Psychiatrie," 841).

69 Kahlbaum, *Die Gruppierung der psychischen Krankheiten und die Eintheilung der Seelenstörungen*, 174–175; Hecker, "Zur klinischen Diagnostik und Prognostik der psychischen Krankheiten." See also footnote 61.

and, at the same time, popularized the longitudinal approach well beyond Heidelberg and Germany. In practice, this meant that while Kraepelin was preaching the significance of the longitudinal approach, he was effectively practicing speed-diagnosis at his clinic. When these ideas were taken up by other psychiatrists, there was often the impression that Kraepelin was the sole and ingenious architect behind these innovations.

In Japan, the impression that Krapelin had single-handedly revolutionized psychiatry was definitely conveyed in one of Kure Shūzō's earliest lectures as professor at Tokyo University. In his talk, Kure explained to his students and assistants that he now considered both mania and melancholia to be obsolete. The lecture was written down by his assistant Matsubara Saburō and published in the *Iji shinbun* 醫事新聞, a medical journal that regularly printed contributions by Tokyo University professors. Kure was one of the more prolific writers who published in this journal, and he made sure that his new ideas would be heard outside of the classroom and reach a wider audience:⁷⁰

夫故發揚を主徴とする躁狂と抑鬱を主症とする鬱狂とは共に全く極端に走れる病氣で兩者毫も相容れざろ無關係の病氣であると云ふのが、往時からの思想であるのみならず、現今でも斯く固信する人が尠くないのであります。

然ろに世人が相容れざろ兩極端の病氣と見做して居る所の躁狂と鬱狂とを合併して同種の精神病なりと斷言した學者が出て來ました。即ち獨國ハイデルベルグのクレペリンKraepelin其人であります。此人は從來及現今も世人が襲用して居る躁狂Manie 及鬱狂Melancholie の名稱を廢して此兩者を合併し、之に躁鬱狂Manischdepressives Irresein といふ病名を冠せしめました。同氏の學説は誠に大膽なる論斷で、又斬新なる卓見であります。⁷¹

The view that mania (with exaltation as the main symptom) and melancholia (with depression as the main symptom) are seen as opposed illnesses that have nothing in common is not merely an opinion of the past. Even nowadays, there are not few people who firmly believe this.

But there was one scholar who succeeded in uniting mania and melancholia, which common people have seen as incompatible, diametrically opposed illnesses. He was able to assert that these two represented one and the same illness. This man was Kraepelin from Heidelberg in Germany. He discarded the disease names mania and melancholia that have been adopted by

⁷⁰ On the journal, see Onodera Shunji, "Past and Present of Japanese Medical Journals," *Bulletin of the Medical Library Association* 46, no. 1 (1958): 78.

⁷¹ Kure Shūzō 呉秀三, "Hatsuyō jōtai" 發揚狀態 [Manic States], *Iji shinbun* 617 (1902): 1004. The extra marks are in the original text as well as the German terms.

the common people, united both into one and gave it the name of manic-depressive insanity. The theory of this man was truly bold and highly original.

It becomes clear from this description that Kure saw Kraepelin's innovations as the revelation of a hidden truth about mental illness that less knowledgeable people just did not or would not see. He portrayed these so-called "common people" as superstitious, nescient, and unenlightened types of people who "believed" in old myths, whereas "the scholar" Kraepelin had already "asserted" new facts. One intention behind this kind of framing could be to present the new theories as state-of-the-art and progressive and to convey the feeling that the students were learning something that would truly set them apart from other, less knowledgeable practitioners. It holds the promise of becoming experts and joining the community of professionals. Another aspect was that Kure's depiction of the new theories had a strong focus on Kraepelin's persona, which allowed him to suggest that the quality of the new knowledge was tied to the authority and credibility of its creator.⁷² This particular aspect of relating the new medical concepts to Kraepelin's personality was not only a characteristic of Kure's classroom presentation but had also appeared in the conference debates discussed in the previous chapter.

However, Kure's depiction of Kraepelin's individual achievements was blown out of proportion. Indeed, at the Munich Conference of 1899 (which Kure had attended during his visit to Europe), Kraepelin had truthfully indicated that his conception of manic-depressive insanity was building on the previous work of other psychiatrists. His claimed predecessors were the French psychiatrists Falret and Baillarger, who had already described a disease form of alternating states of mania and melancholia independently of each other in the 1850s.⁷³ Since then, the concept had been investigated and further developed by other psychiatrists, and although there were disagreements on the exact nature of the disease, the "alternating disease form" had become part of the psychiatrist's repertoire in many European countries and worldwide.⁷⁴

Although the credit for the discovery of an alternating disease form does not belong to Kraepelin, he had united the two disorders in a different way. Kraepelin had argued that all cases of mania and melancholia were periodic in nature and that it was not necessary to distinguish between simple, periodic, and circular forms. By blurring the distinc-

72 A certain reverence for Kraepelin and an emphasis on his personal traits is also very prominent in other works of Kure where he speaks of Kraepelin's selfless character and capacity to take in other people's criticism in the name of scientific progress. (Kure Shūzō 呉秀三, "Sōutsubyō oyobi taishūki utsuyū ni tsukite" 躁鬱病及退收期鬱憂病二就キテ [On Manic-Depressive Illness and Involutional Melancholia], *Nisshin igaku* 1, no. 10 [1912]: 57–58).

73 Kraepelin, "Die klinische Stellung der Melancholie," 327. On their dispute as to who was the true discoverer of this disease form, Pierre Pichot, "The Birth of the Bipolar Disorder," *European Psychiatry*, no. 10 (1995): 1–10.

74 Berrios, "Melancholia and Depression during the 19th Century," 301–302.

tion between two different conceptual changes (the French and the Kraepelinian), Kure made Kraepelin appear as a more industrious nosologist than he actually was. In fact, Kraepelin's contribution to nosology has often been misinterpreted because he coined the term manic-depressive insanity. The term seems to refer to the modern concept of bipolar disorder, when in fact, from our present-day perspective, it would contain both bipolar disorder *and* unipolar depression.⁷⁵

If the work of the German and French psychiatrists is considered and Kraepelin's intellectual borrowing from them is duly acknowledged, his own more modest contribution to the conceptual formation of the "great dichotomy" becomes more easily discernible. Besides popularizing Hecker's and Kahlbaum's longitudinal approach to mental illness, Kraepelin united hebephrenia and catatonia (to which he later added the paranoid form) by stressing the common aspect of mental deterioration. He provided a hypothetical explanation for this one deterioration process by suggesting that its cause might be due to a yet unknown and untraceable internal intoxication that was supposed to stand in relation to processes localized in the sexual organs.⁷⁶

The allusion to toxins and intoxication was a recurring theme in Kraepelin's description of the concept. Earlier in his career, Kraepelin had held aspirations of following in the footsteps of Wilhelm Wundt (1832–1920) and studying the workings of the mind by means of experimental psychology. In the 1880s, while working in Wundt's laboratory in Leipzig, he had been engaged in the investigation of what could nowadays be described as "pharmacopsychology," the study of the effects of recreational and medical drugs on mental processes.⁷⁷ When Kraepelin eventually became a psychiatrist, he transferred his knowledge of psychoactive substances to the psychiatric clinic. In his programmatic speech, held in 1896 in Heidelberg, he stressed the similarities between the mental states caused by poisons such as alcohol, morphine, and cocaine.⁷⁸ Taking this group of diseases of intoxication as a model, he concluded that a similar grouping was justified in the case of the dementia praecox forms. Later, in his textbook of 1899, Kraepelin again argued that these poisons caused very similar disturbances that led to a reduction of volitional impulses. According to him, patients under the influence of alcohol, morphine, and cocaine showed a considerable lack of motivation and initiative that was also very prominent in the later stage of dementia praecox.⁷⁹ Although the intoxication analogy ac-

75 Shorter mentions that these two conceptually different disorders are often incorrectly conflated (Shorter, *What Psychiatry Left Out of the DSM-5*, 165).

76 Kraepelin, *Klinische Psychiatrie*, 203–204.

77 Emil Kraepelin, "Über die Einwirkung einiger medicamentöser Stoffe auf die Dauer einfacher psychischer Vorgänge" [On some Medical Substances' Influence on the Duration of Simple Mental Acts], *Philosophische Studien* 1 (1883): 417–462, 573–605; Jüri Allik, "Why was Emil Kraepelin not Recognized as a Psychologist?," *Trames* 20, no. 4 (2016): 373–374; Eric Engstrom, "Tempering Madness: Emil Kraepelin's Research on Affective Disorders," *Osiris* 31, no. 1 (2016): 168–170.

78 Kraepelin, "Ziele und Wege der klinischen Psychiatrie," 841.

79 Kraepelin, *Allgemeine Psychiatrie*, 203–204.

counts for some of the disease's characteristics, such as its sudden onset and swift course, it does at times seem accessory when other parts of the description are considered.

Upon careful examination of the hitherto-much-ignored first volume of Kraepelin's textbook, the dementia praecox concept appears much less the "purely clinical" and "descriptive" disease form that other authors have made it out to be.⁸⁰ There are several sections in which Kraepelin addresses the "common nature" of seemingly opposed dementia praecox symptoms that indicate his strong affinity with Wundtian associationist psychology.⁸¹ Whereas Kahlbaum's arguments were guided by the metaphor of the "seizure," which explained the co-occurrence of negativism and automatic obedience on the one hand and catalepsy and stereotyped movements on the other, Kraepelin relied on the concept of the "goal idea" (*Zielvorstellung*) that, in associationist theory, was supposed to give sense and direction to all action.⁸² According to Kraepelin, the starting point of every action was such an idea of purpose. However, the "goal idea" was always accompanied by emotions that translated into drives. The direction of all action was thus governed by the content of the "goal idea," while the action's force was governed by the intensity of the accompanying emotions.⁸³ The same explanatory schematic was used to account for the incoherence of speech in dementia praecox patients. Here, the thought process was believed to be disrupted and disturbed by a lack of "goal ideas" that would otherwise give order and direction to the patient's train of thought.⁸⁴

In view of these different statements, dementia praecox appears as a disease that is characterized by an absence of goal ideas during its acute phase and by an increasing loss of emotional activity during its later stage that is allegedly caused by yet unidentified toxins. However, none of this theorizing about general causes and the common root of symptoms had much practical value for psychiatrists. In singling out dementia praecox cases from the multitude of other mental health patients, psychiatric practitioners did not rely on the presence of some unknown toxins or some abstract associationist theories. Rather, they would follow the list of symptoms that had already been put together by Hecker and

80 Wallace, "Psychiatry and Its Nosology," 71; Edward Shorter, *A Historical Dictionary of Psychiatry* (New York: Oxford University Press, 2005), 272; Andrew Scull, *Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from the Madhouse to Modern Medicine* (Princeton: Princeton University Press, 2015), 265.

81 Wundt referred to his own theoretical approach as "voluntaristic" to differentiate it from the "intellectualism" of faculty psychology, associationism, and Herbartian psychology (Martin Kusch, *Psychologism: A Case Study in the Sociology of Philosophical Knowledge* [London and New York: Routledge, 2005], 134). A key difference was Wundt's insistence on the existence of "apperception," a superordinate mental function that directed attention and gave direction to the train of thought.

82 Kraepelin, *Allgemeine Psychiatrie*, 218. Kraepelin's notion of the "goal idea" seems to be inspired by Wundt's apperception doctrine.

83 Kraepelin, 202.

84 Kraepelin, 146, 155.

Kahlbaum and look out for signs of negativism, mutism, stereotyped movements, and other easily observable anomalies.⁸⁵

In contrast, Kraepelin's contribution lies more in his framing of the symptoms within associationist theory and in dividing them according to units of analysis popular in experimental psychology. The tendency to prioritize symptoms that are measurable with instruments is much more significant for manic-depressive insanity, the second element of the great dichotomy. For various reasons, it was not the dementia praecox patients that were most frequently subjected to experimentation but, rather, the group of manic-depressive insanity patients. The very formation of this large category relied on a reconceptualization of the meaning of melancholic depression and manic exaltation in measurable and quantifiable terms that focused almost exclusively on the motor side of the affliction (such as inhibition and exaltation). Consequently, in Kraepelin's concepts, the insane person appears more like a broken machine than a living being suffering from mental pain and distress. In the next chapter, the effects of the experimental setting on the medical categories will be discussed in more detail, but it can already be noted that the fixation on measurable symptoms in manic-depressive insanity went hand in hand with Kraepelin's goal to devise a system of observation criteria that could speed up the diagnostic process.

In this chapter, I have demonstrated the intrinsic relationship between institutions and medical categories. In Germany, the emergence of the great dichotomy between dementia praecox and manic-depressive insanity was the result of institutional changes and of internal and external struggles related to the ongoing professionalization of the discipline. In Japan, the introduction of these conceptual innovations was not owed to a pre-existing global similarity in institutional conditions but to the Meiji government's comprehensive

85 This practical insignificance of Kraepelin's theories concerning the cause and nature of dementia praecox explains why psychiatrists such as Eugen Bleuler (1857–1939) could further develop this concept by relying solely on the description of symptoms. While Bleuler initially identified dementia praecox patients by focusing on motor anomalies, he later came up with his own hypothetical ideas about the nature and possible cause of the disease by studying the group of patients thus selected. Instead of making the lack of “goal ideas” responsible for the lack of coherence in the patients' thoughts and actions, he surmised that the associations themselves were cut into little pieces (*Zerreißen der Assoziationen in kleine Bruchstücke*), thus impeding normal thought and coherent action (Eugen Bleuler, “Die Prognose der Dementia praecox (Schizophreniegruppe)” [The Prognosis of Dementia Praecox (Schizophrenia Group)], *Allgemeine Zeitschrift für Psychiatrie* 65 [1908]: 457). He therefore coined the term “schizophrenia” to emphasize the common root of this process of cutting (*Zerreißen*) and splitting (*Spaltung*) in the disease (Bleuler, 436). In this sense, although there is a certain continuity in Kraepelin's and Bleuler's diagnostic practice, a divergence in their (posterior) conceptual explications constitutes a significant discontinuity. Eventually, Bleuler would mark out quite different symptoms as characteristic for the disorder and turn it into something new entirely. Nevertheless, they both drew from associationist theories, even though Bleuler had an even stronger inclination towards psychologizing abnormal behavior. Kraepelin's and Bleuler's “model of the mind” was therefore not as fundamentally different as Berrios and other historians have depicted it (Berrios, Luque, and Villagrán, “Schizophrenia,” 118).

modernization project and the ensuing establishment of a decidedly modern institutional framework. On a personal level, it was further propagated by the young professor Kure's intention to differentiate his teaching agenda from that of his predecessors and to carve out a name for himself as a progressive and modern psychiatrist.

On a conceptual level, I have reconstructed Kraepelin's indebtedness to other contemporary thinkers and highlighted the metaphors that guided their concept constructions, rather than retelling the story of Kraepelin as a single genius nosologist. The merging of different ideas about adolescence and motor anomalies coupled with theories derived from the research practices of experimental psychology created a heterogeneous concept of dementia praecox whose nature remained extremely ambiguous and open to interpretation for future generations of psychiatrists. The empirical methods and psychological experiments that accompanied the formation of the new concepts opened new possibilities for redrawing the boundaries of established disease forms. Kraepelin's great dichotomy profited from the prestige attached to the image of empirical methods and experimentation, but at the same time, those very same methods opened the door to challenges to the new classification. I will examine the implications of introducing the experiment into psychiatric practice in the following chapter.

3 Madness in the Laboratory and the Rise of Numbers

In the previous chapter, I have outlined how the emergence of the great dichotomy in psychiatric classification was related to changes in institutional structures and hospital administration. I have also shed light on some of the historical antecedents that fed into the newly created medical concepts. I have shown that their wide acceptance was due to their utility in managing the mentally ill, as the great dichotomy was perfectly tailored to satisfy institutional and administrative needs. Yet another crucial factor for the concepts' popularity was related to the rhetoric of "scientific progress," which was associated with the use of diagnostic cards and reliance on instruments to obtain numerical data on symptoms. Kraepelin's dichotomy has often been portrayed as marking the beginnings of "modern psychiatry," and sometimes this assessment was accompanied by the view that this modern psychiatry was characterized by a distinctively "scientific approach." By introducing dementia praecox and manic-depressive insanity, Kraepelin is usually credited for having created the first "modern," i.e. "scientific" classification of mental disorders.¹

For some medical historians, the unquestioned validity of these two concepts lies precisely in the novel and sophisticated methods that allegedly attested their existence. Even though Kraepelin was not the first to conceptualize the new disease forms, he is believed to have been the first to demonstrate their validity by the proper means. Before Kraepelin, the argument goes, "[no] one had ever approached the identification and classification of the insanities using a structured scientific method."² With assessments like this, Kraepelin's name and work is continuously instrumentalized to make claims about the state of present-day psychiatry.³ Proponents of this narrative are less concerned with the understanding of past historical knowledge than with psychiatry's current future and its precarious standing among other medical disciplines.⁴ Recourse to psychiatry's history is

¹ Shorter, *What Psychiatry Left Out of the DSM-5*, 21; Andreas Ebert and Karl-Jürgen Bär, "Emil Kraepelin: A Pioneer of Scientific Understanding of Psychiatry and Psychopharmacology," *Indian Journal of Psychiatry* 52, no. 2 (2010): 191–192.

² Noll, *American Madness*, 63.

³ Shorter, *What Psychiatry Left Out of the DSM-5*, 167.

⁴ In Noll's case, who has been quoted above, this fear of loss of credibility is expressed in a particularly clear way: "But if discrete conceptual boundaries between disorders can dissolve, so can the trust of the American public in psychiatry's claim to be a branch of medicine. [...] For more than a century dementia

made to argue that one should stick to Kraepelin's dichotomy *in the here and now* because he used empirical and scientific methods *in the distant past*.⁵

The labeling of Kraepelin's methods as "scientific" is crucial to this line of argument. In many historical accounts, this label is used as some kind of pan-historical honorific, curiously untouched by the passage of time and independent from the intellectual context which brought about the practices receiving this badge of distinction. It allows speakers to gloss over changes in standards of validity and obscures any differences in past and present methods and in possibilities of "being scientific."⁶ Current assumptions and trends serve as a yardstick to award this label to one historical figure but deny it to others, thereby primarily reconfirming personal tastes and contemporary beliefs while, at the same, time actively rewriting history.⁷ Historians critical of this present-centered view have been skeptical whether "current psychiatry [truly] live[d] in a Kraepelinian world" and are more inclined to assume that it was, rather, the history of psychiatry that was recast in the colors of the present.⁸

In this chapter, I will critically reexamine the "structured scientific methods" that Kraepelin allegedly applied to obtain the new classification. Instead of focusing on the dubious significance of Kraepelin's diagnostic cards (mentioned in the previous chapter), I will re-examine the psychometric experiments that were conducted in the Heidelberg laboratory and were used to support the new classification system. By revisiting the methods and practices of the nineteenth-century laboratories of Imperial Germany, I do not intend to reassess whether they are truly entitled to be called "scientific" by twenty-first-

praecox and schizophrenia have been the principal concepts that have kept American psychiatry tethered to scientific medicine." (Noll, *American Madness*, 285–286).

5 The same ahistorical approach can be found in works that refer to Kraepelin's methods in order to argue for quite the opposite: that present-day disease concepts should be rejected because of the nineteenth-century methods that created them. See, for example, Boyle's appeal to abandon the concept of schizophrenia because it "has been developed [...] in a way which bears little resemblance to the methods of construct formation used in medical and other empirical sciences" (Mary Boyle, *Schizophrenia: A Scientific Delusion?* [London: Routledge, 1990], 193).

6 For an impression of the range of modes of "being scientific" in history, see Daston & Galison's discussion of different epistemic virtues that governed scientists' thoughts and actions through the ages (Lorraine Daston and Peter Galison, *Objectivity* [New York: Zone Books, 2010], 18).

7 See, for example, the invocations of Kraepelin's name in Roger K. Blashfield, *The Classification of Psychopathology: Neo-Kraepelinian and Quantitative Approaches* (New York: Plenum Press, 1984); Nancy Andreasen, "The Evolving Concept of Schizophrenia: From Kraepelin to the Present and Future," *Schizophrenia Research* 28, nos. 2–3 (1997): 105–9; Heinz Häfner, "Schizophrenia: Still Kraepelin's Dementia Praecox?," *Epidemiologia e Psichiatria Sociale* 13, no. 2 (2004): 99–112.

8 The above quote is from German E. Berrios and R. Hauser, "The Early Development of Kraepelin's Ideas on Classification: A Conceptual History," *Psychological Medicine* 18, no. 4 (1988): 813. A similar statement has been made by Jablensky in 1995 (A. Jablensky, "Kraepelin's Legacy: Paradigm or Pitfall for Modern Psychiatry?," *European Archives of Psychiatry and Clinical Neurosciences* 245, nos. 4–5 [1995]: 186). A critique of these uses of the past has been articulated in Eric Engstrom and Matthias Weber, "Making Kraepelin History: A Great Instauration?," *History of Psychiatry* 18, no. 3 (2007): 267–273.

century standards. Considering the rift that separates our world from theirs, I would be surprised if it turned out that scientific practices had *not* changed over the last hundred years. Awarding a badge of honor to those historical figures who happen to appear closest to our (rather discordant) present-day views does not seem to do justice to the plurality of pathways and directions available to nineteenth-century actors.⁹ However, I intend to scrutinize the rhetorical use of the term “scientific” and disaggregate those practices that passed for nineteenth-century science in Kraepelin’s time from those that did not. Moreover, instead of interpreting the introduction of “instrumental objectivity” into psychiatric practice as proof of the scientific maturity of psychiatry as a discipline, I will show that this type of “metric fixation” was closely linked to the rise of the “culture of management” in asylums and mental hospitals that has been examined in the previous chapter.¹⁰

In the late nineteenth century, psychiatry did, indeed, witness a turn towards empirical methods, but the meaning of this shift should not solely be sought in the professionalization of the discipline. It has been argued that the recourse to the supposed objectivity of numbers usually takes place from a weakened position.¹¹ Numbers can obscure complex judgments and contestable assumptions by rendering them invisible and thereby incontestable.¹² This strategy has been described as “black-boxing,” used as a convenient device to establish trust and credibility.¹³ In the previous chapter, I have already sketched the institutional setting in which Kraepelin’s textbook was created and highlighted the insecure position of academic psychiatrists engaging in research in an atmosphere of rivalry and distrust. The recourse to earlier traditions and the illusion of continuity expressed in the textbooks can similarly be seen as a rhetorical strategy to establish credibility by referring to other authorities already invested with professional trust. In the following section, I will scrutinize the Heidelberg School’s claims to objectivity in their attempt to harness the “numbers-producing techniques” of the emerging field of experimental psychology. By re-examining the circumstances and processes in which the numbers were originally

9 For those who are inclined to think that establishing a connection between past and present scientific knowledge is (or should be) the primary task in a history of science approach, please refer to Antonella Romano’s short historiographical essay for an overview of the range of directions taken and the variety of research questions followed within the history of science since the 1990s (Antonella Romano, “Making the History of Early Modern Science: Reflections on a Discipline in the Age of Globalization,” *Annales. Histoire, Sciences Sociales* (English Ed.) 70, no. 2 [2015]: 313–34).

10 On “instrumental objectivity” see Daston and Galison, *Objectivity*. On “metric fixation” and its link to “the culture of management” see Jerry Z. Muller, *The Tyranny of Metrics* (Princeton: Princeton University Press, 2018), 37.

11 Theodore M. Porter, *Trust in Numbers: The Pursuit of Objectivity in Science and Public Life* (Princeton: Princeton University Press, 1995), xi, 12.

12 Rose, “Governing Risky Individuals,” 187.

13 Bruno Latour, *Science in Action: How to Follow Scientists and Engineers through Society* (Cambridge, Massachusetts: Harvard University Press, 1987), 131.

obtained, I will attempt to reopen the “black box” and shed light on the judgments and assumptions behind the metric operations.

Additionally, I will look into the ways and means that allowed the new approaches to take hold with the younger generation of psychiatrists and to become the norm on a global scale. I will show that some of the experimental techniques that will be discussed in this chapter were well suited to being performed in a classroom during patient demonstrations and that teaching the new observation practices together with the new medical concepts ensured the consolidation of the doctrines of the Heidelberg School and allowed for the transmission of its knowledge to the next generation of psychiatrists. In a parallel development, the knowledge transmission also worked on a geographical level, and Kure Shūzō proved essential in transposing the new practices to Japan, where he taught his own students in much the same way as the Heidelberg psychiatrists did. I will investigate how psychophysical research, textbook production, concept formation, and university teaching were intertwined and how all of these activities equally related to observing, testing, documenting, and presenting the patients of the clinic. Lastly, in investigating the relationship between research and presentation, I will examine the structure and language of patient demonstrations in Heidelberg and Tokyo, point out the strategies of guided observation, and highlight the performative character of this teaching format.

3.1 Research in the Laboratory

In the nineteenth century, mental illness was not only put under observation in the wards of asylums, in lecture theaters, on battlefields, in army barracks or military hospitals. Alienists, whose training often comprised a profound knowledge of the fields of pathology and neurology, sought to deepen their understanding of mental illness by extending their knowledge-seeking activities to the laboratory. They meticulously examined tissue, blood, and urine samples of hospitalized lunatics under the microscope and with the aid of an assortment of special chemicals. They regularly dissected the brains of their deceased patients, looking for traces of a diseased mind in the folds and layers of their organic matter. Such efforts were invigorated by the discovery of the cause of general paresis in the 1880s and instilled hope that the laboratory would yield more insights into the origins and workings of other mental disorders. However, when it became apparent that more spectacular findings of this kind were slow in coming, some psychiatrists ventured to explore other laboratory methods and turned their attention to experimental psychology, sometimes also referred to as experimental physiology.¹⁴

¹⁴ Especially in the French-speaking context, it was more common to speak of “experimental physiology.” For a short overview, see Jacqueline Carroy and Régine Plas, “The Origins of French Experimental Psychology: Experiment and Experimentalism,” *History of the Human Sciences* 9, no. 1 (1996): 73–84. For the American case, see James H. Capshew, “Psychologists on Site: A Reconnaissance of the History of the Laboratory,” *American Psychologist* 47 (1992): 132–142. For a contemporary description of existing

It is in this kind of laboratory that melancholia and other supposedly obsolete medical concepts were disassembled into “elementary mental processes” and ultimately lost their form as coherent mental diseases. The configuration of the experimental psychologist’s laboratory, together with its instruments and research practices, had its origins in rather diverse experimental settings, all with their different objectives and theoretical assumptions. When Kraepelin harnessed the practices of experimental psychology for the psychiatric clinic, he mainly referred to the work of Wilhelm Wundt, whose famous laboratory in Leipzig inspired many experimentally minded scientists, physicians, and philosophers. Even though Wundt was not the inventor of the reaction time experiment, nor the first to engage in mental chronometry, he popularized these practices and contributed to the institutionalization of psychology as a distinct field of research. Kraepelin, who was a former student of Wundt’s, was very enthusiastic about the emerging new discipline of experimental psychology at an earlier stage in his career.¹⁵ His other acclaimed predecessors were the physician Ernst Heinrich Weber (1795–1878), who had conducted empirical studies on the human perception of weight and sound, and the physicist Gustav Theodor Fechner (1801–1887), who turned these observations into mathematical form and thus made them calculable.¹⁶ While these earlier experimenters were primarily interested in the study of “normal mental phenomena,” Kraepelin attempted to apply their insights to the field of psychopathology. In this, he not only followed Wundt’s categories to describe the elements of mental activity (reflex, impulse, perception, apperception, cognition, association, judgment) but also his instructions on how to obtain reaction times for separate kinds of mental activity by using the subtractive procedure.¹⁷

German laboratories, see Victor Henri, “Les laboratoires de psychologie expérimentale en Allemagne,” *Revue philosophique* 36 (1893): 608–622.

15 On the connection between Wundt and Kraepelin see Hildebrandt, “Der psychologische Versuch in der Psychiatrie”; Hoff, *Emil Kraepelin und die Psychiatrie als klinische Wissenschaft*; A. H. A. C. van Bakel, “Über die Dauer einfacher psychischer Vorgänge: Emil Kraepelins Versuch einer Anwendung der Psychophysik im Bereich der Psychiatrie” [On the Duration of Simple Mental Acts: Emil Kraepelin’s Attempt to Make Use of Psychophysics in the Field of Psychiatry], in *Objekte, Differenzen und Konjunkturen: Experimentalsysteme im historischen Kontext*, ed. Michael Hagner, Hans-Jörg Rheinberger, and Wahrig-Schmidt Bettina (Berlin: Akademie Verlag, 1994), 83–105; Roelcke, “Laborwissenschaft und Psychiatrie”; Eric Engstrom, “La messende Individualpsychologie: Sur le rôle de l’expérimentation psychologique dans la psychiatrie d’Emil Kraepelin,” *Psychiatrie - Sciences Humaines - Neurosciences* 1, no. 2 (2003): 40–46; Eric Engstrom [Engstrom, Eric J.], “On Attitudes toward Philosophy and Psychology in German psychiatry, 1867–1917,” in *Philosophical Issues in Psychiatry III: The Nature and Sources of Historical Change*, ed. Kenneth S. Kendler and Josef Parnas, International Perspectives in Philosophy and Psychiatry (Oxford: Oxford University Press, 2015), 147–164.

16 Emil Kraepelin, “Der psychologische Versuch in der Psychiatrie” [The Psychological Experiment in Psychiatry], in *Psychologische Arbeiten*, ed. Emil Kraepelin, vol. 1 (Leipzig: Verlag von Wilhelm Engelmann, 1896), 1. On the history of mental chronometry, see especially Henning Schmidgen, *Hirn und Zeit: Die Geschichte eines Experiments 1800–1950* [The Brain and Time: The History of an Experiment 1800–1950] (Berlin: Matthes & Seitz, 2014).

17 There is an enormous number of studies on Wundt, as he is considered by many historians as the fa-

In Wundt's system, higher mental elaboration was understood as being compounded of the above-mentioned basic elements of mental activity.¹⁸ Because the individual elements were perceived as operating independently of each other, they could be studied in isolation, and the mental part-time for each one of them was believed to be fixed. Even though this method did not provide reliable numbers and reproducible results, Wundt's elementism still governed the experimental setting both in the Leipzig and the Heidelberg laboratories.¹⁹ Once the analyzing potential inherent in the elements of mental activity was transferred to the psychiatric clinic, the disease concepts began to change their shape in the process. Remnants of older conceptualizations, such as the divisions assumed in faculty psychology, gave way to new ways of compartmentalizing mental functioning and of reconceptualizing the boundaries of diseases.

The kinds of experiments conducted in Wundt's laboratory in Leipzig were designed to investigate the mental laws that governed human perception, thought, and action. In the field of perception and sensation, most experiments were related to vision. Examples include studies on the psychophysics of light and the excitation of the retina, on the psychophysics of color, on peripheral vision, on visual contrast, and on colorblindness. These were complemented by a few experiments dealing with auditory sensation, touch, and taste. Still other studies tackled the fields of attention, feeling, and association. Nonetheless, it was the "reaction experiments" and the studies on "mental chronometry" that received most acclaim and contributed to the fame of the Leipzig laboratory. These experiments included investigations into the times of different mental processes, the differentiation between sensorial reaction and muscular reaction, and the calculated time for the process of apperception.²⁰

ther of modern psychology. A classical study is Edwin G. Boring, *A History of Experimental Psychology* (New York: Appleton-Century-Crofts, 1950). Wundt was attempting to establish the new discipline of psychology within the field of philosophy thus making psychology an auxiliary discipline for the study of human thought and reasoning (Ash, "Academic Politics in the History of Science"; Mitchell Ash, "Psychologie in Deutschland um 1900: Reflexiver Diskurs des Bildungsbürgertums, Teilgebiet der Philosophie, akademische Disziplin" [Psychology in Germany around 1900: Reflexive Discourse of the Educated Middle-Class, Branch of Philosophy, Academic Discipline], in *Konkurrenten in der Fakultät: Kultur, Wissen und Universität um 1900*, ed. Christoph König and Eberhard Lämmert [Frankfurt am Main: Fischer-Taschenbuch-Verlag, 1999], 79–93). For more recent studies on Wundt see Mitchell Ash, "The Uses and Usefulness of Psychology," *Annals of the American Academy of Political and Social Science* 600 (2005): 99–114; Claudia Wassermann, "Physiological Optics, Cognition and Emotion: A Novel Look at the Early Work of Wilhelm Wundt," *Journal of the History of Medicine and Allied Sciences* 64, no. 2 (2009): 213–249; Schmidgen, *Hirn und Zeit*.

18 On the other hand, Wundt was skeptical whether the experimental method could be usefully applied to study higher mental functioning such as thought, volition, and emotion (Kurt Danziger, *Constructing the Subject: Historical Origins of Psychological Research* [Cambridge: Cambridge University Press, 1990], 36–37).

19 On the problems of applying the subtractive procedure in practice and on the critique of Wundt's elementism, see Boring, *A History of Experimental Psychology*, 149.

20 Boring, 340–342.

However, not all of these research agendas and experiments were appealing to psychiatrists. For their practical purposes, the Heidelberg experimenters mainly adapted the Wundtian reaction-time experiments in order to investigate the pathological phenomena of the disturbance of apprehension (*Störung der Auffassung*) and the disturbance of the release of the volitional impulse (*Störung der Auslösung des Willens*).²¹ Based on his earlier experiments with toxins, Kraepelin claimed that a combination of disturbances in these two fields could account for most of the pathological states that could be observed in mental illness. In fact, he assumed that intoxication was nothing but an artificially produced state of mental illness and that one could understand insanity through the study of the effects of poisons.²² According to Kraepelin, intoxication with alcohol, for example, was characterized by impeded apprehension coupled with a simultaneous facilitation of the release of the volitional impulse.²³ Suitable experimental approaches to investigate these mental states were tests designed to obtain the time for word-reactions (repeating a trigger word) and choice-reactions (pushing one of two buttons after hearing a trigger word).²⁴

The experimental psychology enthusiasts of the Heidelberg laboratory did not merely adopt the methods from Leipzig and other influential sites of experimentation such as Berlin (1886), Göttingen (1887), Giessen (1896), and Würzburg (1896).²⁵ Rather, they created their own experimental setups suited to the clinic, commissioned new instruments and apparatuses, and aimed to shape and promote the field of experimental psychopathology by publishing their own research results in a special series. The first issue of *Psychologische Arbeiten*, which featured a programmatic introduction and detailed descriptions of the experiments, appeared in 1896 and coincided with the fifth edition of Kraepelin's textbook on psychiatry, where the category of dementia praecox had already taken shape.²⁶ In the following section, I will point out the interrelations between the textbooks and the experiments and show how concept formation was linked to laboratory practice. I will

21 Kraepelin, "Der psychologische Versuch in der Psychiatrie," 9–10.

22 Kraepelin, "Über die Einwirkung einiger medicamentöser Stoffe auf die Dauer einfacher psychischer Vorgänge." On artificial madness, see also E. Engstrom, "Tempering Madness," 169–170.

23 Kraepelin, "Der psychologische Versuch in der Psychiatrie," 81–83.

24 Kraepelin, 9–10.

25 The numbers in brackets refer to the founding year of the respective laboratory. On the development of laboratories of experimental psychology in Imperial Germany see Ash, "Academic Politics in the History of Science." For practicing psychiatrists, the laboratory of the psychiatric clinic in Giessen directed by Robert Sommer was an important site of experimentation, although it is rarely mentioned in historical accounts on the development of experimental psychology (most notably it is absent from Boring's *History*). However, it was in Giessen that the German Society for Experimental Psychology was founded in 1904, and Sommer's *Textbook on Examination Methods in Psychopathology* was a source of inspiration for experimentally-minded psychiatrists (Sommer, *Lehrbuch der psychopathologischen Untersuchungsmethoden*).

26 Emil Kraepelin, ed., *Psychologische Arbeiten* [Works in Psychology], vol. 1 (Leipzig: Verlag von Wilhelm Engelmann, 1896).

begin with a particular experiment that was conducted with the help of a device specifically designed for the Heidelberg laboratory.

The Writing-Pressure Scale

The writing-pressure scale experiment appears both in the sixth edition of Kraepelin's textbook and the second issue of *Psychologische Arbeiten*, both published in 1899. Both texts argue that the measurements and graphs obtained in the experiment provide evidence for certain characteristics of the disease concepts that are under examination. Whereas the detailed experiment report documented by Adolf Gross (born 1868) provides most of the numbers and patient data that had been collected, the textbook merely quotes a few lines from that report and presents some selective data as generalized truths about the nature of manic-depressive insanity.²⁷ Both texts present an incomplete account of the numbers-producing technique, but the black-boxing effect is much more pronounced in the textbook because it completely decontextualizes the numbers and elides the scope of the experiment, making it impossible to judge whether the generalizations are justified.²⁸

Following the new hierarchy of significant clinical signs allegedly obtained through statistical record keeping and longitudinal observation, Kraepelin's textbook presents the disease categories dementia praecox and manic-depressive insanity in a descriptive style that coincides with the new system. To supplement these categorizations, the textbook refers to various experiments conducted at the Heidelberg laboratory and thereby offers evidence in the form of charts and figures that are supposed to attest to the empirical, "scientific methods" that were employed to obtain objective observations. Figure 3.1 shows one example of such a chart used for argumentative purposes in the textbook of 1899.²⁹ It supposedly exemplifies characteristics of the symptoms of inhibition and motor excitability obtained through Gross's experiments with the writing-pressure scale. In the textbook, this figure is mainly employed to support Kraepelin's argument that mania and melancholia are in fact manifestations of one single disease (instead of two), namely, the newly coined manic-depressive insanity category, because patients from this group exhib-

27 Adolf Gross, "Untersuchungen über die Schrift Gesunder und Geisteskranker" [Examination of the Writing of the Healthy and the Insane], in *Psychologische Arbeiten*, ed. Emil Kraepelin, vol. 2 (Leipzig: Verlag von Wilhelm Engelmann, 1899), 450–567.

28 The graph of the writing-pressure scale experiment in Kraepelin's textbook has been mentioned in Monika Ankele, "Ausdrucksbewegungen im Fokus des psychiatrischen Blicks um 1900" [Gestures as Focal Point of the Psychiatric Gaze around 1900], in *Wissen und Nicht-Wissen in der Klinik*, ed. Martina Wernli (Bielefeld: Transcript, 2012), 87–114. However, the author does not refer to Gross's original article and denies any connection between experimentation and Kraepelin's classification, mainly relying on the general assessment made in Hoff, *Emil Kraepelin und die Psychiatrie als klinische Wissenschaft*.

29 Kraepelin, *Klinische Psychiatrie*, 373.

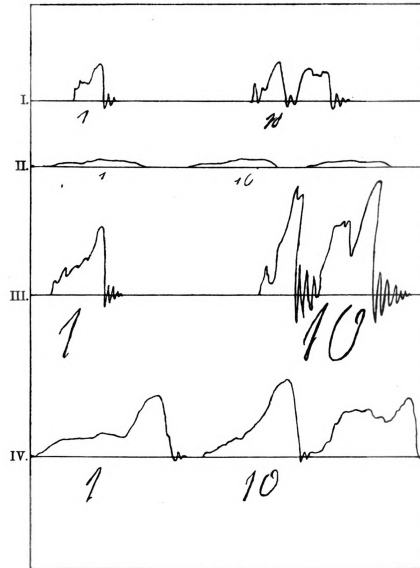


Figure 3.1: Writing-pressure curves in Kraepelin's textbook, 1899

ited the same kind of disturbance in the symptoms of inhibition and motor excitation. However, this presentation is skewed at best, as I will show in the following.

The reference to the psychometric experiment illustrates Kraepelin's mechanistic understanding of the concepts of "inhibition" and "excitation" as well as their relevance for the medical category of manic-depressive insanity. The four graphs (I–IV) in Figure 3.1 represent four different tests in which a person was asked to write the figures "1" and "10" using a writing-pressure scale (for a depiction of such an apparatus, see Figure 3.2). The scale registers changes in the pressure and speed of the subject's writing. The recording is achieved through the use of a kymograph drum that is connected to the device.³⁰ When the writing is slow, the graph takes up more space on the horizontal axis, as can be seen in examples II and IV. Conversely, when the pressure is high, the graph extends in the vertical direction, as in III and IV.

³⁰ The graphic representation of organic and motor functions in the form of curves was a characteristic feature of the early phase of experimental physiology (Schmidgen, *Hirn und Zeit*, 244). On the history of the kymograph and graphic registration, see Hebbel E. Hoff and Leslie Alexander Geddes, "Graphic Registration before Ludwig: The Antecedents of the Kymograph," *Isis* 50 (1959): 5–21; Soraya de Chadarevian, "Die 'Methode der Kurven' in der Physiologie zwischen 1850 und 1900" [The "Method of Curves" in the Field of Physiology between 1850 and 1900], in *Die Experimentalisierung des Lebens: Experimentalsysteme in den biologischen Wissenschaften 1850/1950*, ed. Hans-Jörg Rheinberger and Michael Hagner (Berlin: Akademie Verlag, 1993), 28–49.

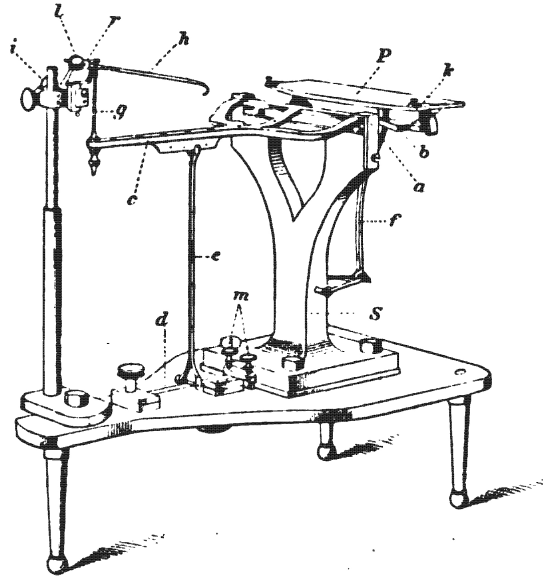


Figure 3.2: Diagram of writing-pressure scale

According to Kraepelin's account, graph I was produced by a healthy hospital nurse, graph II by a female patient in the depressed state, and graph III by another female patient in the manic state.³¹ When compared to the allegedly "normal" writing characteristics of the healthy nurse in graph I, the writing of the depressed patient shows "inhibition" in the form of lower pressure and lower speed. Conversely, the writing of the manic patient shows "excitation" in the form of higher pressure and higher speed. The fourth graph was produced by the same patient as in example III, but at the time of the experiment, the symptoms of mania were already receding. For Kraepelin, this meant that the patient exhibited a mixture of both "inhibition" and "excitation" simultaneously, because while the writing was slower than "normal" it was at the same time executed with higher pressure than "normal."³² In this line of argument, the "mixture" of "inhibition" and "excitation" was considered to be a clear illustration of the fact that the seemingly opposed clinical symptoms of mania and melancholia were closely related phenomena. In extension, it was taken to indicate that both were expressions of the same underlying disorder (*nabe verwandte Erscheinungsformen einer gemeinsamen Grundstörung*).³³

³¹ Kraepelin, *Klinische Psychiatrie*, 371–372.

³² For a historical discussion of the concept of the "norm," see Jürgen Link, *Versuch über den Normalismus: Wie Normalität produziert wird* [Essay on Normalism: How Normalcy Is Produced] (Göttingen: Vandenhoeck & Ruprecht, 2013).

³³ Kraepelin, *Klinische Psychiatrie*, 372.

However, this mode of argumentation is both reductionist and expansionist at the same time. It is reductionist in the sense that it severely limits the necessary range of observable proof required to draw conclusions about a subject's mental state, and it is expansionist in the sense that it overstates the significance of the limited data that the writing-pressure scale experiment allows one to gather. Indeed, it not only suggests that a conceptually central function of the mind, the so-called "volitional impulse" (*Willensantrieb*), is directly observable through peripheral outside phenomena, but it also equates "reduced writing speed" and "reduced writing pressure" with "inhibition," i.e. a dysfunction of a patient's volitional impulse. This double move allowed the Heidelberg experimental psychologists to draw conclusions about complex psychological phenomena such as volition and drive through an experimental device that was designed to document writing speed and writing pressure, nothing more.

This inference from the physical to the psychological was only possible because of pre-conceived assumptions about what disturbed motor functions can stand for in the mental sphere. Specifically, it was Wundt's notion of "psychophysical parallelism" that enabled these kinds of assumptions: through a handy inner-outer synchronicity, the whole nature of a state of depression, including a person's feelings, inner life, self-perception, and attitude towards the outside world could be reduced to a "simple" physical slowing of movement. In Kraepelin's new conception of the disease, "motor retardation" had essentially become the core defining symptom. The same mechanistic approach can be observed in the report by Gross, who employed the metaphor of a "broken clock" in order to describe the nature of manic-depressive illness. According to him, the symptom of inhibition could be compared to the defective mechanism of a clock whose "normal" working was continuously hampered by the friction of a chafing spring.³⁴

By comparing Kraepelin's textbook description with Gross's report, some of the generalized statements can be further contextualized. While the textbook presents the measured insights as universal truths, the original graphs were in fact based on a small series of experiments involving seventeen healthy nurses, three depressed patients, and four manic patients from the Heidelberg clinic conducted in March and April 1897.³⁵ By cross-referencing patient data in Kraepelin's textbook and Gross's article, the graphs reproduced in the textbook can be correlated with experiments involving Gross's patient no. 3 (graph II in Figure 3.1) and patient no. 4 (graphs III and IV in Figure 3.1). From Gross's report, we learn that the range for "normal writing" (*Gesundheitsbreite*) was established by

34 Gross, "Untersuchungen über die Schrift Gesunder und Geisteskranker," 566. Gross contrasted this image of a constant mechanical inhibition in manic-depressive patients with the complete "loss of harmony and rhythm" in dementia praecox patients. Building on his "broken clock metaphor," he suggested that catatonic patients were like clocks that were put out of order through a foreign body inside the clock, sometimes blocking the mechanism completely, sometimes allowing it to run on only to block it again in an unpredictable manner.

35 Gross, 458, 486, 500.

the observation of seventeen clinic attendants and that Gross considered the number of “normal tests” to be high.³⁶ According to him, the intelligence of the healthy test persons was more or less comparable to that of the patients because both groups predominantly belonged to the class of workers and peasants.³⁷ We also learn that the original experiment was composed of five different tasks: drawing four lines, making five dots, writing the small letter “m,” writing the numbers 1–10, and writing the seven numbers that are obtained by repeatedly subtracting 3 from 20 (20, 17, 14, 11, 8, 5, 2).³⁸ The healthy test persons performed these tests only once, but the patients were sometimes asked to repeat the test several times. These numbers provide a first insight into the construction of the normal and the pathological that form the basis of the depiction in Figure 3.1. Some other details reveal more about Gross’s reasoning and judgment and also show the selective nature of Kraepelin’s use of the graphs.

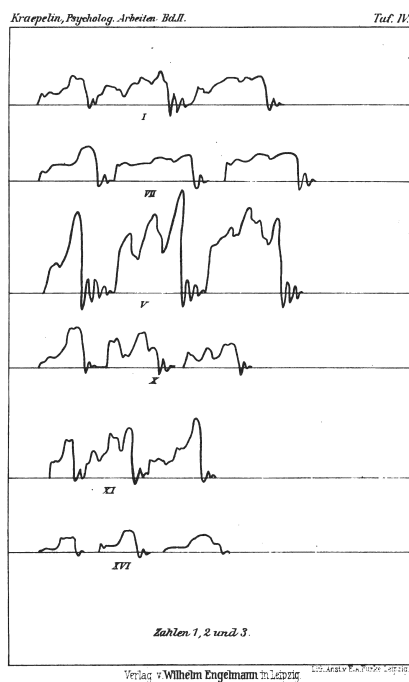


Figure 3.3: Curves produced by healthy staff in Gross’s study, 1899

All of the female staff members in Gross’s experiment (nine nurses) had small, accurate, and tidy handwriting. Gross observed that some of them were timid and shy during the

36 Gross, “Untersuchungen über die Schrift Gesunder und Geisteskranker,” 458.

37 Gross, 458.

38 Gross, 456–457.

test and were afraid of embarrassing themselves in front of the doctor and of making mistakes in the subtraction exercise.³⁹ Although this group of women wrote their numbers with less speed and pressure than the male staff, even here some variation in the writing style is discernible in the corresponding graph in Figure 3.3.⁴⁰ The same can be said for the female manic patients participating in the writing scale experiment. While patient no. 4 (Mrs. M. L., a 53-year-old lady) writes in big characters and with much pressure and speed, the graphs of patients no. 5 (Ms S. R., 46 years) and no. 6 (Mrs. K. S., 54 years) are much more flat (see Figure 3.4).⁴¹ From the wider range of writing samples contained in Gross's article, one can conclude that Kraepelin's choice was deliberately made to enforce his argument about manic exaltation and melancholic inhibition because in direct comparison, it becomes clear that he chose the most extreme example from among Gross's manic patients to enhance the visual effect of contrast.

Apart from the effect of selection, some more problematic aspects concerning the interpretation of the numbers and curves ought to be mentioned. As was not unusual at the time, Gross and Kraepelin show hardly any concern for the immediate context of the experiments, and the tests are presented as taking place in a discrete space, free from any internal or external influences that might distort the results. It was only later generations of experimenters who started to record factors such as attitude, medication, and mood, which are by now commonly perceived as exerting an influence on people's writing.⁴² Furthermore, if they ever considered extraneous factors at all, this was more likely to happen in the case of healthy test subjects who showed irregular test results, whereas the irregularities shown by mental patients were usually seen as direct reflections of insane minds.

On a more individualized level, Gross and Kraepelin seem to pay little heed to their patients' professional background and the wider context of the phenomena that they record as well. For instance, whereas both of them agree that the female patient No. 4 has "patho-

³⁹ Gross, 458.

⁴⁰ The graph represents the curves resulting from writing the numbers 1, 2, and 3. The first three lines show the writing of men and the last three the writing of women.

⁴¹ The upper two lines are filled with graphs from patient no. 4 (4 lines followed by the numbers 1, 2, 9, and 10). The third line as well as the left side of the fourth line belongs to patient no. 5 (one line followed by the numbers 1, 2, 9, and 10, followed by the letter "m"). The remaining graphs represent patient no. 6's writing (the same numbers as above). There is a typo on the plate, but the attribution made in Gross's text is unambiguous. Gross mentions in the patient history of patient no. 4 that she was usually treated with continuous bath treatment during the day while she spent the nights in an isolation cell (Gross, 500).

⁴² Helmut Enke, *Der Verlauf in der Klinischen Psychotherapie: Probleme und Möglichkeiten einer objektivierenden Psychodiagnostik des Behandlungsverlaufs bei stationär psychotherapeutisch behandelten Patienten mit Organfunktionsstörungen und psychosomatischen Erkrankungen* [Progression in Clinical Psychotherapy: Problems and Possibilities of an Objectifying Psychodiagnosis of the Course of Treatment for Patients Who Are in Stationary Psychotherapeutic Treatment with Organ Malfunction and Psychosomatic Affections] (Berlin: Springer, 1965), 34–35.

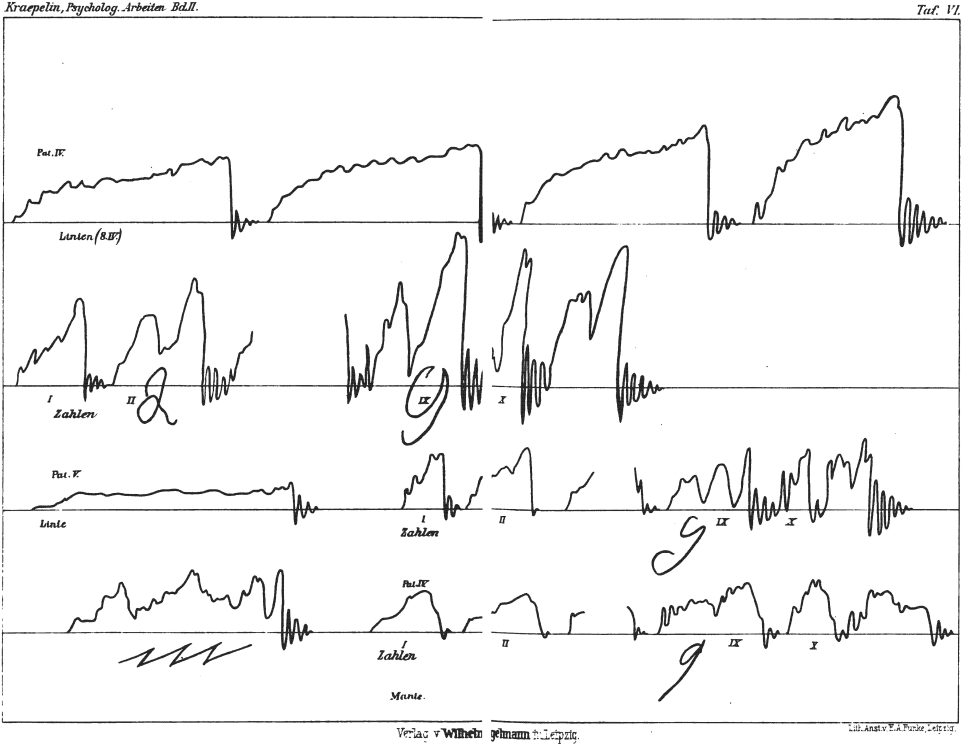


Figure 3.4: Curves produced by manic patients nos. 4, 5, and 6 in Gross's study, 1899

logically big handwriting” for a woman, they provide no evidence that she ever wrote in the same small and delicate record-keeping characters that the Heidelberg nurses used.⁴³ Since they did not bother to record her profession but Gross did note that most patients were from the working class, it is possible that she was working in a physically demanding profession or had otherwise no interest in neat scripture, and their failure to take any of this into account in their judgment reveals a blind spot in their perception of the plurality of contemporaneous female life styles more than it does anything else.⁴⁴

The Counting Test

Psychometric experiments, which Kraepelin emphatically recommended alongside the well-established laboratory practice of cerebral pathology, could provide empirical, objectively obtained evidence where the microscope still failed to yield results.⁴⁵ References to all sorts of experiments conducted by Kraepelin and his Heidelberg team can be found throughout the textbook. The section on patient examination, for example, contains the description of a method to establish disturbances in the field of attention. By letting the patient repeatedly subtract 7 from 100 while recording speed and potential irregularities, one could gain a measurable result of the patient’s attention capacity and distractibility.⁴⁶ Exactly the same method was used by Kraepelin’s student Adolf Gross to examine disturbances of attention in ten patients exhibiting various kinds of stupor (a state of mental and physical inertness).⁴⁷ The subtraction exercise and similar experiments (like counting from 1 to 20) were mostly conducted between the spring and fall 1896 and were intended to prove that the unresponsive, stuporous state in catatonic patients (*katatonischer Stupor*) was different in kind from the stupor exhibited by manic-depressive patients (*circulärer Stupor*).⁴⁸ Unsurprisingly, Gross’s experiment served to buttress Kraepelin’s dichotomous distinction between dementia praecox and manic-depressive insanity.

Without any context, Gross’s argument may sound convincing, but when his experiment description is more closely examined, it shows some noteworthy particularities: the experiment encompassed tests with three manic-depressive patients, two cases of general paresis, and five catatonic patients. The main argument relied on attesting the existence of “motor inhibition” or the lack thereof. The time measurements were performed with a stopwatch that allowed time to be read to the fifth of a second. According to Gross’s

43 Gross, “Untersuchungen über die Schrift Gesunder und Geisteskranker,” 509; Kraepelin, *Klinische Psychiatrie*, 374.

44 Gross, “Untersuchungen über die Schrift Gesunder und Geisteskranker,” 458.

45 Kraepelin, “Ziele und Wege der klinischen Psychiatrie,” 844. It has also been noted that Kraepelin was physically not fit to pursue laboratory work in cerebral pathology because of his poor eyesight (Scull, *Madness in Civilization*, 263).

46 Kraepelin, *Allgemeine Psychiatrie*, 276.

47 Adolf Gross, “Ueber Stupor” [On Stupor], *Allgemeine Zeitschrift für Psychiatrie* 53, no. 5 (1897): 857.

48 Gross, 856, 859.

observations, all manic-depressive patients showed “motor inhibition,” which in practice meant nothing more than that all three of his patients (*Patients I–III*) required more than approximately three to five seconds to speak out the numbers 1 to 20.⁴⁹ While detailed test results were given for the manic-depressive and general paresis patients, no numbers were offered to document the catatonic patients’ lack of “motor inhibition.”⁵⁰ Instead, Gros noted that a systematic examination was impossible because of the catatonic patients’ lack of cooperation.⁵¹ Lack of cooperation, or “negativism,” as Gross referred to the phenomenon, was considered to be one of the main characteristics of the dementia praecox disease as it had been conceptualized by Kraepelin and his followers. Because of the catatonic patients’ “negativism,” their “motiveless resistance” to treatment and experimentation, Gross could only offer his personal impression that none of the catatonics *seemed* to show “motor inhibition.” Having experimentally provoked undetermined “defense reactions,” he was able to observe that the patients’ movements were in most cases rapidly performed.⁵² This clearly shows that Gross’s reasoning was only partly dependent on measurements and numbers and that he was willing to fill in the blanks with more basic observational data, although this contradicted the claim to numerical objectivity. Specifically, although he had obtained exact numbers for one half of his patients, he had had to rely on his subjective perception of movement speed for the other half.

Moreover, in this experimental setup, counting from 1 to 20 and performing a defensive movement were treated as one and the same type of activity, for which one and the same level of speed was assumed to be appropriate. These circumstances put the experiments in a different light and show a less straightforward relationship between scientific obser-

49 Elsewhere, Gross indicated that he considered three to five seconds to be a normal value for counting from 1 to 20 as fast as possible (Adolf Gross, “Zur Psychologie der traumatischen Psychose” [On the Psychology of Traumatic Psychosis], in Kraepelin, *Psychologische Arbeiten*, 2:583). Normal values were usually obtained from hospital staff of the Heidelberg clinic. If you try this at home with a timer, you will notice that scoring less than four seconds is actually not that easy without blurring the words.

50 Patient I scored 60/5 sec. on 28 April 1896, 110/5 sec. on 23 July 1896, 77/5 sec. on 14 August 1896, 63/5 sec. on 2 September 1896, and 50/5 on 11 September 1896. The performance of patient II was recorded with the extreme value of 1117/5 sec. on 4 May 1896, 164/5 sec. on 14 May 1896, and 20/5 sec on 1 August 1896. The numbers for the last test were considered normal and the patient considered healthy at the time. Patient III showed 56/5 sec. (no dates provided) (Gross, “Ueber Stupor,” 858).

51 Gross, 859. Gross used the same rhetoric to describe the resistance of the catatonic patients who participated in the writing-pressure scale experiment (Gross, “Untersuchungen über die Schrift Gesunder und Geisteskranker,” 535). He complained that it was difficult to make the patients do what was asked of them (Gross speaks of “commands” (*Befehle*), rarely about “requests” (*Aufforderungen*)). Some patients deliberately ignored the instructions by writing an upper case “M” instead of a lower case “m” or instead of dots, also dashes instead of dots, or by writing their name and address instead of the sequence of numbers, see (Gross, 551).

52 Unfortunately, we do not learn what kind of defense reactions Gross provoked by what means. In his textbook Kraepelin mentions testing patients for “negativism” by causing a painful sensation, making some threatening movements, like holding a needle close to the patient’s eye, or forcing them to change their position in bed (Kraepelin, *Klinische Psychiatrie*, 208).

vation and nosological argumentation. Although Gross's experiments did involve measurements of psychophysical phenomena and the production of numbers, his argument about difference in "motor inhibition" did not rely on a comparison of differing numerical values. Furthermore, by decontextualizing the setting in which the movement speed was measured or estimated, Gross was able to subsume very different types of movement under the label of motility. Only in very abstract terms can it be assumed that counting numbers and defending oneself involves a kind of body movement that can be measured with a stopwatch. However, this abstract comparison also assumes that the notion of threat (or motivation, or any other kind of context) does not influence a person's movement speed. By analogy, his reasoning seems to suggest that running around in one's apartment and running away from a lion would objectively be performed with comparable speed and enthusiasm.

The Word Association Test

Another test that the Heidelberg experimental psychologists carried out was the word association test. Like the previous test schemes, it pretended to rely on a rigid system of statistical analysis, but its conceptual flaws may lie even closer to its analytical core. The general argument that Gustav Aschaffenburg (1866–1944) tries to make with the case of his male subject no. 4, for instance, is that there is a strong correlation between the manner in which the latter forms associations and his mental state. Aschaffenburg notes that the number of "sound associations" is far greater during the patient's manic state than during the depressed state.⁵³ Furthermore, he attests that there is an increase in "internal associations" and a decline of "external associations" when the manic state recedes. The experimental setting in which these statistics are produced is relatively simple. The patient is prompted to give a verbal reaction to a trigger word pronounced by Aschaffenburg, and the test setup posits that he replies with whatever first comes to mind. Aschaffenburg notes down the result and subsequently evaluates the answers given by the patient. Every test series contains 100 words (usually nouns), and sometimes the reaction time is also recorded, though not in this subject's case.

The evaluation of the patient's responses to the trigger words is the crucial part of the experiment. When Aschaffenburg conducted his experiments, there were many theories around about how to interpret the answers and how to categorize them. However, among all of those engaging in experimental psychology there was a general agreement that the word association tests provided insights into the workings of the mind and the

⁵³ Thirty in December 1894; seventeen in January 1895; fifteen in July 1895; 10 in August 1895; four in October 1895; one in November 1895; none in the next three tests (April–July 1896) (Gustav Aschaffenburg, "Experimentelle Studien über Associationen. III. Theil: Die Ideenflucht" [Experimental Studies on Associations. Part III: The Flight of Ideas], in *Psychologische Arbeiten*, ed. Emil Kraepelin, vol. 4 [Leipzig: Verlag von Wilhelm Engelmann, 1904], 322).

particularities of the thought process. Two different types of associations were usually distinguished, which were attributed to different mental operations. Either the connection from trigger word to response word was based on a similarity that was grounded in the meaning of the two words, or it was based on some form of co-occurrence (in time, space, or language). A meaning-based association was considered to represent a higher mental elaboration than an association based on external criteria. According to Aschaffenburg, the lowest kind of associations was those that were formed based on the sound of the word (like bite–site; house–mouse) without being (internally) connected by meaning. After having conducted experiments on himself, his Heidelberg colleagues, and some visiting scholars (altogether seventeen medical men) between 1892 and 1895, Aschaffenburg concluded that a healthy individual would rarely produce more than four sound-associations in a test series of 100 words.⁵⁴ Unfortunately, Aschaffenburg did not provide a list of the response words and trigger words obtained in the experiment, so there is no way to critically reassess his judgment, and the black box of the number-producing operation has to remain closed. However, Aschaffenburg gives several examples in the introduction to his 1896 article which offer insights into his categorization approach and allow us to infer the general reasoning behind his judgment.

As examples of internal associations, he lists the following word pairs: confinement–jail, tea–coffee, advantage–disadvantage, attack–defense; after which he adds that “the subjective perception of the test person [in this case, the physician] is crucial in classifying the association.”⁵⁵ Although it is easy to recognize the meaningful connection between these word pairs, it is harder to comprehend why the pair tea–coffee should not be considered a customary linguistic co-occurrence, as in the question “tea or coffee?,” or why the pair advantage–disadvantage (*Vor-teil* and *Nach-teil* in German) should be more than a play on words. Examples of external associations are represented by mouth–nose; plant–pot; Luzern–Rigi; teacher–school; etc. In these cases, Aschaffenburg argues, the association is made because of the objects’ spatial proximity, and not because of the meaning of the word.⁵⁶ Again, while it is clear enough why he grouped these pairs under the header “external associations,” it is harder not to deconstruct his judgment, as a physician interested in taste might very well see a meaningful connection between the mouth and the nose, just as a horticulturist might see a meaningful connection between the pot and the plant. Lastly, some sound associations are: profile–professor; batiste–battery; crown–chrome; etc., and this is likely to be the category that is most convincingly self-contained.⁵⁷ On the other hand, one can easily imagine how the test environment itself can induce the production of rhymes with its sing-song scenario of trigger words and re-

⁵⁴ Gustav Aschaffenburg, “Experimentelle Studien über Associationen” [Experimental Studies on Associations], in Kraepelin, *Psychologische Arbeiten*, 1:295.

⁵⁵ Aschaffenburg, 231–232.

⁵⁶ Aschaffenburg, 236.

⁵⁷ Aschaffenburg, 241.

sponse words being bounced back and forth between examiner and examined. Moreover, being aware of the hierarchy of associations could also be a contributing factor. If the patients do not know that sound associations are equated with lower mental capacity and lower intelligence in the psychiatrist's framework, they do not try to avoid them. When doctors test each other, on the other hand, being fully aware of what passes for smart answers in the community of university physicians, they always seem to have their own self-perception as cultured and sophisticated people reconfirmed by the test.⁵⁸

As should be clear by now, this kind of classification of associations relies on the subjective perception not only of the subject but also of the person evaluating the test results in many if not most of the cases. When Aschaffenburg provides a carefully compiled table of numbers which shows that at the height of his manic phase in December 1894, his patient produced merely twenty-five internal associations, the numbers then gradually climbing up to the value of thirty-nine at the moment of his release from the clinic in November 1895, he suggests an objective and judgment-free observation.⁵⁹ This kind of black-boxing is very effective when the trigger words and response words are not provided and the reader is only presented with neat columns of numbers. That Aschaffenburg was very confident about his own categorizations and did not question the validity of his numbers becomes apparent from his discussion of other experimenter's work.

In participating in the academic debate on word association tests, Aschaffenburg was very critical of some of his colleagues. For instance, he severely attacked Hugo Münsterberg's (1863–1916) classification approach, which he described as “superficial” and “arbitrary.”⁶⁰ Aschaffenburg doubted that associations like brother–sister or knife–fork were truly based on a relationship in meaning. He argued that, at least in his own case, these associations were not evoked because of their conceptual relationship (kinship, cutlery) but because they co-occurred in spoken language and were formed through the principle of training and experience.⁶¹ Although this reasoning is highly suggestive, it is questionable whether it is actually possible to know how a thought is formed through pure introspection.

Furthermore, with his vision of a hierarchy of associations, Aschaffenburg assumes a hierarchy in mental functioning that his own tests sometimes fail to substantiate. As a case in point, among the test results obtained from association tests with healthy individuals, there was one person who “scored” even more sound associations than patient no. 4. This happened with the case of Doctor M. J. van Erp Taalman Kip (1866–1926), a visiting

58 Aschaffenburg, 288. Aschaffenburg takes pride in the performance of his colleagues, who have produced a number of rather similar associations like colossus–Rhodes (a statue), Apollo–Belvedere (another famous statue), and music–Wagner (referring, of course, to the composer Richard Wagner (1813–1883)) (Aschaffenburg, 289).

59 Aschaffenburg, “Experimentelle Studien über Associationen. III. Theil: Die Ideenflucht,” 322.

60 Aschaffenburg, “Experimentelle Studien über Associationen,” 227–228.

61 Aschaffenburg, 227.

physician from the Netherlands, who produced forty-four sound associations in a test conducted in March 1895.⁶² Aschaffenburg argued this irregularity away by the fact that the subject was a foreigner with limited understanding of the German language who was, therefore, inclined to react more to the sound of the word than to its meaning.

A similar argument was offered in the case of the test results of August Hoch (1868–1919), a Swiss physician who had emigrated to the United States and visited Kraepelin's laboratory in 1894. His word associations showed an anomaly that consisted in a prevalence of what Aschaffenburg conceived of as external associations. In a sequence of three tests, Hoch produced associations that were categorized as translations and, thus, external. In many cases, Hoch gave an equivalent in Latin for the trigger word.⁶³ According to Aschaffenburg's reasoning, translating was a mental process that involved practice and training (of language skills), not so much thinking in conceptual terms, but this did not mean that he called Hoch's mental faculties into doubt. Other excuses were made for other healthy test subjects when they did not perform as Aschaffenburg expected that healthy people should and would. Tiredness, exhaustion, and lack of sleep were given as reasons for under-performing. Nonetheless, none of these mitigating circumstances seemed to be applicable to the constitution of mental health patients, whose performance was always perceived as the pure expression of their dysfunctional minds.

3.2 Teaching in the Lecture Theater

As I have already outlined in chapter 2, it was considered desirable in the context of the Heidelberg mental hospital to quickly remove from the institution those patients who were of no interest for the research and teaching activities of the clinic. Conversely, there were patients who were kept in the clinic longer than usual because they were exceptionally well suited for demonstrations and experiments.⁶⁴ Unlike the “negativistic” dementia praecox patients, manic-depressive patients were considered especially interesting research material because they willingly produced a considerable amount of measurable and seemingly homogeneous research data. Kraepelin's assistant and experimental-psychology enthusiast Aschaffenburg admitted that no other psychosis was more enticing to conduct experiments on than manic-depressive insanity.⁶⁵ As we have already seen in the discussion of the association test, Aschaffenburg was especially fascinated by sub-

62 Aschaffenburg, “Experimentelle Studien über Associationen,” 263.

63 Aschaffenburg, 262.

64 This phenomenon was not restricted to the Heidelberg clinic. “Talented” patients, who were able to reproduce and show off the symptoms that were expected from them in patient demonstrations usually remained longer in the clinic and had more stage appearance than other patients; see Rainer Herrn and Alexander Friedland, “Der demonstrierte Wahnsinn: Die Klinik als Bühne” [Demonstrated Madness: The Clinic as Stage], *Berichte zur Wissenschaftsgeschichte* 37, no. 4 (2015): 309–331.

65 Aschaffenburg, “Experimentelle Studien über Associationen. III. Theil: Die Ideenflucht,” 235.

ject no. 4, who had yielded more “uniform results” than all other examined cases.⁶⁶ This “special case” was the patient Hermann Sch. (1851–1899), whose remarkably demonstrable illness was also exploited by Aschaffenburg’s other Heidelberg colleagues. Apart from Aschaffenburg’s word association tests, Hermann Sch. also appears as one of Gross’s subjects, namely, as patient no. 1 in the writing scale experiment, and he is presented as a typical case of a depressed state in Wilhelm Weygandt’s textbook of psychiatry, which provides several photographs of the patient as case no. 41.⁶⁷ In quite a different format, Hermann Sch. also features in one of Kraepelin’s lectures involving patient demonstrations for students.⁶⁸ These textual and personal interrelations clearly show how Heidelberg patients served several functions including university teaching, psychophysical research, textbook production, and concept formation.

In many ways, Weygandt’s enterprise of creating an “atlas of madness” is reminiscent of the myriads of atlases produced by natural historians in the latter half of the nineteenth century. His richly illustrated textbook is a representative of the “new brand of scientific objectivity” which was characterized by a turn to mechanically produced images in an effort to minimize human interference and to eliminate suspect mediation.⁶⁹ But Weygandt’s detailed photo-documentation was not the only means to use the patients in order to teach the Heidelberg School’s new strand of psychiatry. In the following, I will sketch the medical history of Hermann and show how his illness was exploited for teaching purposes by serving as illustrative material in Weygandt’s textbook and being shown off in Kraepelin’s lecture theater.

Hermann Sch.’s Highly Demonstrable Illness

From the different documents produced by Kraepelin, Gross, Aschaffenburg, and Weygandt, we learn that patient Hermann Sch. was an insurance inspector who had first been admitted to the Heidelberg clinic in March 1894, when he was 42 years old. Earlier in his life, he had experienced several unhappy relationships. In 1877, he had married a woman “far below his education and status” at the age of 26, and he had subsequently become depressed and gotten divorced.⁷⁰ In 1882, he had again been deceived by a woman who later abandoned him. Once more, the patient fell into a dejected mood that his relatives interpreted as a reaction to his unhappy experiences, but not so Kraepelin, who suspected that the patient must have been a little mad prior to this already, since he had taken the unwise

⁶⁶ Aschaffenburg, 320–28.

⁶⁷ Wilhelm Weygandt, *Atlas und Grundriss der Psychiatrie* [Atlas and Outline of Psychiatry] (München: J. F. Lehmann’s Verlag, 1902), 322–24.

⁶⁸ Emil Kraepelin, *Einführung in die psychiatrische Klinik: Dreissig Vorlesungen* [Introduction to Clinical Psychiatry: Thirty Lectures] (Leipzig: Verlag von Johann Ambrosius Barth, 1901), 11–15.

⁶⁹ Lorraine Daston and Peter Galison, “The Image of Objectivity,” *Representations*, 1992, 81.

⁷⁰ Aschaffenburg, “Experimentelle Studien über Associationen. III. Theil: Die Ideenflucht,” 320.

decision to marry an unsuitable candidate.⁷¹ Hermann Sch.'s father, as well as two of his brothers, were alcoholics (one sister was considered to be suffering from manic-depressive insanity), and it was also in connection with alcoholism that he had first been hospitalized in Heidelberg. In 1893, Hermann fell sick with delirium tremens and experienced shivers and a variety of disturbing visual hallucinations.⁷² This episode was followed by an agitated state, during which he caused public nuisance in pubs by throwing objects out of the window. Hermann was admitted to the clinic as a manic patient and treated with "segregation" (*Isolierung*) and "continuous bath" therapy (*Dauerbad*).⁷³ During his first stay in the Heidelberg clinic, from March 1894 to November 1895, he was predominantly in a cheerful mood, which Weygandt documented with a photograph showing Hermann simultaneously smoking a cigar *and* a pipe.⁷⁴ However, the photograph alone was not sufficient to convey the idea that Hermann was truly mad rather than simply in the mood for jokes. Therefore, Weygandt supplemented some additional information in the text, where he noted that in the manic state, the patient also decorated himself with twigs and flowers, used to sing, smoked two cigars at once, expressed delusions of grandeur, and wrote many letters and other texts.⁷⁵ Aschaffenburg conducted most of his word association tests during this manic period as well (December 1894–November 1895).

The second stay in the clinic was, in turn, characterized by a depressed mood, which Weygandt captured in a photograph showing Hermann in bed.⁷⁶ Hermann had been admitted to the clinic in January 1896 and could hardly be motivated to perform any kind of activity at all. He was lying in bed, did not move, did not eat, was barely able to speak, and appeared frightened.⁷⁷ The depressed state lasted until the patient's death in July 1899. During this second period, Aschaffenburg conducted the second series of his word association tests (April 1896–March 1897), but he regretted that it was very difficult to persuade the patient to take part in the experiments.⁷⁸ Gross also performed his writing scale tests during Hermann Sch.'s depressed phase (March 1897), and Kraepelin presented

71 Kraepelin, *Einführung in die psychiatrische Klinik*, 13–14. Kraepelin surmised that the marriage proposal most likely happened during an agitated state.

72 Nowadays, the term delirium tremens is associated with the symptoms which are caused by alcohol withdrawal. In the nineteenth century, the actual causes were disputed, although the connection between alcohol abuse and the psychotic symptoms of delirium tremens were generally accepted. Kraepelin explicitly denied any causal relation between alcohol withdrawal and delirium tremens arguing instead for a metabolic cause (Kraepelin, *Klinische Psychiatrie*, 90).

73 Weygandt, *Atlas und Grundriss der Psychiatrie*, 323. In the context of the clinic "Segregation" could effectively mean "solitary confinement" where the patient was put into a solitary cell, usually naked (Kraepelin, *Allgemeine Psychiatrie*, 320).

74 Weygandt, *Atlas und Grundriss der Psychiatrie*, 324; Figure 116.

75 Weygandt, 323.

76 Weygandt, 323; Figure 114.

77 Kraepelin, *Einführung in die psychiatrische Klinik*, 14.

78 Aschaffenburg, "Experimentelle Studien über Associationen. III. Theil: Die Ideenflucht," 320.

him in his lecture as an exemplary case of circular depression about half a year before the patient died from tuberculous pleurisy in 1899.

The classroom presentation served the double purpose of teaching the new classification of mental disorders and of training the students to spot the signs that point to these disorders. Kraepelin's guided observation was crucial to focus the students' gaze and to transmit the teacher's interpretation of what there was to see. The rhetoric of the demonstration implies objective description, but on close inspection the language is laden with interpretative expressions. Hermann Sch.'s demonstration typically begins with Kraepelin commenting upon the patient's appearance, posture, and expression as the demonstration subject enters the room:

He is well-built, albeit malnourished, shows an ashen skin and an ailing facial expression. He enters [the room] with small and tired steps, sits down slowly and remains seated in a somewhat hunched position, staring straight ahead with almost no movement at all. Upon questioning he turns his head slightly and answers in a low voice and monosyllabically but to the point. One gets the impression that he has great trouble speaking; his lips are already slightly moving before any sound comes out.⁷⁹

Although the patient can hear all that is being said about him and the manner in which this is being done, he seems to ignore the comments. He himself believes that he suffers from an affective disorder (*gemüthskrank*), but his judgment is of little significance in the demonstration except for establishing the fact that Hermann Sch. is himself aware of being ill. The above quote already contains one of the key observations that Kraepelin wants his students to make in this particular case. He notes that "one gets the impression that he has great trouble speaking," a phrasing that implies that everyone else should have the same impression as the professor. Kraepelin builds upon this "observation" by adding some argumentative thoughts and some more interpretations about the presumable causes behind this symptom:

[...] It is especially the fact that the answers regarding casual matters are produced slowly as well that shows us that the patient is not impeded by a shyness to express himself but that there is a general impairment of verbal expression. Indeed it is not only that but all of his volitional impulses that are extremely impaired.⁸⁰

This remark, which now interprets the observable slow verbal reaction as an inhibition of volitional impulse, is supplemented by a series of observations made outside of the classroom and intended to support Kraepelin's general assessment. The students are told

79 Kraepelin, *Einführung in die psychiatrische Klinik*, 11.

80 Kraepelin, 12.

that Hermann was unable to get up, to dress, or to occupy himself with anything for the last three years, during which he mostly remained in bed motionless (a scene that was also documented by Weygandt).⁸¹ These additional observations are treated as belonging into the same category of “inhibition of volitional impulse” and eventually this characteristic is declared to be the defining feature of manic-depressive insanity:

We clearly recognize his efforts to act and to comply with our requests but at the same time [we also recognize] the retardation and impediment that each volitional impulse encounters. Under these circumstances it is permissible to speak of an inhibition of volition in the sense that the transformation of volitional impulses into actions encounters obstacles that can only be overcome slowly and often not by his own force at all. This inhibition is the most salient trait of the pathology by far. In contrast, the saddened and low-spirited mood matters comparatively little; other mental impairments are not discernible for the time being.⁸²

Again Kraepelin uses “we” instead of “I,” thereby subsuming the students’ observation and judgment under his own and encouraging them to believe to see what he sees and believes. The demonstration does not involve much activity on Hermann Sch.’s part. He is later asked to write his name on the blackboard, and he complies with the request after having got up lumberingly (*schwerfällig*).⁸³ Obviously, Kraepelin deemed these few actions to be sufficient to give a mechanistic interpretation of his ailment while at the same time de-emphasizing the affective side of his illness. The explanations about the supposed nature of manic-depressive insanity are followed by a prognosis and a short description of Hermann Sch.’s illness record, which serves to provide evidence of the alternating nature of the disease. The general structure and sequence of the demonstration is rather typical for Kraepelin’s performances in Heidelberg, and the same format was to be encountered in other psychiatric institutions’ lecture theaters. In the following section, I will present a similar demonstration performed in the summer of 1902 in Tokyo which not only testifies to the fast dissemination of Kraepelin’s teaching but also exemplifies some cultural and linguistic tricks and alterations in demonstrating the mechanic aspect of the disease as well as in illustrating the temporal dimension.

Mrs. Kurosawa’s Dance Performance

When Kure Shūzō returned from his four-year-long research trip to Europe, which had taken him mainly to Austria and to Germany, but also to France, in order to assume professorship at Tokyo Imperial University, he took over some of the patients that had been

81 Weygandt, *Atlas und Grundriss der Psychiatrie*, 323; Figure 114.

82 Kraepelin, *Einführung in die psychiatrische Klinik*, 12–13.

83 Kraepelin, 12.

in the care of his predecessors. One such patient who was not released in 1901 but relayed to the care of Kure Shūzō was the former nurse Mrs. Kurosawa 黒澤, born in January 1874.⁸⁴ Her medical record reveals that she displayed a joyful mood and a boastful attitude at the time of her hospitalization in December 1899. She was cheerful, telling jokes, and loved to argue. However, she could also become angry and abusive at times. Sometimes, she was seen running through the hallways of the hospital ward, performing sword dances, singing, and reciting. She was boastful and used to discuss matters of loyalty and filial duty, regretting that she had not been born as a boy.⁸⁵ At the time of her hospitalization, she might have been diagnosed with mania, but when it became apparent that her condition would switch from mania to melancholia from time to time, her diagnosis seems to have been changed to circular insanity.⁸⁶ However, these concepts were to be seriously challenged by Kure, who returned from Europe as a convinced follower of the Heidelberg School and initiated reforms that would banish melancholia and related concepts from the classrooms and hospital wards of Tokyo Imperial University.

In order to illustrate the notion of Kraepelin's manic-depressive insanity to his students, who had until then been taught to see things differently, Kure used the case of Mrs. Kurosawa's illness. When Mrs. Kurosawa was brought into the lecture room of the Sugamo Mental Hospital on July 2, 1902, she walked in with her head hanging down, her body all hunched up and her gaze fixed on the floor. Moving slowly and heavily, she did as she was told and as if she did not apprehend the things around her.⁸⁷ Kure asked her how she was feeling and whether she experienced any pain or headache. When he asked her what day it was, she tried to remember how many days had passed by, carefully folding the fingers of her left palm one after another with her right hand.⁸⁸

Time was an essential analytic tool to explain Mrs. Kurosawa's illness. In order to convince his students that the present state of the patient was not conclusive, Kure presented a chart that documented the evolution of her moody states over the last two years and seven months (see Figure 3.5). Kure argued that, although she had experienced alternating states of exaltation (marked in red) and depression (marked in blue), her current state in July 1902 was characterized by a mixture of exaltation and depression (both colors in the same column). For Kraepelin, the existence of these mixed states was one of the proofs that

84 Usually, the names of the patients were not mentioned in public journals. This was also true for Mrs. Kurosawa, whose name only appeared as “Ku. Sa.” く、さ、 on the first page of the case history. However, she is later addressed as “Mrs. Kurosawa” (*Kurosawa-san* 黒澤さん) in the rendition of the doctor–patient dialogue (Kure Shūzō 呉秀三, “Utsuyū jōtai” 鬱憂状態 [Depressed States], *Iji shinbun* 620 [1902]: 1243, 1244).

85 Kure Shūzō, 1247–1248.

86 Kure Shūzō, 1250.

87 Kure Shūzō, 1243.

88 Kure Shūzō, 1244. In Japan, finger-counting is practiced differently than in Continental Europe or the United States. When counting for oneself, one begins with an open palm and then folds the fingers inwards from the thumb to the little finger.

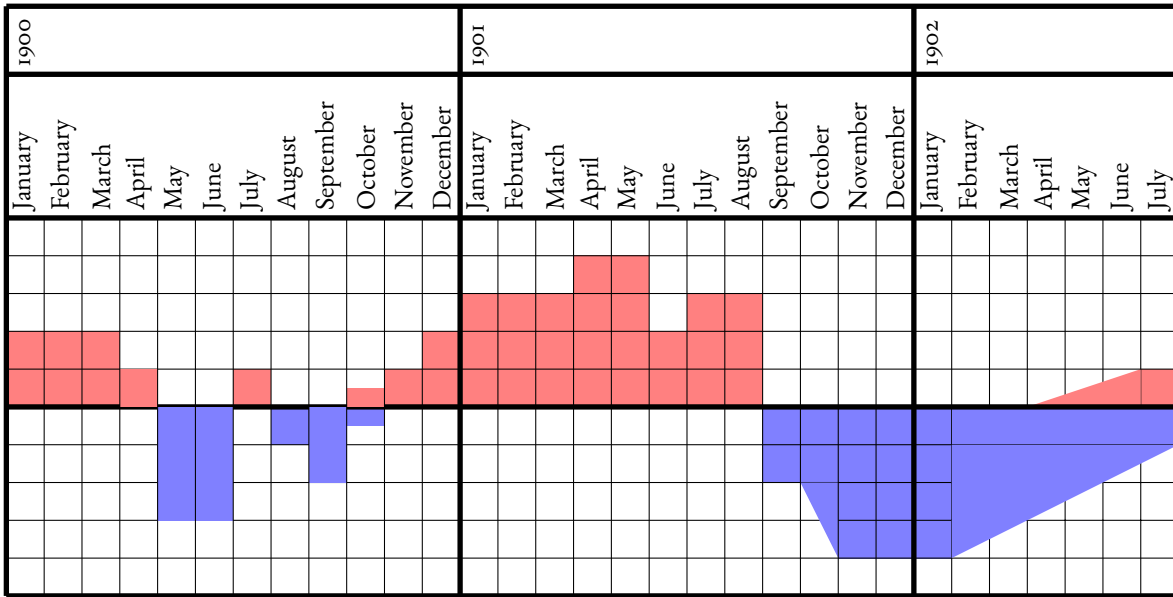


Figure 3.5: The evolution of Mrs. Kurosawa's illness

there was no real boundary between mania and melancholia.⁸⁹ The otherwise gloomy and motionless patient would sometimes show a little smile or make some unexpected movement.⁹⁰ The same phenomenon could be demonstrated through Mrs. Kurosawa's case. Although she appeared withdrawn (*ustubei shite iru* 鬱閉して居る) and brooding (*fusagikonde iru* 閉ぎ込んで居る), Kure believed that her occasional smiles announced the transition towards an exalted state.⁹¹

Although the mood chart was a convenient tool to visualize the temporal dimension of Mrs. Kurosawa's illness, another trick was even more effective at showing that inhibition could be easily turned into excitation right before the eyes of the audience. To demonstrate that his patient was not as stiff and inanimate as she looked, he encouraged her to perform a sword dance by reciting poems by the famous Japanese historian Rai San'yo 頼山陽 (1780–1832).⁹² The patient was known to have performed sword dances before and seems to have been familiar with the text. One of the poems was the famous piece “On a Painting of Kenshin Attacking Shingen” (*fushikian kizan wo utsu no zu ni dasu* 題不識庵擊機山図), which is apparently still recited today and is noted for its rhythm and sound:⁹³

Bensei shaku-shaku yoru kawa wo wataru
akatsuki ni miru senpei no taiga wo yōsuru wo
ikon nari jūnen ikken wo migaki
ryūsei kōtei ni chōda wo issu

Sound of the horse whips, softly, softly, crossing the river at night.
 At dawn the sight of a thousand soldiers protecting the great tusk.
 A lasting regret! For ten years, polishing one sword
 Beneath the light of a falling star, the long snake escapes.⁹⁴

89 Kraepelin, *Klinische Psychiatrie*, 372.

90 Kraepelin, 394–399.

91 Kure Shūzō, “Utsuyū jōtai,” 1246–1254.

92 It is perhaps an interesting coincidence that the poet himself was also known for his madness, which apparently took the form of changing moods (Kitanaka, *Depression in Japan*, 29). If the patient had known of the connection between the mad poet and her own condition, her performance could also be interpreted as a self-conscious expression of her own insanity. However, there is no indication of this sort in the text. This kind of artistic escape strategy is explored in Hugh Shapiro, “Operatic Escapes: Performing Madness in Neuropsychiatric Beijing,” in *Science and Technology in Modern China, 1880s–1940s*, ed. Jing Tsu and Benjamin A. Elman (Leiden: Brill, 2014), 297–325.

93 Haruo Shirane, *Early Modern Japanese literature: An Anthology, 1600–1900*, Translations from the Asian Classics (New York: Columbia University Press, 2002), 919. In the transcription of Kure's lecture, the poems are indicated by the beginning lines (Kure Shūzō, “Utsuyū jōtai,” 1254). The first as *Bensei shaku shaku* 鞭聲肅々 and the other verse as (*koromo wa kan ni itari* 衣至戔) which is the first line of the “Former Song of a Youngster” (*Zen beko no uta* 前兵児謡). See Samuel Shooklyn, “Moral Instruction in Budō: A Study of Chiba Chōsaku with a Translation of his Major Work” (PhD diss., McGill University, 2009), 30, for the translation of *beko* as “young boy” instead of “soldier infant” in the Satsuma dialect.

94 Translation by Haruo Shirane in *Early Modern Japanese literature*, 919.

Slowly and with her voice breaking off in between, Mrs. Kurosawa joined in the singing and eventually managed to perform a sword dance on her own.⁹⁵ The students and assistants for whom this spectacle was staged were to learn that inhibition and exaltation of the volitional impulses were states that could easily follow one after another and were not, in fact, opposed phenomena. The dance performance was the ultimate proof that mania and melancholia did not exist as independent disease categories. These kinds of presentations were an integral part of psychiatric education in many parts of the world, and it is quite obvious that they shared some elements with a theater performance.⁹⁶ Clearly, there is some degree of artificiality or even incitement involved when Kure encourages Mrs. Kurosawa to sing and to dance, as he surely knew she would be willing to do. However, the show would not have been effective without the accompanying interpretation and without Kure lecturing the students on the meaning of what they had just witnessed.

Kure explained the mechanisms involved in the processes of inhibition and exaltation by evoking the image of a bridled horse.⁹⁷ In this metaphor, which was also popular in the European context, the human will was subjected to a force that controlled the speed and intensity of movements and speech.⁹⁸ Not unlike Gross's "broken clock metaphor," Kure's image of slackened or tightened reins also implied the interference of an external disruptive element, manipulating the "normal" flow of movements. As in Kraepelin's lecture, the depressed state of manic-depressive insanity was ultimately understood as an expression of the inhibited volitional impulse. Because the term *fusagu* (variously written as 鬱ぐ, 塞ぐ, or 閉ぐ) could be used to indicate inhibited movement as well as gloomy moods in Japanese, Kure was able to shift the meaning from "mood disorder" to "physical inhibition" without discarding the translation term used by his teacher Sakaki, who had used the same term to refer to affect-defined melancholia. Through the use of language Kure made it explicit that he understood the concept of manic-depressive insanity in this mechanistic way where the disease was primarily defined by alternating states of inhibition and exaltation. Usually, the Japanese term for manic-depressive insanity, 躁鬱狂, is pronounced *sōtsu-kyō*, but Kure also referred to the illness as *sawaki fusagu-byō* (さわきふさぐ病 [騒塞病]), which could be translated as "agitation-inhibition-illness."⁹⁹

With this new mechanistic conception of the pathological process that could explain both melancholic and manic states, the role of affect became less important. Indeed,

95 Kure Shūzō, "Utsuyū jōtai," 1255.

96 Asti Hustvedt, *Medical Muses: Hysteria in Nineteenth-Century Paris* (London: Bloomsbury, 2012), 74–82; Katja Guenther, *Localization and Its Discontents: A Genealogy of Psychoanalysis and the Neuro Disciplines* (Chicago: The University of Chicago Press, 2015), 49–56; Herrn and Friedland, "Der demonstrierte Wahnsinn," 311.

97 Kure Shūzō, "Utsuyū jōtai," 1245.

98 For the origin and usage of the metaphor in the medical context as well as its moral connotations, see Roger Smith, "The Meaning of 'Inhibition' and the Discourse of Order," *Science in Context* 5, no. 2 (1992): 244.

99 Kure Shūzō, "Utsuyū jōtai," 1251.

when Mrs. Kurosawa was presented to the students in July, she did not show any signs of morbid emotionality. During the patient demonstration, Kure literally said that no pathological changes (*byōhen* 病變) presented themselves in the mental activity (*seishin sayō* 精神作用) of the emotional sphere (*kanjō no hō* 感情の方).¹⁰⁰ As with the Heidelberg School, de-emphasizing affectivity as a distinctive disease criterion had become an important part of Kure's new understanding of classifying mental disorders. His classroom presentation resonates with Kraepelin's characterization of Hermann Sch.'s illness, where "saddened and low-spirited mood" was equally delegated to the rank of the less significant symptoms. This new definition of depressed states exemplified in Kraepelin's and Kure's lectures indicates a general shift toward prioritizing measurable symptoms in psychiatric diagnosis and classification. The performances staged in the lecture theaters illustrated the new interpretations and were a useful tool to transmit the new knowledge to the next generation of psychiatrists. However, none of this would have been possible without the introduction of experimental practices into the laboratory of the clinic.

Psychometric experiments like those described in this chapter gave psychiatry the appearance of a scientific discipline. The numbers produced in the experiments had the appeal of hard empirical facts, although in many cases they were based on subjective perceptions and preconceived ideas. With a fixation on metrics like the one expressed in twentieth-century experimental psychology, one also has to ask the very fundamental question of whether what is measured is actually important, or, as a pointed saying goes, "[n]ot everything that can be counted counts, and not everything that counts can be counted."¹⁰¹ It is questionable whether the measurable expressions of patients' motor anomalies really provide a more sophisticated explanation of the nature of their illness than an examination that was focused on mood, delusions, and perceptions. This shift towards prioritizing motor functions certainly contributed to the disintegration of older disease concepts such as melancholia, which relied on completely different diagnostic hierarchies. However, it remains disputable whether this shift from qualitative evaluations towards more quantitative evaluations actually corresponded to naturally occurring disease entities that could be differentiated along these lines. The psychological experiment, with its limitations of measuring such attributes as speed and force, certainly introduced a new kind of reductionism into the examination and conceptualization of mental disorders.

In the case of the experiments conducted in the Heidelberg laboratory, there also is a striking correlation between the institutional needs to devise differentiating criteria that could be easily measured at first examination and the design of the new concepts of manic-depressive insanity and dementia praecox. Likewise, it seems very convenient that those disease forms that were less suitable and interesting in experimental settings were the same

¹⁰⁰ Kure Shūzō, 1246.

¹⁰¹ William Bruce Cameron, *Informal Sociology: A Casual Introduction to Sociological Thinking* (New York: Random House, 1963) quoted in Muller, *The Tyranny of Metrics*.

that were declared incurable and whose futile treatment could be reduced to a minimum by transferring the patients to long-term hospitalization facilities. The numbers produced through the new experimental techniques served to reinforce the validity of the new concepts, but at the same time, the new concepts guided the directions of inquiry that produced the numbers. In effect, the system seems to have been circular.

On the other side of the globe, Kure's demonstration of Mrs. Kurosawa's illness provides evidence for the fast adaptation and dissemination of the mechanistic model of what we today conceive of as mood disorders. However, other Japanese psychiatrists challenged these views. In the following chapter, I will return to Araki and Kadowaki, my other two Japanese protagonists introduced in chapter 1. When they presented their own classifications of mental disorders at the Tokyo Conference of 1905, they challenged Kraepelin's ideas and, by implication, Kure's adaptation of it. I will closely examine their contribution to psychiatric classification and analyze their attack on Kraepelin, which they mainly fought on conceptual grounds. Along the same dividing line, yet another young Japanese psychiatrist, who had gained much of his experience in American asylums, launched his own repudiation of Kraepelin's dichotomy with the tools of experimental psychology. Following the traces of Matsubara Saburō's lost doctoral thesis on melancholia and the medical cases he examined in the United States will allow us to re-imagine an alternative path for classifying mental disorders that was not taken.

4 Japanese Visions of Melancholia

The downfall of melancholia at the end of the nineteenth century went hand in hand with the sanctification of new conceptual schemes that allegedly announced the coming of a new scientific era in Japanese psychiatry. Clad in the rhetoric of progress and popularized by Kure, the displacement of melancholia became a symbol for psychiatry's metamorphosis into a modern science and Japan's participation in this scientific modernity. But this new vision of a "modern psychiatry" was not shared by all Japanese physicians. Araki and Kadowaki went against the current and displayed their creativity in juggling different strands of psychiatric theory at the Tokyo Conference of 1905. Through the appropriation and creative reinterpretation of existing theoretical frameworks, they were able to come up with new and contemporary visions of melancholia. Their engagement with theoretical schemes other than the one propagated by Emil Kraepelin attests to the plurality of opinions and pathways co-existing at the time. Especially their recourse to the work of Theodor Ziehen, one of Kraepelin's main antagonists who is nowadays largely forgotten by historians of psychiatry, puts Araki's and Kadowaki's engagement with mental disorders in a new light.

In addition to examining Araki's and Kadowaki's theoretical constructions, I will introduce the work of the Japanese psychiatrist Matsubara Saburō, whose redefinition of melancholia can be understood as a contribution to the ongoing project of concept formation and a challenge to Kraepelin's "great dichotomy." Although the two aspects that are usually associated with the "scientific method," which in turn characterized "modern psychiatry," are clearly discernible in Matsubara's work, they are used to deconstruct the "great dichotomy" rather than to reinforce it. Like Kraepelin, Matsubara employed statistical record-keeping and psychological experimentation in order to argue for specific disease boundaries. Drawing on the data collected from the enormous patient population of the New York State Hospital, Matsubara did not hesitate to generalize his findings. In this chapter, I will analyze Matsubara's work on melancholia as a contribution to the attempt to redraw the boundaries of psychiatric categories by harnessing the methods of experimental psychology.

4.1 Araki Sōtarō, Kadowaki Masae, and the Work of Theodor Ziehen

Whereas the reforms introduced by Kure in 1902 directly affected the patients at the Sugamo Mental Hospital and the curriculum of his students, they did not instantly change the way other Japanese psychiatrists conceptualized mental illness. The classification systems presented by Araki and Kadowaki at the Tokyo Conference of 1905 can be seen as alternative approaches to psychiatric theory that continued to play a role outside of the confines of Tokyo Imperial University. Neither Araki nor Kadowaki embraced the concept of manic-depressive insanity in their classification systems (see Table 4.1 and Table 4.2), and although they used the term *dementia praecox*, it is clear from their classification systems' structure that it was conceptually different from Kure's usage of the term.

Upon close examination, both Araki's and Kadowaki's classification systems share their conceptual framework with the teachings advocated by Theodor Ziehen, one of the main adversaries of Kraepelin and a representative of the Berlin School. At the time of the conference, Ziehen already held the prestigious chairmanship of psychiatry at the Berlin Charité Hospital. He was a known proponent of associationism, and his *Leitfaden der physiologischen Psychologie* was a popular textbook on physiological psychology that reached a twelfth edition and was translated into several languages, including English, Russian, and Japanese.¹ However, he openly distanced himself from physiological psychology as it was being practiced by Wilhelm Wundt and particularly rejected Wundt's concept of "apperception," which played an important role in Kraepelin's theory on mental disorders, as we have already seen.²

Ziehen also harshly criticized Kraepelin's and his associates' methods of practicing experimental psychology at the Heidelberg clinic. His critique in this field is especially significant because it concerned one of the arguments that Kraepelin used to support his conception of the *manic-depressive insanity* category. Based on association-test experiments investigating the reaction time of *manic* patients, Kraepelin had argued that the

1 Boring, *A History of Experimental Psychology*, 427. Some of the early translations and adaptations of Ziehen's *Leitfaden* include Theodor Ziehen, *Introduction to Physiological Psychology*, trans. from the German by Charles van Liew and Otto Beyer (London: Swan Sonnenschein & Co., 1892); Theodor Ziehen [Chihen チーヘン], *Seiriteki shinrigaku* 生理の心理学 [Physiological Psychology], trans. from the German by Matsumoto Kōjirō 松本孝次郎 (Tōkyō: Seibidō, 1901); Theodor Ziehen [Zigen, Teodor], *Fiziologičeskaja psihologija v 15 lekcijach* [Physiological Psychology in 15 Lessons], trans. from the German by Vladimir Dinze (St. Petersburg: Izdanie O. Bogdanowoj, 1909). The translation of several terms (tone of feeling, apperception) used in Matsumoto Kōjirō's (1870–1932) translation differs from Araki's. It seems likely that Araki consulted the German original without relying on Matsumoto's Japanese translation.

2 Ziehen explicitly distances himself from Wundt's associationism in the preface of his *Leitfaden* Theodor Ziehen, *Leitfaden der Physiologischen Psychologie in 14 Vorlesungen* [Outline of Physiological Psychology in 14 Lectures] (Jena: Verlag von Gustav Fischer, 1891), iii.

process of the “association of ideas” in these patients was not accelerated, as Ziehen and others believed, but was in fact considerably retarded, like in the case of *melancholic* patients.³ He consequently used these results to argue for his hypothesis that mania and melancholia were indeed one and the same illness, marked by the same underlying disease process. Ziehen openly challenged these results, dismissively labeled Kraepelin’s approach as a fruitless exercise in “chronoscope-psychology,” and scoffed at Kraepelin’s attempt to redefine mania as being primarily a disease of motor dysfunction.⁴

But Ziehen’s critique against this argument was not only aimed at discrediting the validity of the results obtained in the laboratory of the Heidelberg clinic. He also challenged Kraepelin’s aspirations of establishing the norms of psychological experimentation in psychiatry. Ziehen questioned the methods by means of which the results had been obtained and argued that the experimental design was ill-suited to advance these claims. According to him, the higher test values obtained in association tests with manic patients could not be unambiguously explained by the inhibition of the association process proper or by a (mechanically) inhibited verbal response. He particularly insisted that when manic patients were forced to produce associations for a certain period of time, as in Aschaffenburg’s experiments, they would naturally need longer than healthy test persons because of all the disruptive thoughts that went through their heads.⁵ He further stated that many other psychiatrists, such as Hermann Ebbinghaus (1850–1909) and Carl Wernicke, had developed far better experimental settings and openly mocked Kraepelin for his arrogance in trying to monopolize the psychological experiment and to set new standards all by himself.⁶

3 Kraepelin, *Psychologische Arbeiten*, 12. The results of these experiments (discussed in the previous chapter) were presented by Aschaffenburg at the Heidelberg Conference of 1896 following Kraepelin’s talk on “Aims and Means of Clinical Psychiatry” (Gustav Aschaffenburg, “Psychophysische Demonstrationen,” *Allgemeine Zeitschrift für Psychiatrie* 53, no. 5 [1897]: 848–854). In the ensuing discussion, the methods and assumptions on which the experiments relied were criticized by two speakers from Berlin and Halle (Aschaffenburg, Laehr, and Beyer, “Jahressitzung des Vereins der deutschen Irrenärzte am 18. und 19. September 1896 in Heidelberg,” 854–855).

4 Theodor Ziehen, “Über Messungen der Assoziationsgeschwindigkeit bei Geisteskranken, namentlich bei zirkulärem Irresein” [On Measurements of the Velocity of Associations with Mental Patients, Namely with Circular Instancy], *Neurologisches Centralblatt* 15, no. 7 (1896): 305. Ziehen must have used the expression “chronoscope-psychology” at a public meeting as one of Kraepelin’s loyal disciples indignantly complained about his tone at the occasion (Ernst Roemer, “Zur Frage der psychischen Zeitmessungen bei Geisteskranken” [On the Question of Mental Chronometry of Mental Patients], *Zeitschrift für Psychologie und Physiologie der Sinnesorgane* 12 [1896]: 140). If Ziehen’s attack on Kraepelin was personal, so were the counter-attacks from the members of the Heidelberg School. The above mentioned article by Ernst Roemer (dates unknown) is nothing but a vigorous defense of Kraepelin’s methods and a scathing review of one of Ziehen’s own work on experimental psychology.

5 Ziehen, review of *Psychologische Arbeiten*, vol. 1, issue 1 by Emil Kraepelin, 250.

6 *Zahlreiche Psychiater stellen solche und ähnliche Versuche an, welche den rohen Beobachtungen, welche K. für das Laboratorium empfiehlt, und auf Grund deren er den psychologischen Versuch monopolisiert zu haben glaubt, weit überlegen sind* [Numerous psychiatrists conduct like and similar experiments that sur-

Concurrently, Ziehen was far better known for his work among the more philosophically oriented adherents of experimental psychology, and unlike Kraepelin, he made a guest appearance at the inaugural meeting of the German Society of Experimental Psychology in Giessen in 1904, where he presented his experience in mental chronometry with healthy and mentally ill individuals.⁷ Later in life, Ziehen accepted a position as professor of philosophy in Halle, following his lifelong ambition to investigate philosophical and epistemological questions raised by psychological experimentation.⁸ At the time of the conflict between the Heidelberg School and the Berlin School, psychology mostly existed as a branch of philosophy, which was primarily due to Wilhelm Wundt's efforts to institutionalize the discipline within the existing system.⁹ Ziehen's interest in philosophy set him apart from Kraepelin and his associates, who were mostly interested in the application of experimental psychology but were unable to participate in the philosophical debate on the same level.¹⁰

With regard to the general approach to classifying mental disorders, Ziehen strongly disagreed with Kraepelin, who propagated disease specificity (i.e. the idea that diseases are static natural entities) as well.¹¹ Although Ziehen used a division that took the outcome of the disease into account himself, his classification allowed for an evolution of mental disorders under certain conditions. His basic subdivision was based on the experience that some psychoses passed without any lasting damage to mental functioning, whereas other psychoses caused a defect of intelligence (weakness of judgment or memory). How-

pass the crude observations that [Kraepelin] recommends for the laboratory, and on the basis of which he thinks to have monopolized the psychological experiment] in Ziehen, review of *Psychologische Arbeiten*, vol. 1, issue 1 by Emil Kraepelin, 250.

7 Robert Sommer, *Die Ausstellung von experimental-psychologischen Apparaten und Methoden bei dem Kongress für experimentelle Psychologie Gießen 18.–21. April 1904* [The Exposition of Experimental Psychological Apparatuses and Methods at the Congress for Experimental Psychology in Gießen on April 18–21, 1904] (Leipzig: Johann Ambrosius Barth, 1904). Ziehen gave a presentation on “Measurement of the reaction-time of mentally ill and mentally healthy individuals” (*Messung der Reaktionszeiten bei Geisteskranken und Geistesgesunden*). Among Kraepelin's immediate followers, only Wilhelm Weygandt was present, by then based in Würzburg, and giving a presentation on the psychology of sleep “Contributions on the Psychology of Sleep” (*Beiträge zur Psychologie des Schlafes*). The only speaker from Heidelberg was Theodor Elsenhans (1862–1918), assistant professor for philosophy and psychology and not affiliated with Kraepelin (by then based in Munich) and the psychiatric clinic of Heidelberg.

8 Baethge, Glovinsky, and J., “Manic-Depressive Illness in Children,” 204.

9 Ash, “Academic Politics in the History of Science”; Ash, “Psychologie in Deutschland um 1900.”

10 Wilhelm Weygandt's contributions to the field may perhaps be regarded as an exception to the otherwise predominantly practical approach of the Heidelberg School (Wilhelm Weygandt, “Zur Frage der materialistischen Psychiatrie” [On the Issue of Materialistic Psychiatry], *Centralblatt für Nervenheilkunde und Psychiatrie* 12 [1902]: 409–415; Wilhelm Weygandt, “Ueber Psychiatrie und experimentelle Psychologie in Deutschland” [On Psychiatry and Experimental Psychology in Germany], *Münchener Medizinische Wochenschrift* 50, no. 45 [1903]: 1945–1949). Before joining the Heidelberg team in 1897 he had obtained his doctorate in philosophy in Wundt's laboratory in Leipzig.

11 E. Engstrom, “Tempering Madness,” 170–171.

ever, Ziehen did not believe that this bipartite division was absolute, and he noted that disorders referred to as *secondary dementia* represented a link between the two groups.¹² Neither did he assume that psychoses were natural kinds, but instead he regarded them as being composed of a series of manifestations whose logical ordering depended upon the intention of the psychiatrist.¹³

Although the construction of Araki's classification system of mental disorders was entirely built on the associationist theory as it was taught by Ziehen, it did not reflect Ziehen's classificatory divisions. At the same time, it was fundamentally different from Kure's system, but the difference did not lie between "old" and "new."¹⁴ When compared to earlier classifications used in Tokyo, Araki's classification system was at least as "new" as Kure's method, but it moved in a completely different direction. It is largely due to later historical accounts that Kraepelin's work has been retrospectively labeled as having modernized psychiatry and turned it into a scientific discipline, and that everyone associated with his work is automatically regarded as being on the path to psychiatry's future, whereas his opponents are considered to be backward and old-fashioned. Furthermore, Araki's classification was not simply copied from a German textbook, and although it would be appropriate to call Kure's classification system "Kraepelinian," Araki's method could not be called "Ziehenian." Instead, it was so much his own invention that it has never been correctly attributed to any particular school.

Unfortunately, Araki's actual talk at the conference of the Japanese Society for Neurology has not been recorded, and its only trace is an outline of the classification system that he presented at the occasion.¹⁵ In lieu thereof, the main source of information on Araki's method of classifying mental disorders is his textbook on psychiatry, which was published in 1906.¹⁶ It seems that Araki used the conference in Tokyo to present the contents of the book that he was about to publish shortly afterwards. The classification that

12 Theodor Ziehen, *Psychiatrie für Ärzte und Studierende* [Psychiatry for Doctors and Students] (Leipzig: S. Hirzel, 1902), 315–316.

13 Theodor Ziehen, "Ueber einige Lücken und Schwierigkeiten der Gruppierung der Geisteskrankheiten" [On Some Omissions and Problems in Grouping Mental Disorders], *Monatsschrift für Psychiatrie und Neurologie* 15 (1904): 147.

14 In his discussion of the introduction of the dementia praecox concept in Japan, Okada Yasuo (1931–) mentions Araki's talk and his textbooks, but his analysis is mostly limited to establish the occurrence of the term *dementia praecox* in Japanese medical texts. Thus he does not primarily compare disease concepts but disease names (Okada Yasuo, "Nihon ni okeru sōhatsu chikyō," 13).

15 I use the outline from the *Igaku chūō zasshi* for formal reasons, because in the *Shinkeigaku zasshi*, it was reproduced over two pages (Araki Sōtarō 荒木蒼太郎, "Kyōshitsu no ruibetsu" 狂疾ノ類別 [Classification of Mental Disorders], *Igaku chūō zasshi*, no. 34 [1905]: 1078). There are no differences in content, except that in the *Igaku chūō zasshi* the character *kon* 昏 is missing in the term *konmeikyō* 昏迷狂 (stupidity).

16 Araki Sōtarō 荒木蒼太郎, *Seishin byōri hyōshaku* 精神病理氷釋 [On the Pathology of Mental Illness] (Tōkyō: Tohōdō, 1906).

he presented as well as the topics that he discussed in two subsequent talks at the same event were all part of his new book.¹⁷

The original outline of Araki's classification in Figure 4.1 shows a basic division into four main categories, marked as A (*kō* 甲), B (*otsu* 乙), C (*bei* 丙), and D (*tei* 丁). Without knowledge of the associationist theory, the meaning of these four categories does not become readily apparent, but the names of the diseases that are contained in the categories are established well enough to be translated right away: the first category (A) contains *hallucinatory insanity* with the sub-categories of *alcoholic hallucinatory insanity*, *delirium tremens*, *epileptic hallucinatory insanity*, *hysteric hallucinatory insanity*, *periodic hallucinatory insanity*, and *transitory hallucinatory insanity*. The second category (B) contains *melancholia*, *mania*, and *circular insanity*, with their respective subdivisions. The third category (C) consists of *stuporous insanity* (comprising *acute stupidity*) and *compulsive disorders*. Finally, the last category (D) is made up of *paranoia*, *idiotism*, and *dementia*, which are in turn divided into various sub-forms.

The logic behind this division only becomes understandable when Araki's textbook is consulted and his terminology is matched with contemporary concepts used in associationist theory. According to this theory, all mental activity can be reduced to a few basic elements. "Sensation" (*kankaku* 感覚)—usually caused by an external stimulus (*gairai shigeki* 外来刺激)—is the first link in the psychic process (*seishin sayō no kishu nari* 精神作用ノ起首ナリ).¹⁸ It gives rise to a "mental image" or an "idea" (*kannen* 観念), which can reproduce an idea that is similar to the original idea in content (*sōji kannen* 相似観念) or an idea with which it has already appeared simultaneously (*dōji ni kannen shōjitaru kannen* 同時ニ生シタル観念). These two mechanisms, also referred to as the "law of similarity" and the "law of contiguity," govern the "association of ideas" (*rengō sayō* 聯合作用) and are understood as the principal laws of association (*rengōritsu* 聯合律) that lay at the basis of all thought. "Action" and "body movement" (*shintai undō* 身體運動) are understood as the result of the "association of ideas" that has arisen from a "sensation."¹⁹

17 The second talk dealt with the subject of war-related mental illness and the third with the relationship between crime and insanity as well as with the Japanese jurisdiction regarding mental illness (Araki Sōtarō 荒木蒼太郎, "Hatsukyō to hōritsu to no kankei" 發狂ト法律トノ關係 [The Relationship between Mental Illness and the Law], *Shinkeigaku zasshi* 4, no. 5 [1905]: 36–40; Araki Sōtarō 荒木蒼太郎, "Seneki ni insuru seishinbyō ni tsukite" 戦役ニ因スル精神病ニ就キテ [On Psychoses Caused by the War], *Shinkeigaku zasshi* 4, no. 5 [1905]: 40–41). The text of the former was included into the chapter on etiology (Araki Sōtarō, *Seishin byōri hyōshaku* 106–108), see also fn. footnote 9 on p. page 194. Parts of the latter were put into the section on jurisdiction and into the appendix (Araki Sōtarō, 167–171, 248–269).

18 Araki Sōtarō, 2.

19 Araki Sōtarō, 5. Psychiatrists who based their work on the associationist theory are sketchily discussed in Boring's whiggish history of experimental psychology. They are described as "belonging on the periphery" (Boring, *A History of Experimental Psychology*, 426). Rapaport ends his philosophical inquiry into the conceptual history of the association of ideas with David Hume (1711–1776) and Immanuel Kant

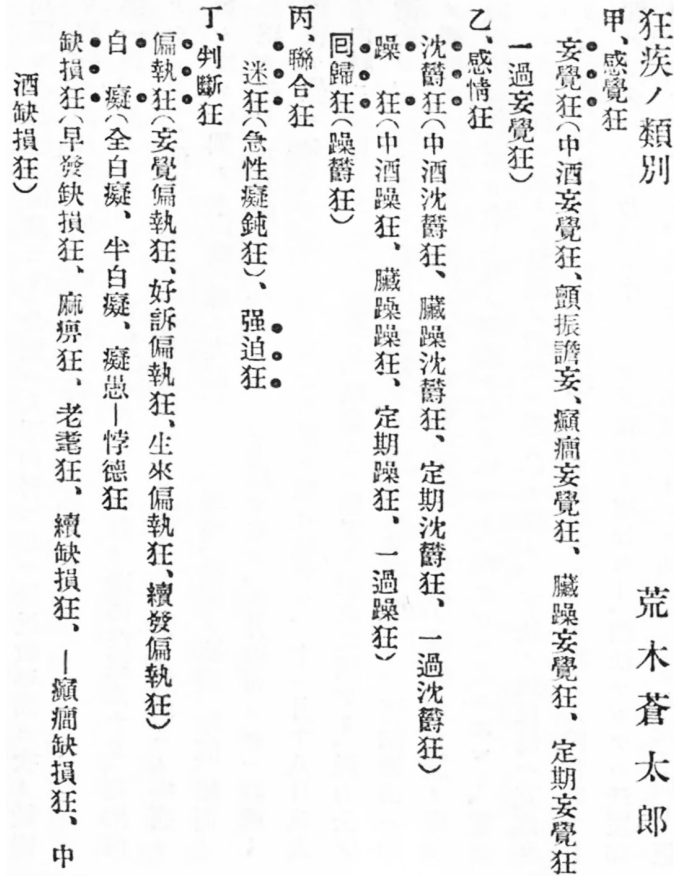


Figure 4.1: Araki's classification of mental disorders in 1905

Associationists such as Ziehen and Araki generally rejected the idea of the existence of separate mental faculties (imagining, feeling, and willing) and explained all mental activity on the basis of the associationist theory, even though it is hard to tell this from reading their works, in which they keep using terms like “tone of feeling,” “affect,” and “action.”²⁰

(1724–1804). He mentions Wilhelm Wundt and Theodor Ziehen (1862–1950) merely as the inheritors of the English associationist tradition. He also notes that associations were the focus of Sigmund Freud's psychoanalysis (David Rapaport, *The History of the Concept of Association of Ideas* [New York: International Universities Press, 1974], 2–3). This particular aspect is more thoroughly discussed in Guenther, *Localization and Its Discontents*, 81–85.

20 *Die sog. Seelenvermögen, welche die ältere speculative Psychologie unterschied, existiren nicht. Speciell ist die Annahme eines besonderen Willensvermögens, welches über der Ideenassociation schweben und “willkürlich” diese oder jene Bewegung innerviren würde, überflüssig und irreleitend* [The so-called mental facul-

Table 4.1: Araki’s classification of mental disorders

Insanity of sensation		Insanity of intellectual feeling		Insanity of association		Insanity of judgement	
Hallucinatory insanity		Circular insanity		Compulsive insanity		Dementia	
		Mania				Idiotism	
						Paranoia	
		Alcoholic mania				{ Hallucinatory paranoia Querulent paranoia Congenital paranoia Secondary paranoia	
		Hysterie mania				{ Idiocy Imbecility Debility (moral insanity)	
		Periodic mania				{ Dementia praecox Dementia paralytica Senile dementia Secondary dementia (epileptic dementia, alcoholic dementia)	
		Transitory mania		Acute stupidity			
		Manic-melancholic insanity					

Still, as their system did not allow for a faculty of volition, there also could not be a faculty of affection. According to Araki's terminology, sensations and ideas could be accompanied by "tones of feeling" (*jō* 情).²¹ Tones of feeling attached to sensation were called sensorial feelings (*kanshoku* 感觸), and those attached to ideas were called intellectual feelings (*kanjō* 感情).²² Negative tones of feeling could slow down the association of ideas (i.e. the process by which ideas were linked to one another), whereas positive tones of feeling accelerated the process. Even "judgment" was conceptualized as resulting from the association of ideas, and intelligence was, in turn, understood as the product of associations of judgment (*handan rengō* 判斷聯合).²³ Once the conceptual intricacies of Araki's classification system have been disentangled, it is possible to give a full picture of the outline that he presented at the conference. Following the explanations in his textbook, the four main categories in his classification must be translated as follows: A) insanity of sensation (*kankakukyō* 感覺狂), B) insanity of intellectual feeling (*kanjōkyō* 感情狂), C) insanity of association (*rengōkyō* 聯合狂), and D) insanity of judgment (*bandankyō* 判斷狂). When those basic categories are combined with the list of diseases and their respective sub-diseases, Table 4.1 unfolds.²⁴ To my knowledge, it gives the first complete rendition of Araki's classification system in any European language.

According to the structure of his classification system, melancholia (*chinutsukyō* 沈鬱狂), which was listed as a disorder in the category of insanity of intellectual feeling, was understood as an illness in which ideas were colored by negative tones of feeling.²⁵ Within the associationist framework, this pathological state was deemed to cause an inhi-

ties, which had been differentiated within the older speculative psychology, do not exist. The assumption of a special volitional faculty that stood above the association of ideas and "arbitrarily" triggered this or that movement is particularly superfluous and misleading] in Ziehen, *Psychiatrie für Ärzte und Studierende*, 1st ed., 5. On the influence of faculty psychology on psychiatric classifications see Radden, "Lumps and Bumps." Wilhelm Griesinger (1817–1868) was the first German psychiatrist to apply associationist psychology to explain mental disorders (Schmidt-Degenhard, *Melancholie und Depression*, 44–45).

21 I deliberately translate *jō* 情, which means "emotion" or "feeling" in common language, with the technical term "tone of feeling" used in associationist terminology. Although the first edition of Araki's textbook (1906) did not feature any German translations, the second edition of his textbook (1911) gives "Gefühlston" (tone of feeling) as a translation for *jō* (Araki Sōtarō, *Seishinbyōgaku sūki* 2). However, even without the additional information provided in the second edition, the context of Araki's text does not allow any other translation than the one required by the conceptual framework of associationist theory. Unfortunately, there are no German translations for his four main disease categories, as these are Araki's own creations.

22 Araki Sōtarō, *Seishin byōri hyōshaku* 2, 6.

23 Araki Sōtarō, 6.

24 To read the table in portrait view: Read vertical script from bottom to top and horizontal script from top to bottom. In landscape view: Read horizontal script from left to right and vertical script from right to left.

25 In the second edition of Araki's textbook, *chinutsukyō* 沈鬱狂 is identified as *Melancholie*, *sōkyō* 躁狂 as *Manie*, and *kaikikyō* 回歸狂 as *Zirkuläres Irresein* (Araki Sōtarō, *Seishinbyōgaku sūki* 205, 215, 222).

bition of the association of ideas that resulted in slowed thought and slowed movements. Melancholia was then further subdivided into *alcoholic melancholia*, *hysteric melancholia*, *periodic melancholia*, and *transitory melancholia*.²⁶ As mentioned above, Araki's way of classifying mental disorders was different from Ziehen's classification, even though the conceptual framework within which it had been devised remained the same. More remarkably, Araki's conception of melancholia was radically opposed to Kraepelin's definition of the disorder because the hierarchy of pathognomonic (disease-characteristic) symptoms was reversed. Whereas Kraepelin defined the disorder primarily as a disease of motor dysfunction and considered the disturbed mood to be accessory, Araki inversely considered the negative emotions to be responsible for the mental inhibition and the motor dysfunction.

On a less obvious level, the difference between Araki's and Ziehen's systems becomes more palpable when the contribution of Kadowaki Masae is examined. Kadowaki was discussant for Araki's talk and briefly commented on the latter's classification method. He generally agreed with Araki's classification, which he characterized as "based on psychology" (*shinrigaku-jō* 心理學上). However, he criticized it as being a bit too simple and opined that there should be further subdivisions.²⁷ He then presented his own classification system, which was basically an adaptation of Ziehen's method. He stated that he regarded Ziehen's classification as the clearest (*mottomo meiseki* 最モ明晰) and best suited to practice (*jitchi ni atte ii* 實地ニ當ツテ善イ) among all the classifications found in foreign literature.²⁸ Compared to Araki's four-part division, Kadowaki's classification did, indeed, show a more complex layered structure (see Figure 4.2).

In Kadowaki's version, all mental disorders were first divided into psychoses *without* defect of intelligence (*tenkyō* 癲狂) and into those *with* defect of intelligence (*chikyō* 癡狂). Under the first category he grouped the affective psychoses (*kandōkyō* 感動狂), comprising *mania*, *melancholia*, *manic melancholia*, and *melancholic mania* as well as the intellectual psychoses (*chiseikyō* 智性狂), including *stupidity*, *paranoia*, *dreamy states*, *deliria*, *compulsive insanity*, and *psychopathic constitutions*. Within the category of defect

26 Some of Araki's translations are relatively rare in Japanese medical literature. For instance, his translations of *dementia praecox* (*sōhatsu kessonkyō* 早發缺損狂) or *stuporous insanity* (*konmeikyō* 昏迷狂) are not commonly used. The term *kyūsei chidonkyō* 急性癡鈍狂 does not reappear in any of Araki's textbooks, but it is probably an alternative writing for the homophone and more common *chidonkyō* 遲鈍狂 that was used to translate *stupidity* in other textbooks (Kure Shūzō, *Seishinbyōgaku shuyō* 207; Kadowaki Masae, *Seishinbyōgaku* 658). There are also some terms in the group of *hallucinatory insanity* which do not reappear in Araki's textbooks. Epileptic and hysteric "hallucinatory insanity" (*mōkakukyō* 妄覺狂) are discussed under the terms of epileptic and hysteric "dreamy states" (*mubi jōtai* 夢寐狀態) in the 1906 version and are changed into epileptic and hysteric "delirium" (*senmō* 譫妄) in the 1911 version. *Hakuchi* 白癡, translated here as *idiotism*, refers to a group of disorders characterized by congenital mental defect, whereas *zenhakuchi* 全白癡 [full idiotism] denotes the severest kind within that group, usually referred to as *idiocy*.

27 Kadowaki Masae, discussion following Araki Sōtarō's talk on Classification, 34–35.

28 Kadowaki Masae, 35.

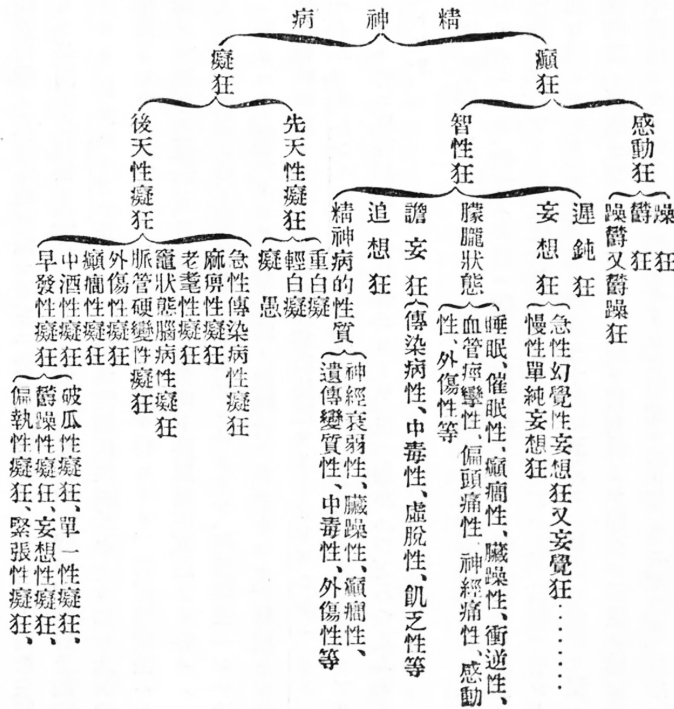


Figure 4.2: Kadowaki's classification of mental disorders in 1905

psychoses he firstly grouped the states of congenital defect (*sentensei chikyō* 先天性癡狂), comprising *idiocy*, *imbecility*, and *debility* and secondly the psychoses from acquired defects (*chikyō kōtensei* 後天性癡狂), consisting of nine forms of *dementia* (see Table 4.2 for the complete English translation).²⁹

Upon comparing their respective classifications, it becomes apparent that many of the individual elements in Araki's and Kadowaki's classifications are the same but that their systems' differing structures modify the meaning of the individual components. Conversely, although Kadowaki translated *melancholia* with a different Japanese term (*utsukyō* 鬱狂) than Araki, its categorization as an "affective disorder" was very similar to Araki's categorization as a form of "insanity of intellectual feeling." According to Ziehen, who remained the point of reference for both authors, "affect" described intellectual tones of feeling (or "intellectual feeling" for short) that had an impact on both the as-

29 To read the figure in portrait view: Read vertical script from bottom to top and horizontal script from top to bottom. In landscape view: Read horizontal script from left to right and vertical script from right to left.

Table 4.2: Kadowaki's classification of mental disorders

Mental diseases			
Psychoses without defect of intelligence		Psychoses with defect of intelligence	
Affective	Intellectual	Congenital	Acquired
Mania Melancholia Manic melancholia and melancholic mania	Deliria Compulsive insanity Psychopathic consti- tutions Dreamy states Paranoia Stupidity	Idiocy Imbecility Debility	Dementia after acute infections Dementia paralytica Senile dementia After brain lesions Arteriosclerotic dementia Traumatic dementia Epileptic dementia Alcoholic dementia Dementia praecox
	Neurasthenic, hysterical, epileptic, hereditary-degenerate, toxic, traumatic		Hebephrenic dementia, dementia simplex, manic-depressive dementia, hallucinatory dementia, dementia paranoides, catatonic dementia
	Infectious, toxic, from collapse, from hunger		
	Sleep-related, hypnotic, epileptic, hysterical, congestive, angiospastic, from migraine, neuralgic, affective, traumatic		
	Acute hallucinatory paranoia, hallucina- tory insanity, paranoia simplex chronica		

sociation of ideas and the patient's actions.³⁰ Whereas "intellectual feeling" was defined as a basic thought process that could either have an impact on cognition, on action, or on both, "affect" was defined as a specific category of "tones of feeling" that always affected both. Generally speaking, Kadowaki's category of "affective disorders" can be thought of as a subset of Araki's category of "insanity of intellectual feeling." In principle, the only difference was that, while Araki's concept implied that the patient's negative emotions *could potentially affect motor function* as well, Kadowaki's definition suggested that negative emotions *always affected motor function*. In this regard, Araki's and Kadowaki's conceptualizations had in common that they both prioritized the role of negative emotions over motor functions, a hierarchization directly opposed to Kraepelin's definition of *manic-depressive insanity*.

This "intrinsic" definition of melancholia is additionally shaped by an "extrinsic" definition that is predicated on the relationship between all other disease concepts within the classification system. This structural relationship affects the meaning of the individual components in the sense that the configuration of the whole system exerts an influence on its constituent parts. In other words, melancholia is as much defined by what it *is* on an intrinsic level and by its relative position within the extrinsic conceptual framework as it is defined by what it explicitly *is not* within the compounded sum of concepts in the extrinsic structural frame. In Araki's system, the emphasis in the melancholia concept was put on the disturbance of the tone of feeling, whereas the role of disturbances in the area of sensations, associations, and the ability to form judgments was simultaneously de-emphasized. As was the case for all other diseases within his general framework as well, the prognosis for melancholia remained undecided. In Kadowaki's system, on the other hand, melancholia was characterized as an illness that always proceeded without permanently damaging the mental faculties of the patient. It primarily affected the emotional sphere and only secondarily caused disturbances in sensation and ideation (in an associationist sense). It was a shared feature of Araki's and Kadowaki's classifications that the diseases were arranged by order of severity, which also attests to the relatively lesser severity of the disease in Kadowaki's view.

Despite all of these similarities, Kadowaki described his own approach as "clinical" (*rinsbō-jō* 臨床上), in contrast to Araki's "psychology-based" classification, and stressed its practical value. Whereas Araki arranged illnesses according to basic disorders of the thought process (sensation, tone of feeling, association, and judgment), Kadowaki stuck to Ziehen's original classification for the most part.³¹ However, whereas Araki's classification listed *secondary dementia* in the category of "insanity of judgment" and accordingly reflected Ziehen's view of a dynamic disease evolution (in contrast to Kraepelin's static

30 Ziehen, *Psychiatrie für Ärzte und Studierende*, 1st ed., 59.

31 Kadowaki abandoned Ziehen's division of the psychoses without defect into simple and composite psychoses, but otherwise mostly followed the classification laid out in the second edition of the latter's textbook.

disease concept), it remains unclear whether Kadowaki also used this category, which appeared neither in his talk nor in his general outline, but which he had discussed in writing on at least one other occasion.³²

It is possible that Kadowaki deliberately left out this critical topic from his talk to meet the expectations of the pro-Kraepelin audience at Tokyo, as is evidenced by several other details. For instance, in arguing for his classification, he explicitly emphasized its applicability to the Japanese case. He insisted that Ziehen's classification was "consistent with the clinical experience in Japan," by which he not only implied that the categories reflected disease forms encountered among the Japanese population, but also made a connection to the German tradition instead of the Japanese medical tradition that he had still stressed in the presentation of his textbook in 1902.³³ Furthermore, by dividing mental disorders into psychoses *with* defect and psychoses *without* defect, he created a connection to the Heidelberg School, as this differentiation was in line with Kraepelin's insistence on the primacy of prognosis. Lastly, Kadowaki went so far as to imply that his method was compatible with the Kraepelinian system, and when he discussed the category of dementia praecox, he explicitly stated that he took care to consult the latest edition of Kraepelin's textbook, which was currently in vogue in Tokyo.³⁴

However, although Kadowaki presented his classification as inspired by both Ziehen and Kraepelin, it was still in conflict with the reforms introduced by Kure Shūzō at Tokyo Imperial University in 1902.³⁵ In point of fact, the term dementia praecox may very well have appeared in both Araki's and Kadowaki's outlines, but the presence of other disease terms in their classifications precludes that it could have had the same meaning as in Kure's system. Indeed, as the term dementia praecox had also undergone transformations in meaning, its usage did not automatically imply an acceptance of Kraepelin's newest classification principles—not even when it was used with reference to his name.³⁶

32 In his textbook published three years before the conference, Kadowaki did use the concept of *secondary dementia* (Kadowaki Masae, *Seishinbyōgaku* 815–817). However, this text was based on the first edition of Ziehen's textbook (1894), where secondary dementia was discussed as one of the defect psychoses (Ziehen, *Psychiatrie für Ärzte und Studierende*, 1st ed., 446). In his talk in 1905, Kadowaki followed the second edition of Ziehen's textbook (1902), where secondary dementia was a special case treated outside of the general discussion of mental disorders (Ziehen, *Psychiatrie für Ärzte und Studierende*, 2nd edition, 715). Therefore, the absence of this concept from his classification does not prove that Kadowaki did not consider it as a possible deterioration.

33 Kadowaki Masae, discussion following Araki Sōtarō's talk on Classification, 35.

34 Kadowaki Masae, 35.

35 According to Okada, Kadowaki's method was a mixture of the "conventional" and the Kraepelinian classification method (Okada Yasuo, "Nihon ni okeru sōhatsu chikyō," 13). However, this opinion seems to be based on the observation that, while Kadowaki accepted the dementia praecox concept, he refused the manic-depressive insanity concept (as we have already seen in chapter 2, Kraepelin's rationale for classifying mental disorders was characterized by the dichotomy of these two disorders).

36 In his textbook, Araki attributes the terms dementia praecox and its paranoid variety to Kraepelin, whereas catatonia is attributed to Karl Ludwig Kahlbaum. In the history of psychiatry, the attribution of

Araki's and Kadowaki's engagement with foreign medical concepts such as melancholia and dementia praecox has revealed itself to be a multifaceted issue. Generally speaking, it consists of a complicated process that comprises inventive translations, partial adaptations, and creative appropriations. On a linguistic level, the choice of the term *utsu* 鬱 as a loanword for a variety of melancholia concepts has proven its usefulness to Japanese psychiatrists in accommodating different layers of the aggregated meaning of melancholia over the centuries. On a personal level, it reveals a great skill for the assimilation of new ideas on the part of the Japanese physicians. Yet another approach to dealing with the controversial issue of depressed states can be found in the work of Matsubara Saburō, who explored the pathways opened by experimental psychology along different lines than those mapped out by the Heidelberg and Leipzig Schools and formulated his own definition of melancholia.

4.2 Matsubara Saburō's Work on Melancholia in the United States

At the time when Matsubara Saburō, the third and last Japanese antagonist to the pair formed by Kraepelin and Kure, submitted his doctoral thesis "On the Nature of the Depressive Psychosis," several other psychiatrists around the world were pursuing a similar quest by trying to harness the methods of experimental psychology to redefine psychiatric categories. Matsubara's main point of reference were Kraepelin's ideas on manic-depressive insanity and the arguments put forward by his pupil Georges Dreyfus (1879–1957).³⁷ As we have already seen in the preceding chapter, Kraepelin and Aschaffenburg had argued that the duration of associations was not shorter in manic states than in healthy individuals, but that it was almost as long as in depressed states. They had obtained these results through psychological experiments and concluded that, since both manic and depressed states were characterized by a slowing of the association process and an inhibition in motor activity, it was justified to combine the two disorders into the large super-category of manic-depressive insanity. When other psychiatrists put these

dementia praecox to Kraepelin is controversial. The term was already used in its Latin form by Heinrich Schüle (1840–1916) in 1880, although Schüle was referring to a different disease concept than Kraepelin (Kieran McNally, "Dementia Praecox Revisited," *History of Psychiatry* 24, no. 4 [2013]: 507). Berrios, Rogelio and Villagrán argue that the concept of *dementia praecox* as it was used by Kraepelin in 1896 had first been described by the Prague psychiatrist Arnold Pick (1851–1924), in 1881 (Berrios, Luque, and Villagrán, "Schizophrenia," 128). As I have already shown in chapter 2, Kraepelin himself used the term in different variations. In the 1896 edition of his textbook, it was basically identical with the hebephrenia concept and seen as separate from catatonia and *dementia paranoides*. However, in the 1899 edition of his textbook, it became an overarching category for "dementing processes" that included hebephrenia, catatonia, and dementia paranoides. While Araki used the term in the sense of the 1896 edition, Kadowaki used it in the sense of the 1899 edition with some personal additions.

³⁷ Dreyfus, *Die Melancholie*.

results to the test, some of them were able to reproduce the results, while others obtained contradicting numbers.³⁸ The issue of manic-depressive insanity and its exact delineation through experimental methods remained open, and it is in this field that Matsubara's contribution should be seen. From all that we can tell, his thesis was an audacious attempt to redefine the boundaries of a mental disorder whose nature and characteristics were controversial and which at the time was referred to as "melancholia," "manic-depressive insanity," or "circular insanity" by different physicians. It was the most extensive study written by a Japanese psychiatrist on the subject of "depressed states" in the Meiji period (1868–1912), and it is a remarkable and unusual piece of work in many respects.³⁹

Matsubara's thesis was submitted at Tokyo Imperial University in 1910, but it was mainly based on research conducted at the Manhattan State Hospital in the United States between 1903 and 1908.⁴⁰ It was a voluminous book of more than 1,000 typewritten pages, composed in both English and German, and is nowadays regrettably believed

38 Similar association tests as those performed by Aschaffenburg were conducted by Carl Gustav Jung and Franz Riklin, "Diagnostische Assoziationsstudien: I. Beitrag. Experimentelle Untersuchungen über Assoziationen Gesunder" [Diagnostic Association Studies: I. Contribution. Experimental Studies on the Associations of Healthy Persons], *Journal für Psychologie und Neurologie* 3, nos. 1–2 (1904): 55–83; Carl Gustav Jung and Franz Riklin, "Diagnostische Assoziationsstudien: I. Beitrag. Experimentelle Untersuchungen über Assoziationen Gesunder. II. Teil Versuchsergebnisse" [Diagnostic Association Studies: I. Contribution. Experimental Studies on the Associations of Healthy Persons. II. Part. Test Results], *Journal für Psychologie und Neurologie* 3, no. 4 (1904): 145–164; Carl Gustav Jung and Franz Riklin, "Diagnostische Assoziationsstudien: I. Beitrag. Experimentelle Untersuchungen über Assoziationen Gesunder. Schluss" [Diagnostic Association Studies: I. Contribution. Experimental Studies on the Associations of Healthy Persons. End], *Journal für Psychologie und Neurologie* 4, nos. 1–2 (1904): 24–67; Eugen Bleuler, "Diagnostische Assoziationsstudien: v. Beitrag. Bewußtsein und Assoziation" [Diagnostic Association Studies: v. Contribution. Consciousness and Association], *Journal für Psychologie und Neurologie* 6, nos. 3–4 (1905): 126–154; Max Isserlin, "Psychologische Untersuchungen an Manisch-Depressiven" [Psychological Studies on Manic-Depressive Patients], *Monatsschrift für Psychiatrie und Neurologie* 22, no. 4 (1907): 302–355; Max Isserlin, "Psychologische Untersuchungen an Manisch-Depressiven" [Psychological Studies on Manic-Depressive Patients], *Monatsschrift für Psychiatrie und Neurologie* 22, no. 5 (1907): 419–442; Max Isserlin, "Psychologische Untersuchungen an Manisch-Depressiven" [Psychological Studies on Manic-Depressive Patients], *Monatsschrift für Psychiatrie und Neurologie* 22, no. 6 (1907): 509–36; Lazar' Gersonovič Gutman, "Éksperimental'no-psichologičeskie issledovanija v maniakal'no-melancholičeskom psichoze: sostojanie sosredotočenija resp. vnimanija, umstvennaja rabotosposobnost' i asociacii" [Experimental-Psychological Investigations of Manic-Melancholic Psychosis: The State of Concentration, Attention, Capacity for Mental Work, and Association of Ideas] (PhD diss., Imperatorskaja Voenno-Medicinskaja Akademija, 1909); Emil Moravcsik, "Diagnostische Assoziationsuntersuchungen," *Allgemeine Zeitschrift für Psychiatrie* 68, no. 5 (1911): 626–673; Martin Dettler, "Experimentelle Studien über Assoziationen Manisch-Depressiver im depressiven Zustand" [Experimental Studies on the Associations of Manic-Depressive Patients in the Depressed State] (PhD diss., Friedrich-Wilhelms-Universität zu Berlin, 1918).

39 A general description of Matsubara's sojourn in the U. S. is given in Terahata Kisaku 寺畑喜朔, "Matsubara Saburō kyōju to beikoku ryūgaku."

40 Iseki Kurō, *Igaku Hakushi (Hakushi of Medicine)*, 120 (jap); 128 (eng).

to be lost.⁴¹ Fortunately, the rough outlines of its contents can be reconstructed from a number of other primary materials, e.g. Matsubara's much shorter Japanese articles and abstracts of his public talks on related topics, such as the classification of mental disorders.⁴² Additionally, a one-page summary of his thesis that conveys the assessment of his work by his examiners at Tokyo University still exists.⁴³ However, the most valuable source is the detailed account of his main arguments that was published in the German edition of the Japanese Society of Neurology's official organ—the German-language journal *Neurologia*.⁴⁴ Nevertheless, all of these sources combined offer but a first glimpse into Matsubara's research methods, and they are ill suited to shedding a satisfyingly bright light on the question of how Matsubara actually challenged the theories of Kraepelin and Dreyfus by themselves.

The context from which Matsubara's work originated was quite unusual for an early-twentieth-century Japanese doctoral thesis in psychiatry.⁴⁵ His study was based on research that he had conducted at the United State's largest mental asylum, the Manhattan

41 Matsubara Shirō 松原四郎, "Matsubara Saburō sono tetchōtekina shōgai" 松原三郎その鉄腸的な生涯 [Matsubara Saburō: The Life of a Strong-Willed Man], *Brain and Nerve* 65, no. 11 (2013): 1410. The author of this article is Matsubara's grandson. It is presumed that Matsubara's thesis was destroyed in the fires following the Great Kantō earthquake of 1923. I am indebted to Murata Katsutoshi, the librarian of the Medical Library of Kanazawa University, for pointing me to this article and for providing me with information on Matsubara's lost thesis.

42 Matsubara Saburō 松原三郎, "Seishinbyō no bunrui ni kansuru shiken" 精神病ノ分類ニ關スル私見 [My View on the Classification of Mental Diseases], *Kanazawa igakkai kaihō* 1 (1910): 21–37; Matsubara Saburō 松原三郎, "Utsuyūbyō no hontai" 鬱憂病ノ本態 [The Nature of Melancholia], *Dai sankai Nihon igakkai shi*, 1911, 1147–1151; Matsubara Saburō 松原三郎, "Seishinbyō no bunrui" 精神病ノ分類 [The Classification of Mental Diseases], *Iji shinbun* 910 (1914): 1409–1410; Matsubara Saburō 松原三郎, "Seishinbyō no bunrui" 精神病ノ分類 [The Classification of Mental Diseases], *Shinkeigaku zasshi* 13, no. 7 (1914): 52–53.

43 The examiners' summary (*shinsa yōshi* 審査要旨) was published in the *Official Gazette* (Kanpō 官報), Japan's comprehensive government gazette which regularly informed the public about appointments in civil service and the granting of academic degrees (Matsubara Saburō 松原三郎, "Utsuyūsei seishinbyō no hontai" 鬱憂性精神病ノ本態 [The Nature of Depressive Psychoses], *Kanpō*, no. 8049 [1910]: 605).

44 Matsubara Saburō 松原三郎 [Matsubara, Saburo], "Das Wesen der depressiven Psychosen" [The Nature of the Depressive Psychoses], *Neurologia* 2 (1911): 37–47. Although all the Japanese sources mentioned above have already been used by Japanese historians to reconstruct Matsubara's legacy, the *Neurologia* article has been ignored so far. See Akitomo Harao 秋元波留夫, "Matsubara Saburō, furontia seishin igakusha" 松原三郎フロンティア精神医学者 [Matsubara Saburō, a Psychiatrist at the Frontier], *Rinshō seishin igaku* 8, no. 10 (1979); Okada Yasuo 岡田靖雄, "Senzen gasshūkoku ni ryūgaku shita seishinbyō gakusha tachi: Matsubara Saburō, Saitō Tamao, Ishida Noboru hoka" 戦前合州国に留学した精神病学者たち: 松原三郎、齋藤玉男、石田昇ほか, part 1 [Japanese Psychiatrists in the United States before World War II: Matsubara Saburō, Saitō Tamao, Ishida Noboru and Others], *Nihon ishigaku zasshi* 40, no. 3 (1994): 255–279; Matsubara Shirō, "Matsubara Saburō sono tetchōtekina shōgai."

45 In this period, it was common to obtain a doctoral degree for submitting two to three academic papers written at some point during one's medical career. In the medical faculty, most of these papers were written in German (Iseki Kurō, *Igaku Hakushi (Hakushi of Medicine)*).

State Hospital, located on Ward's Island in the East River.⁴⁶ He had received his basic training in medicine at the Kanazawa Medical School, from which he had graduated in 1899, and then specialized in psychiatry at Tokyo University, where he worked as one of Kure Shūzō's assistants at the Sugamo Mental Hospital in 1899–1903.⁴⁷ After that, Matsubara was the first Japanese psychiatrist to go to the United States for practical training and research.⁴⁸ On November 17, 1903, he ventured into this foreign country without having been able to procure a scholarship and without any first-hand experience or third-party guidance that he could rely on.⁴⁹ Equipped with a letter of recommendation from his professor in Tokyo, Matsubara explained his intentions and motivation to his future mentor Adolf Meyer in an introductory letter after he had already crossed the Pacific and landed in San Francisco:

Honourable Director,

It is me a great honour, that at first time I have a happy opportunity to write you. As my professor Sh. Kure wrote you in regard to me lately, I wish to study our special Psychiatry and Neurology by the microscopical and experimental ways under your supervision [sic!] for a long time.⁵⁰

From these few handwritten lines, it seems that Matsubara was especially interested in laboratory work and that he had chosen the American institution for its focus on practice and experimentation. The Manhattan State Hospital was indeed known for its innovative combination of a traditional asylum with modern research facilities. The hospital's status and reputation as an avant-garde institution was mostly the result of reforms initiated by Adolf Meyer after he became director of the hospital in 1902. Meyer was a Swiss German émigré from Niederweningen, a small village north of Zurich, who had gone on to make an exceptional medical career in the United States. Reportedly, he spoke with

⁴⁶ Lamb, *Pathologist of the Mind*, 55.

⁴⁷ Terahata Kisaku 寺畑喜朔, "Matsubara Saburō kyōju to beikoku ryūgaku," 17.

⁴⁸ Matsubara Shirō, "Matsubara Saburō sono tetchōtekina shōgai," 1412. According to Okada Yasuo, the influence of "German psychiatry" was predominant in Japan before the Second World War. It was only after WWII that trends and theories originated in the US became popular in "Japanese psychiatry" (Okada Yasuo, "Senzen gasshūkoku I," 255). It is certain that most Japanese psychiatrists at that time went to Germany and German-speaking countries when they wished to study abroad. This was a general trend. In the whole period between 1875–1940 the Japanese Ministry of Education sent 1,392 students to Germany while only 594 students enrolled at American universities. The prevalence of Germany was even more apparent for overseas students from the medical faculty; see Tsuji Naoto 辻直人, *Kindai nihon kaigai ryūgaku no mokuteki hen'yō: Monbushō ryūgakusei no haken jittai ni tsuite* 近代日本海外留学の目的変容—文部省留学生の派遣実態について [Change in the Purpose of Studying Overseas in Modern Japan: A Focus on Student Overseas Sponsored by the Ministry of Education] (Tōkyō: Tōshindō, 2010), 52–54.

⁴⁹ Okada Yasuo, "Senzen gasshūkoku I," 257.

⁵⁰ Matsubara Saburō to Adolf Meyer, 11 December 1903, from San Francisco, Adolf Meyer Collection (hereafter AMC), I/2615/1, Alan M. Chesney Medical Archives, The Johns Hopkins Medical Institutions.

a Swiss German accent, and there can be no doubt that he would have been able to read Matsubara's letter in German as well.⁵¹ Nonetheless, Matsubara had chosen English as the medium of correspondence despite being well aware that he only had a limited command of the language, but he seems to have been seriously committed to plunging into his new life in the United States headlong.

During what eventually became a five-year stay in New York, Matsubara gained his teacher's trust and respect, and in their later correspondence (which shows much better language skills), he would simply address him as "my dear doctor." Meyer had provided him with a room to study in and with laboratory equipment to pursue his research, and during his spare time, his mentor's wife had given him English language lessons.⁵² After his time in New York came to a close, the patient files which he had worked on during his stay were sent to Japan.⁵³ This material then formed the empirical basis for his study on "The Nature of the Depressive Psychosis."

Unlike his pupil, Adolf Meyer was neither particularly interested in research on depressed types, nor was he much concerned with classifying mental disorders. In fact, he was widely known for his aversion to classification systems and the endless debates they spurred among psychiatrists.⁵⁴ In light of this, Matsubara's interest in the topic would appear somewhat unusual if one attempts to explain it solely within the context of his New York environment. However, his thesis was not simply a product of some "Meyerian psychiatry" but points to debates and practices beyond the confines of the Manhattan State Hospital.

A thorough reconstruction of Matsubara's thesis and an evaluation of his contribution to global trends in psychiatric nosology can only be achieved by drawing on other texts that similarly took part in the global debate. In his thesis, Matsubara specifically contested the claims put forward by Kraepelin and Dreyfus.⁵⁵ He argued that the excessively broad category of manic-depressive insanity created by Kraepelin that had been enlarged even further by Dreyfus was both unnecessary and useless.

Kraepelin had coined this category to include all kinds of manic and depressed states, regardless of whether the patient experienced the one or the other, or otherwise alternate states of mania and depression.⁵⁶ He only excluded from this large group one type of de-

⁵¹ Lamb, *Pathologist of the Mind*, 11, 32.

⁵² These details are mentioned in Mrs. Matsubara's letter to the Meyers on the occasion of her husband's death (Matsubara Sada to Mr. and Mrs. Meyer, 16 August 1936, in Japanese, AMC, I/2615/4, Alan M. Chesney Medical Archives, The Johns Hopkins Medical Institutions).

⁵³ Among the documents with relation to Matsubara preserved in the Adolf Meyer Collection in Baltimore, there is a list of sixty-nine patients titled "Index of case records sent to Japan by Dr. Matsubara" (AMC, I/2615/7). It contains patient names, age, dates of admission, diagnoses, medical record numbers, and a few additional notes by Matsubara.

⁵⁴ Noll, *American Madness*, 160; Lamb, *Pathologist of the Mind*, 152–160.

⁵⁵ Matsubara Saburō, "Utsuyūsei seishinbyō no hontai."

⁵⁶ Kraepelin's conception of manic-depressive insanity and its introduction into Japanese psychiatry by

pression, namely *involutional melancholia*, which, according to him, only occurred late in life during the period of involution (starting at the age of forty) and which was usually accompanied by feelings of anxiety and was related to the group of *senile disorders*. Kraepelin had argued that, since it was impossible to differentiate clinically between different types of depression (i.e. the simple recurring and the alternating types), it was of no use to give them different names and to put them into different categories. Dreyfus went still further and proposed extending the category of manic-depressive insanity to *involutional melancholia*, to which Kraepelin ultimately agreed by expressing his approval in the preface of Dreyfus's book.⁵⁷

Admittedly, Kraepelin had had hardly any choice but to agree with Dreyfus's reasoning, since the latter had based his arguments on an extensive follow-up study of Kraepelin's former melancholia patients from his time as director of the Heidelberg clinic (1891–1903). By re-examining Kraepelin's patients or questioning their relatives, Dreyfus claimed that he was able to disprove Kraepelin's assumption that involutional melancholia was incurable.⁵⁸ He further observed that most of the patients previously diagnosed with melancholia had later shown "typically circular symptoms" (i.e. exhibiting repeated signs of exaltation or depression at some later point in their life). This directly contradicted Kraepelin's hypothesis that involutional melancholia was non-recurrent and slowly but inevitably progressed towards debility after the initial onset.

In his thesis, Matsubara continued this debate, but he claimed that, unlike Dreyfus and Kraepelin, he had developed a method that allowed him to distinguish between different types of depressed states. He asserted that he had elaborated diagnostic criteria that allowed him to predict from the start whether a patient would experience repeated attacks of a depressed kind or switch between alternate states of mania and depression.⁵⁹ Matsubara's most explicit surviving attack on Kraepelin can be found in the article published in *Neurologia*:

There is no doubt that Kraepelin has found the right approach [key] for the scientific investigation of psychiatry. Unfortunately, he conceives his *manic-depressive insanity* in too broad a way and assumes all different kinds of depressed states under one single disease form without analyzing individual, few, but clear differences in the various mental states more precisely. He was unable to find any significant differential diagnostic indicators that allow to differentiate between the truly circular from other forms of depressed

Kure Shūzō has been discussed in detail in chapter 2. Recall that many of Kure's lectures had been recorded (to be published) by Matsubara, who at the time served as assistant at Tokyo University's teaching hospital.

⁵⁷ Dreyfus, *Die Melancholie*, V–VI.

⁵⁸ Dreyfus, 265.

⁵⁹ Matsubara Saburō, "Utsuyūsei seishinbyō no hontai"; Matsubara Saburō, "Das Wesen der depressiven Psychosen," 42.

states, which are psychologically different from the common circular depression and never appear together with mania in the same individuals.⁶⁰

Apart from the direct attack on Kraepelin, the key term in this paragraph is “psychologically different.” In his article, published in the journal of his alma mater, Matsubara used a similar expression in Japanese:

要スルニクレペリン氏ノ鑑別診断ハ頗ル粗漏ノモノニシテ種々ノ鬱狂ニ於ケル微小ノ差異ヲ發見スルコト能ハズト唱フルモ精密ニ心理學ノニ研究スレバ其異ル所ヲ發見シ得ル事左程ニ困難ノ業ニ非ラズト信ズ⁶¹

In short, Kraepelin's differential diagnosis is highly deficient. Although he declared that he was unable to identify the tiniest difference between the various types of depressed states, I believe that if he had conducted a careful psychological examination, it would not have been particularly difficult for him to discover these differences.

In his shorter academic papers and in his public talks, Matsubara never fully explained how this “psychological examination” (*psychologische Analyse* in the German version) should be carried out. He merely stated that his differentiating method was somewhat complicated and that he would give a more detailed account some day in the future.⁶² Unfortunately, he never did, but fortunately, the general idea of his method can be inferred from his line of argumentation in the extant texts.

According to Matsubara, the main differentiating criteria to distinguish between the different kinds of *depression* were “subjective psycho-motor inhibition” (*jikakuteki seishi* 自覺的制止) and “objective psycho-motor inhibition” (*takakuteki seishi* 他覺的制止), for which he stated clear differentiating factors: in the case of the former, the patient is able to perceive a deficiency (*ketsubō* 缺乏) or retardation (*chijo* 遲徐) of his/her mental capacity (*seishin sagyō nōryoku* 精神作業能力); in the case of the latter, this kind of retardation can only be verified by an outside observer (i.e. a doctor).⁶³

The distinction between objective and subjective psycho-motor inhibition as well as excitation allowed Matsubara to propose a finely graded classification of depressed states that worked along very different lines from those presented by Araki and Kadowaki.⁶⁴ Matsubara's nosological scheme consisted of five main types:

⁶⁰ Matsubara Saburō, 41.

⁶¹ Matsubara Saburō, “Seishinbyō no bunrui ni kansuru shiken,” 29–30.

⁶² Matsubara Saburō, 28–29; Matsubara Saburō, “Das Wesen der depressiven Psychosen,” 37.

⁶³ Matsubara Saburō, “Utsuyūbyō no hontai,” 1148–1149.

⁶⁴ The following list (with appended German translations in the original) can be found in Matsubara Saburō, 1149–1150.

1. 自覺的及ビ他覺的ニ精神運動ノ抑制ヲ有スル鬱憂病
Depressed states *with* subjective *and* objective psycho-motor *inhibition*
2. 自覺的及ビ他覺的ニ精神運動ノ不安（煩悶）ヲ有スル鬱憂病
Depressed states *with* subjective *and* objective psycho-motor *excitation*
3. 自覺的及ビ他覺的ニ精神運動ノ障碍ナキ鬱憂病
Depressed states *with neither* subjective *nor* objective psycho-motor disorders [neither inhibition nor excitation]
4. 自覺的精神運動抑制アルモ、他覺的ニハ同症ノナキ鬱憂病
Depressed states *with* subjective but *without* objective psycho-motor *inhibition*
5. 複雜性鬱憂病
Mixed depressed states [inhibition and excitation co-occurring simultaneously]

It follows that Matsubara's "psychological examination" consisted mainly in differentiating between *subjective* and *objective* psycho-motor disorders that presented themselves either in the form of inhibition or in the form of excitation. Within his system, Matsubara identified Kraepelin's category of the depressed states of manic-depressive insanity with his own category of "depressed states with subjective and objective psycho-motor inhibition" (No. 1).⁶⁵ Likewise, he understood Kraepelin's involutional melancholia as being equivalent to his category of "depressed states with subjective and objective psycho-motor excitation" (No. 2). According to Matsubara, his third (No. 3) and fourth (No. 4) class of depressed states formed distinct categories but were erroneously conflated with the first category (No. 1) in Kraepelin's classification system because the latter had failed to differentiate between subjective and objective psycho-motor inhibition.

In terms of practical applicability and relevance, the advantage of a classification that was based on a fundamental distinction between subjective and objective inhibition lay in the ability to predict whether a patient who presented symptoms of depression would remain depressed or was to be expected to show symptoms of mania in the near future. Matsubara at least was convinced that his research in the United States allowed him to make this general argument about the nature of depressed states:

In my own experience, I have never seen cases in which the depressed states without subjective and objective psycho-motor disturbances or depressed states with only subjective inhibition had appeared together with other manic attacks in the same individuals throughout the whole course of the disease.⁶⁶

⁶⁵ Kraepelin's manic-depressive insanity can present itself in three different states: 1. depressed states; 2. manic states; 3. mixed states.

⁶⁶ Matsubara Saburō, "Das Wesen der depressiven Psychosen," 42–43.

This experience is also reflected in the case files that Matsubara collected in New York and sent to Japan. Using the same terminology as in his articles, he indicated which of his melancholia patients showed subjective or objective inhibition, and indeed, there is not one example in his list where manic exaltation appears together with objectively observable inhibition. His categories are clearly discernible in his case collection, which already appears to be sorted according to his classification of depressed states. Although the structure of Matsubara's classification seems both very logical and systematic, his categories bear highly descriptive names. Ultimately, the fact that he did not propose a new terminology for the different depressed states may have contributed to the fact that his system had hardly any impact within the broader psychiatric community. As Matsubara did not challenge the terminology introduced by Kraepelin but “only” argued that his categories of manic-depressive insanity and involuntional melancholia ought to be applied to a slightly different group of patients and that these groups could be clearly differentiated, his pointed attack on the Kraepelinian classification seems to have been lost on his contemporaries—his modest self-representation apparently did not pay off. Especially in the case of involuntional melancholia, this stance seems very conservative, as Matsubara himself was convinced that the symptoms associated with the illness were not in fact limited to the period of involution.⁶⁷

The ideas on depressive states that Matsubara had developed in his doctoral thesis became part of his lectures during his time as professor of psychiatry at Kanazawa Medical School (1909–1927). Although he did not compile a textbook on psychiatry, he provided outlines of his lectures in German that contained basic overviews on mental disorders and their symptoms. A copy of such a “lecture book” is nowadays preserved in the museum archive of the medical department of Kanazawa University under the title “Die Neurologie, Psychiatrie u. Gerichtliche Medizin von Prof. Dr. S. Matsuhara” [sic!] [Neurology, Psychiatry and Forensic Medicine by Prof. Dr. Matsubara].⁶⁸ It contains the same classification of depressed states as the one presented above. The types of depression are listed under the heading “Dpressive [sic!] psychosen nach Matsubara” [Depressive Psychoses according to Matsubara]. In the lecture book, Matsubara's classification was presented as the last item following three other classifications: “Depressive psychosen accord-

⁶⁷ Matsubara Saburō, 38.

⁶⁸ I am indebted to Murata Katsutoshi for having located this unique document at the university museum (*Kanazawa daigaku igakubu kinenkan shiryōshi* 金沢大学医学部記念館資料室) and having kindly provided me with copies. At the time when Okada Yasuo was conducting his research on Matsubara, the lecture-book seems to have been located at the medical library of Kanazawa University (Okada Yasuo 岡田靖雄, “Senzen gasshūkoku ni ryūgaku shita seishinbyō gakusha tachi: Matsubara Saburō, Saitō Tamao, Ishida Noboru hoka” 戦前合州国に留学した精神病学者たち：松原三郎、齋藤玉男、石田昇ほか, part II [Japanese Psychiatrists in the United States before World War II: Matsubara Saburō, Saitō Tamao, Ishida Noboru and Others], *Nihon ishigaku zasshi* 40, no. 4 [1994]: 431). According to Okada, Matsubara was teaching forensic medicine between 1909–1914. Thus, the lecture-book must have been compiled around this time (Okada Yasuo, “Senzen gasshūkoku I,” 265).

ing to Ziehen,” “According to Reichardt,” and “According to Kraepelin.” Once more, he was presenting his own work as a modest continuation and elaboration of the theories of three prominent contemporary German psychiatrists: Theodor Ziehen, Martin Reichardt (1874–1966), and Emil Kraepelin.⁶⁹

Despite Matsubara’s explicit references concerning the assessment of his own nosology in relation to classification systems devised by contemporary colleagues, his elaborations on his own method and practical approach remain vague. The actual procedure of differentiating between subjective and objective inhibition is only mentioned in passing in some of the extant texts, and it may well be that he overestimated the apparentness of the practical applicability of his diagnostic system. As far as the objective psycho-motor inhibition that had to be verified by an outside observer is concerned, Matsubara solely suggested that this could be achieved ...

例ヘバ患者ノ談話、動作、運動等ガ遅徐タルヤ否ヤヲ檢シ⁷⁰

[...] for example by examining whether a patient’s speech, behavior and movement were slowed or not [...]

In the case of subjective psycho-motor inhibition, he noted that patients might report (*utafu* 訴フ) symptoms that indicate inhibition but that, in reality, (*jissai* 實際) there was absolutely no retardation in the association of ideas (*kannen rengō* 感念聯合) that “we” (*gojin* 吾人), i.e. the doctors, could objectively (*takakuteki ni* 他覺的二) detect.⁷¹

Nonetheless, these statements imply that, in order to establish whether a patient showed objective psycho-motor inhibition or not, Matsubara had to perform a series of tests that were designed to measure mental functioning. Matsubara’s reclassification of depressed states ultimately relied upon these tests, as they provided him with the necessary data to regroup the patients according to their type of inhibition. According to his reasoning, it was wrong to put those patients into the broad category of manic-depressive insanity because it could be predicted with certainty that they would never experience alternate states of mania and depression. Instead, these were conceptualized as being “purely depressed states,” clearly distinguishable from the “alternating states” by means of the psychological examination that Matsubara briefly sketched. From all that we can know, it is safe to assume that the practice that informed Matsubara’s diagnostic method had its origins in the discipline of experimental psychology that was on the rise in many parts of the world. However, since his original thesis with all of its case studies (*jikken rei*

69 On the two rival schools of Ziehen (in Berlin) and Kraepelin (in Heidelberg), see chapter 1. Martin Reichardt was teaching psychiatry in Würzburg. He divided the melancholias into: 1. *melancholia simplex*; 2. *melancholia attonita*, and 3. *melancholia agitata*. See his textbook: Martin Reichardt, *Leitfaden zur Psychiatrischen Klinik* [Guideline to the Psychiatric Clinic] (Jena: Verlag von Gustav Fischer, 1907), 158.

70 Matsubara Saburō, “Utsuyūbyō no hontai,” 1148–1149.

71 Matsubara Saburō, 1149.

實驗例) and examples is lost, we are left to speculate about what exact method he used to obtain objective observations.⁷²

For instance, the experiment with the writing-pressure scale would have been one method for Matsubara to objectively establish “inhibition,” but it was not the most commonly used technique, and there is no evidence that such an apparatus existed in the New York psychiatric institute. Most psychiatrists studied “inhibition” and “excitation” by measuring reaction time in word association tests, but as we have seen, this method presents severe disadvantages for non-native speakers because both the execution and the evaluation of the test require a high level of familiarity with the semantico-conceptual framework of the target language. Supposing that Matsubara conducted the experiments himself at all, it would have been easiest for him to rely on a simpler method such as the counting test, but he might also have received help from the American staff or utilized test results obtained in a test series carried out by one of his colleagues.

There is no doubt that word association tests were being performed at the Manhattan State Hospital at the time of Matsubara's stay in New York, as Adolf Meyer, the director of the psychiatric institute of the State Hospital, regularly reviewed foreign literature on association tests in *The Psychological Bulletin* and indicated that similar tests were being conducted at his clinic.⁷³ For example, at a conference in April 1908 for which Matsubara was mentioned as a participant, Meyer commented upon a presentation on association tests and mentioned that he preferred an application of the tests that Carl Gustav Jung (1875–1961) was promoting, and noted that “it is in that direction we have been working at the Institute with fair success.”⁷⁴ Meyer made it clear that he was familiar with the methods of Kraepelin and Aschaffenburg, but he distanced himself from their approach by concluding that “after all, association experiments, if we deal with them only in a numerical way for the purpose of getting figures, are a scheme which may satisfy those who are anxious to get numerical representations.”⁷⁵ In any case, it is obvious that word association tests were very popular in New York at the time of Matsubara's US-based research activity and that there was a great interest in probing a variety of experimental

72 The cases studies are mentioned in the examiners' summary (Matsubara Saburō, “Utsuyūsei seishinbyō no hontai”).

73 Adolf Meyer, review of *Diagnostische Assoziationsstudien: I. Beitrag. Experimentelle Untersuchungen über Assoziationen Gesunder* [Diagnostic Association Studies: I. Contribution. Experimental Examinations of Associations by Healthy Persons] by C. J. Jung and Fr. Riklin, *The Psychological Bulletin* 2, no. 7 (1905): 242–250; Adolf Meyer, “The Problems of Mental Reaction-Types, Mental Causes and Diseases,” *The Psychological Bulletin* 5, no. 8 (1908): 245–261.

74 Discussion following the *Preliminary Report of an Application of Sommer's Association Test* by G. H. Kent, *State of New York State Hospitals Bulletin* 1, no. 4 (1908): 565–566. The speaker from the Kings Park State Hospital had been following Robert Sommer's method of applying the association test (G. H. Kent, “Preliminary Report of an Application of Sommer's Association Test,” *State of New York State Hospitals Bulletin* 1, no. 4 [1908]: 552–564).

75 Discussion following the *Preliminary Report of an Application of Sommer's Association Test* by G. H. Kent, 566.

methods. The only aspect of Matsubara's commitment to psychological experimentation that seems curious is that he used the experimental results to make an argument about the classification of mental disorders, while Meyer had dismissed any such attempt and preferred to use the methods for purposes of treatment. Despite being oblivious to his actual motivation, all the knowledge and practical resources necessary for Matsubara's research were available in New York, and he might simply have wished to do things his own way and to try something different, just as he had done in devising a singular nosological scheme and in becoming the first Japanese psychiatrist to train in the United States when everyone else around him had their eyes set on Europe.

Matsubara's contemporaries, his examiners, and his colleagues perceived his work on melancholia as an exercise in "clinical" (*rinshōteki* 臨床的) psychiatry, which at the time referred to the clinical observation of a selected group of patients, as opposed to the dissection and study of their brains, which was the psychiatrists' "pathological" approach. His friend and former college-mate Kitabayashi Sadamichi recalled that Matsubara's thesis was a monumental clinical study on depressed states that relied on a large patient population selected from the 5,000 patients of Adolf Meyer's New York hospital. However, Kitabayashi mused, even though he himself had studied under the Zurich professor Constantin von Monakow (1853–1930), who was Meyer's former teacher, his own approach to psychiatry seemed directly opposed to that of Matsubara.⁷⁶

This statement implies some kind of genealogy and continuity in the work of psychiatrists and their pupils. Kitabayashi expresses his astonishment at the apparent discrepancy between his and Matsubara's methods despite the fact that they both were "descendants" of the same Swiss psychiatric tradition. He does not mention that Constantin von Monakow was a neuropathologist by training and that Meyer's other Swiss teacher had been Auguste-Henri Forel (1848–1931), who combined expertise in laboratory research and psychopathology.⁷⁷ He also seems to underestimate the many pathways that were open to psychiatrists at the beginning of the twentieth century: neither was Matsubara a "Meyerian" follower, nor was Araki's work a simple Japanese copy of Robert Sommer's or Theodor Ziehen's works.

Compared to Araki's and Kadowaki's modest and reserved critique, Matsubara's direct attacks on Kraepelin appear very outspoken and sometimes downright blunt. He did not hesitate to point out errors and negligence where he recognized them, and he presented his own ideas with a good deal of self-confidence. Although he clearly seems to have sided with the Heidelberg faction of the Berlin–Heidelberg rift, he systematically attacked the Kraepelinian classification from "within" and used the methods and argumentative logic that had originally supported the dichotomy to argue for its rebuttal. In hindsight, his insistence on separating pure depression from the alternating types of depression and his

76 Terahata Kisaku 寺畑喜朔, "Matsubara Saburō kyōju to beikoku ryūgaku," 18.

77 Lamb, *Pathologist of the Mind*, 36.

search for specific differentiating markers between the two resonates with later developments in psychiatry. Concurrently, a widely shared distinction is being made between *unipolar depression* and *bipolar disorder*, which echoes Matsubara's attempt at differentiating between various types of depressed states.⁷⁸ As long as that distinction holds, it continues to undermine Kraepelin's purely risk-management-oriented categorization system that tried to separate the curable from the incurable, paid little heed to the patients' personal experience, and had no interest in more emphatic and finely grained diagnostic fields.

Lastly, as we have seen in the discussion of institutional frameworks, different settings fostered different nosological schemes. Conversely, different diagnoses entailed different implications for patients' daily lives, since their treatment in the clinics and madhouses hinged on what their presumed disease was. After returning to his hometown, Kanazawa Matsubara opened a private clinic for mentally ill patients and was able to orient his treatment towards his clients' actual personal experience of depression or mania, but Kraepelin and the other Japanese psychiatrists continued to be constrained by institutional pressures and had to target their treatment accordingly.

However, the different directions that the psychiatrists took and the differing treatments that they deemed proper were influenced not only by their individual academic backgrounds but also by their personal experiences during their professional exercise: while Matsubara had spent the middle years of the first decade of the twentieth century doing research in the US, his Japanese colleagues Araki, Kadowaki, and Kure had all been implicated in the 1904/05 Russo-Japanese War, an experience that greatly contributed to shaping their respective outlooks, as I will show in the next part.

⁷⁸ It has been claimed that patients in the two different disease groups react differently to the same class of psychotropic drugs, thus justifying the conceptual division. This mode of thinking has been described as one of the side-effects of the "psychopharmacological revolution" that dominates present mainstream psychiatry (Scull, "Contending Professions," 151).

Part II

War and Mental Illness

5 Mental Health Provision in the Russo-Japanese War & the Construction of Cases

The discussion of mental illness in the army was a minority discourse both in Japan and Russia. Matters of classification were only addressed by a small group of specialists schooled in the art of diagnosing mental disorders. The majority of army doctors did not diagnose mental illness in the Russo-Japanese War at all. As in other military conflicts before World War I, when confronted with psychiatric-looking illness behavior, army doctors preferred the organic-sounding *neurasthenia*.¹ According to reports by the military authorities, the total number of nervous diseases (including *neurasthenia* and *hysteria*) in the Russian Army was 6,943 cases (9.5‰) and the number of cases of mental illness was 1,915 (2.6‰) in the Russo-Japanese War.² On the Japanese side, the proportion between nervous diseases (2,653 cases; 4.28‰) and mental diseases (545 cases; 0.98‰) equally points to the relatively minor importance of mental disorders in the army.³ Although this rigid division into nervous and mental diseases is questionable from today's perspective, it mattered to contemporary authors and framed their reasoning. Furthermore, when compared to the huge numbers of cases of infectious diseases and *kakke* 脚氣 (which was associated with beriberi by contemporary physicians but whose identification remains a subject of historical debate) that were diagnosed, the presence of both nervous and mental diseases was negligible and was not a main concern of military medicine.⁴

1 Blazer, *The Age of Melancholy*, 120–121.

2 N. Kozlovskij, ed., *Vojna s Japoniej 1904–1905 g.g. Sanitarno-statističeskij očerok* [The War with Japan in the Years 1904–1905: Sanitary-Statistical Report] (Petrograd: Voennaja tipografija Imperatricy Ekateriny Velikoj, 1914), 31–32.

3 Hanabusa Kenya 英健也, “Guntai ni okeru seishinbyō narabi ni sono onkyū shindan ni tsuite” 軍隊ニ於ケル精神病竝ニ其恩給診断ニ就テ [On Mental Illness in the Army and How to Determine the Pension of Such Patients], *Dai sankai Nihon igakkai shi*, 1911, 1980–1981. There are diverging views concerning the image of *neurasthenia* in Japan. Satō Masahiro argued that in the general public opinion, *neurasthenia* only gained popularity in Japan after the Russo-Japanese War, partly because it was seen as an illness of enlightenment and civilization. Only after Japan had defeated Russia did Japanese men become eligible to be diagnosed with this affliction in the eyes of the public (Satō Masahiro, *Seishin shikkan gensetsu no rekishi shakaigaku* 158). Because of Satō's focus on mass media and the popularization of mental disease concepts in the public, his presentation of the view of medical professionals is understandably short.

4 The numbers for *kakke* vary enormously depending on the author. According to the official statement

Psychiatrists were not provided for under the medical service regulations of the Japanese Army, and military doctors received no training in psychiatry at medical military schools at the time of the Russo-Japanese War. Although Eguchi Noboru 江口襄 (1854–?) had started teaching psychiatry at the Medical Military Academy (*rikugun gun'i gakkō* 陸軍軍醫學校) in Tokyo in 1891, the subject was soon dropped from the curriculum, only to be introduced again after the end of the war in September 1906.⁵

Additionally, there were no military asylums in Japan. In both cases, the situation was most likely due to the fact that Japanese military institutions were modeled after the German system.⁶ In contrast to other European countries such as Russia, England, and Austria, the German Army neither had its own military asylums, nor was military psychiatry fully institutionalized within the German military administration before 1914.⁷ In the

of Koike Masanao 小池正直 (1854–1913), the Surgeon General (*gun'i sōkan* 軍醫總監) of the Japanese Army, 25% of all hospitalized suffered from *kakke* (59056), which amounted to 15,94% of all the men in the field (Koike Masanao 小池正直, “Nichiro seneki ni okeru eisei jimū no taiyō” 日露戦役ニ於ケル衛生事務ノ大要 [General Observations on Sanitary Features during the Russo-Japanese War], *Dai nikai Nihon rengō igakkai kaishi*, 1907, 199). Takaki Kanehiro 高木兼寛 (1849–1920), the former director-general of the Medical Department of the Imperial Japanese Navy, gave almost double the number of *kakke*-sufferers, namely 97572 (Takaki Kanehiro, “Three Lectures on the Preservation of Health amongst the Personnel of the Japanese Navy and Army: Lecture III. Delivered on May 11th,” *The Lancet* 167, no. 4318, 1521). In 1908, the medical journal *Ikai jibō* 醫海時報 even gave numbers as high as 250000 afflicted by the disease (quoted from Alexander R. Bay, *Beriberi in Modern Japan: The Making of a National Disease* [Rochester: University of Rochester Press, 2012], 100). However, it should be noted that there were considerable tensions between the Army and Navy with regards to the etiology and treatment of *kakke*, see Bay. For a critical discussion on identifying thiamine deficiency with the premodern concept of beriberi see David Arnold, “British India and the ‘Beriberi Problem,’ 1798–1942,” *Medical History* 54 (2010): 295–314.

- 5 Kure Shūzō, *Wagakuni ni okeru seishinbyō ni kansuru saikin no shisetsu* 57; Kashida Gorō, *Nihon ni okeru seishinbyōgaku no nichijō* 42. Eguchi first enrolled at the Tokyo School for Western Sciences in 1873, but later changed to the Tokyo Medical School (on the precursors of Tokyo University see section 1.2). In 1881, he graduated from the Medical Department of Tokyo University and chose a military career, becoming an instructor at the Medical Military School (*Rikugun gun'i gakkō* 陸軍軍醫學校) in Tokyo, a precursor of the Medical Military Academy. In 1887, he was sent to Germany by the Ministry of War to study psychiatry and forensic medicine, and upon returning he published one of the first Japanese textbooks on psychiatry based on a German psychiatric literature. He took his inspiration from the works of Heinrich Schüle and Krafft-Ebing and explicitly referred to his own book as an abridged translation (*shōyaku* 抄譯). The classification system was also expressly attributed to Schüle (Eguchi Noboru 江口襄, *Seishinbyōgaku* 精神病学 [Psychiatry] [Tōkyō: Shimamura Risuke, 1887], Preface, 1). For Eguchi's biography see Mitani Toshiichi 三谷敏一, *Shinto meikashū* 神都名家集 [Famous People from the Sacred City [Ise]] (Ujiyama: Mitani Toshiichi, 1901), 8–10; On psychiatry at the Medical Military Academy see Kure Shūzō, *Wagakuni ni okeru seishinbyō ni kansuru saikin no shisetsu* 57; Kashida Gorō, *Nihon ni okeru seishinbyōgaku no nichijō* 19; On the institutional history of the Medical Military Academy see Rikugun gun'i gakkō 陸軍軍醫學校, ed., *Rikugun gun'i gakkō gojū-nen shi* 陸軍軍醫學校五十年史 [50 Years of the Military Medical Academy] (Tōkyō: Rikugun gun'i gakkō, 1936).

- 6 After the war, military authorities suggested that such institutions should be established (Hanabusa Kenya, “Guntai ni okeru seishinbyō narabi ni sono onkyū shindan ni tsuite,” 1987).

- 7 Martin Lengwiler, *Zwischen Klinik und Kaserne: Die Geschichte der Militärpsychiatrie in Deutschland*

absence of psychiatrists at the front and near the battlefields, the Japanese Army tried to evacuate mental health patients to the mainland as quickly as possible. The first part of the transfer was done by train, usually passing through the “line of communication hospitals” (*beitan byōin* 兵站病院) established along the southern branch of the Chinese Eastern Railway that had been constructed by the Russian Empire (see Figure 5.1).⁸

Such hospitals were located at Kaiyuan 開原, Tieling 鐵嶺, Mukden, Liaoyang 遼陽, and Dalny and were staffed with military doctors and Japanese Red Cross medical attendants.⁹ When the patients reached Dalny, they embarked on a transport or hospital ship for Ujina 宇品, the harbour of Hiroshima. The journey from the battlefields near Mukden to the mainland could take about a month.¹⁰ On arrival in Ujina, medical officers boarded the ships and divided the patients into those who would stay at the hospitals of the 5th Division at Hiroshima and those who were physically fit enough to be transported to the reserve hospitals (*yobi byōin* 豫備病院) of their own divisions.¹¹ The reserve hospital of Hiroshima thus served as a distribution hub for most of the patients who arrived from the Manchurian battlefields.

During the Russo-Japanese War, the Japanese military authorities employed a number of civilian practitioners in these reserve hospitals. University professors and other medical degree holders from the various medical schools in Japan served as assistant medical staff (*eisei hōjoin* 衛生幫助員) and were assigned to the reserve hospitals of the divisions that they found themselves closest to. Hence, physicians from Tokyo Imperial University served in the Tokyo Reserve Hospital; those from Okayama Medical College in Hiroshima and Himeji; and those from Kyoto Imperial University in the reserve hospitals of Ōsaka 大阪 and Kokura 小倉.¹²

und der Schweiz 1870–1914 [Between Clinic and Barracks: The History of Military Psychiatry in Germany and Switzerland 1870–1914] (Zürich: Chronos Verlag, 2000), 177–183, 371. There were some military doctors who found fault with this situation and argued for an emulation of the Austrian model, see for example Ewald Stier, “Neuere psychiatrische Arbeiten und Tatsachen aus den außerdeutschen Heeren,” Schluß [Recent Psychiatric Studies and Facts from Non-German Armies (Conclusion)], *Deutsche militärärztliche Zeitschrift* 37, no. 4 (1908): 181.

8 This map is based on the location of the historic railway lines and stations in Map 1, “Sketch Map of the Theatre of War”, 1904 published in General Staff, War Office, ed., *The Russo-Japanese War: Medical and Sanitary Reports from Officers Attached to the Japanese and Russian Forces in the Field* (London: Printed for His Majesty’s Stationery Office, by Eyre / Spottiswoode, 1908). It has been created with QGIS software using *Natural Earth* vector map data and *OpenStreetMap* data.

9 Mukden is present-day Shenyang 瀋陽, the provincial capital of Liaoning 遼寧 Province. In the Japanese case histories, it appears as Hōten 奉天 (chin. Fengtian). Dalny is present-day Dalian and is referred to as *Tairen* 大連 (chin. Dalian) in the Japanese sources.

10 Charles Lynch, “Report of Maj. Charles Lynch, Medical Department, General Staff, U. S. Army, Observer with the Japanese forces in Manchuria,” in *Reports of Military Observers Attached to the Armies in Manchuria during the Russo-Japanese War*, vol. 4 (Washington: Government Printing Office, 1906), 94.

11 This procedure is described in the report of military observer Charles Lynch (1868–1937), who inspected the port and hospitals at Hiroshima in January and September 1905 (Lynch, 86).

12 Rikugunshō 陸軍省, ed., *Rikugun eisei kinmu hōjoin kaijo no ken* 陸軍衛生勤務幫助員解除の



Figure 5.1: The Chinese Eastern Railway in Manchuria in 1904

The reserve hospitals on the Japanese mainland were the first institutions where the patients from the battlefield encountered mental health specialists. According to the documents of the Japanese Ministry of War, the Tokyo psychiatrists Kure Shūzō, Ishida Noboru, Kitabayashi Sadamichi, and Amako Shirō 尼子四朗 (1865–1930) were employed at the Tokyo Reserve Hospital. Araki Sōtarō served in Hiroshima and Himeji. Shimamura Shun'ichi treated mental health patients in Ōsaka, and Shima Ryūji 島柳二 (1874–1910) was employed in the north of Japan in the Sendai Reserve Hospital.¹³ These psychiatrists did not all share the same theoretical approach to mental health disorders. The Tokyo Conference, which had taken place while the war in Manchuria was being fought, clearly showed that some of these physicians had very different views on how to classify mental disorders.

Although Kure's and Araki's reports on mental illness in the army emerged from a military context, both physicians were civilians. Unlike their peers among the Red Cross staff, they were not part of the medical organization of the Japanese Army.¹⁴ Their education and training was independent from military structures and institutions, and their writing was characterized by their academic background and their practical experience in civilian institutions. They neither recognized any difference between mental illness in civilians and in soldiers, nor were they concerned with questions of organizing and controlling mental health care in the army.¹⁵

Since Kure's and Araki's work was spatially restricted to the reserve hospitals in the Japanese cities of Hiroshima 廣島, Himeji 姫路, and Tokyo, they were dependent on third parties for the narration of their case histories. They relied on army doctors' reports from field hospitals and from line of communication hospitals at the front to gather the information they needed. This division was reflected in the structure of their case histories, where they first described the symptoms reported by medical staff at the front (under the header "anamnesis"), and in the second part described the symptoms they personally observed.¹⁶ Even though the original patient files from which Araki and Kure constructed

件 [Releasing Assistant Staff from the Army Sanitation Duty] (October 1905), accessed June 1, 2016, JACAR: C03026752200, <https://www.jacar.archives.go.jp>.

13 Rikugunshō, *Rikugun eisei kinmu hōjoin kaijo no ken*.

14 On the relation between the Japanese Army and the Red Cross Society see Aya Takahashi, *The Development of the Japanese Nursing Profession: Adopting and Adapting Western Influences* (London: RoutledgeCurzon, 2004), 84, 97, III.

15 These aspects were a concern for some Japanese army doctors, see for example Hanabusa Kenya, "Gun-tai ni okeru seishinbyō narabi ni sono onkyū shindan ni tsuite"; Kawashima Keiji 川島慶治, "Shinhei seishin jōtai kensa no yōgi" 新兵ノ精神状態検査ノ要義 [Notes on the Psychological Examination of Recruits], *Gun'idan zasshi* 軍醫團雜誌 29 (1912): 1033–1052.

16 Kure does not always make a clear distinction between the two sections. Moreover, there are a few cases in which he could not have seen the patients in person at all, because they were discharged before he started to work at the hospital. However, according to his statement in the introduction, all of the case histories were based on his personal observations, made during his work from January 7 to October 22 in 1905 (Kure Shūzō 呉秀三, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite" 日露戦

their case histories are no longer available, a comparison of those cases which they both observed reveals their different narrative strategies. In this chapter, I focus on the case of one soldier to reconstruct the acts of formalizing, abstracting, and rewriting that allowed the construction of different medical identities.

5.1 Manchuria: Confused Satō

Private Satō was a Japanese soldier who attracted the attention of several medical practitioners in Manchuria, Hiroshima, and Tokyo. His medical records suggest that he had tried to drown himself in a well, but we know nothing about the exact circumstances of that incident. By the end of the second year of the Russo-Japanese War, 8,089 Japanese soldiers had committed suicide, and the military authorities were on their guard to identify suspicious individuals and to send them back to the mainland.¹⁷ Some soldiers committed suicide to evade mobilization, but others simply could not bear the emotional stress and hardships of army life. One soldier gave the following reasons for his act of suicide: “[E]ver since the day I entered the barracks, there has not been a single day without any violence [...] I hate to be in the army more than anything else, and there is nothing but death [...]”¹⁸

The historical material on the case of Private Satō does not include a first-person view. We only know about his thoughts, fears, and actions because military doctors and psychiatrists have translated what they observed in Satō’s behavior into medical terms and turned his experience into a medical case. Becoming a case of mental illness often starts with an incident that is being observed and reported outside the confines of the mental hospital.¹⁹ Case histories always betray the view of the doctor and are constructed in such a way as to convince students, colleagues, decision-makers, and all kinds of readers in general.²⁰ Satō’s case is full of uncertainties and ambiguities and has provoked disparate interpretations and case constructions. Before I analyze the case constructions of

役中余ノ實驗セル精神障礙ニ就キテ [On Mental Diseases That I Encountered during the Russo-Japanese War], in *Meiji sanjūshichi-hachinen sen’eki rikugun eiseishi: Densenbyō oyobi shuyō shikkan*, ed. Rikugunshō 陸軍省 [Tōkyō: Rikugunshō, 1912], 7). As some patients were discharged several months before January 7, this leaves open the question who actually observed the symptoms and what Kure’s part in the diagnosis was.

17 Suganuma Tōichirō 菅沼藤一郎, “Guntai ni okeru jisatsu oyobi sono yobō” 軍隊ニ於ケル自殺及び其ノ豫防 [On Suicide in the Army and Its Prevention], *Dai sankai Nihon igakkai shi*, 1911, 1989.

18 Quoted in Naoko Shimazu, *Japanese Society at War: Death, Memory and the Russo-Japanese War* (Cambridge: Cambridge University Press, 2009), 39.

19 Stefan Nellen and Robert Suter, “Unfälle, Vorfälle, Fälle: Eine Archäologie des polizeilichen Blicks” [Accidents, Incidents, Cases: An Archeology of the Police’s Gaze], in *Zum Fall machen, zum Fall werden: Wissensproduktion und Patientenerfahrung in Medizin und Psychiatrie des 19. und 20. Jahrhunderts*, ed. Sibylle Brändli, Barbara Lüthi, and Gregor Spuhler (Frankfurt: Campus-Verlag, 2009), 159–161.

20 On the function and logic of narrative in texts that assume the form of case histories see Jean-Claude Passeron and Jacques Revel, “Penser par cas: Raisonner à partir de singularités,” in *Penser par cas*, ed. Jean-

Araki and Kure, who examined him in Hiroshima and Tokyo, I want to present a case construction that narrates Satō's Manchurian episode in my own words.

In my account, Satō does not appear as an unambiguously insane person. This is not to suggest that he was not really insane, but to show that by using the same narrative techniques as the psychiatrists, one can easily change the perspective and tell a different story. By selectively choosing elements from his medical record, rearranging the order of symptoms, changing the line of events, and stressing certain aspects while de-emphasizing others, I imitate the psychiatrist's writing strategies to show how they can influence the reader's perception:

Satō had joined the army on March 11, 1904, and arrived with his division in Manchuria on June 13. In the summer of 1905, he was stationed in Changtu, China, where he worked as an engineer. He was known as a quiet but diligent worker. At the beginning of August, he came under the impression that some of his money had gone missing. When he found a 10-*sen* note in military currency, he assumed that it was his. After a while, he became anxious that his comrades suspected him of stealing. He doubted whether the 10-*sen* note was really his own after all, and tried to get rid of it. However, no one would accept it, even though Satō kept asking for the owner. Satō grew ever more suspicious that the other soldiers were talking about him behind his back. He became withdrawn and downhearted. It seemed as if he harbored thoughts of suicide, and one night he attempted to escape from the barracks. He was caught, and when he was questioned, he appeared confused.

My account of Satō's experience in Manchuria prominently features his preoccupation with the small amount of money of 10 *sen*, which is also mentioned in Kure's report (discussed in section 5.3). During the Russo-Japanese War, military currency was put into circulation to facilitate business transactions with the Chinese and Korean inhabitants.²¹ The note that was found by Satō was, therefore, a regular item in Japanese military camps. The notes could be spent in the various shops and canteens that followed the army around. The shops were usually run by civilian merchants who were allowed to have their goods brought over from Japan for free in the government transports, but whose prices were regulated by the military authorities. They provided "Japanese pipes and tobacco,

Claude Passeron and Jacques Revel (Paris: Éditions de l'École des Hautes Études en Sciences Sociales, 2005), 25.

21 There were war-notes in denominations of 10, 20, and 50 *sen* and 1, 5, and 10 *yen*. According to an American military observer, the notes were "redeemable in silver at any administrative office and freely accepted by the inhabitants of both Manchuria and Korea" (Joseph E. Kuhn, "Report of Major Joseph E. Kuhn, Corps of Engineers," in *Reports of Military Observers Attached to the Armies in Manchuria during the Russo-Japanese War*, 3:96). There were instructions in Chinese and Korean on the back of every note.

cigarettes, matches, *saké*, small tins of Japanese pickles, tooth-brushes and powder, soap, writing materials, paper, candles, odds and ends of underclothing, toothpicks, and other little luxuries dear to the hearts of the Japanese.”²²

Satō’s monthly wage as a first class soldier was 1.20 *yen*,²³ and 10 *sen* was no more than a twelfth of his monthly allowance. It does not seem that the note that he found could have had much financial importance for Satō. The value of the note becomes more tangible when some prices from the wartime period are compared. On July 12, 1905, the prices for the Japanese army at Fakumen (a settlement northwest of Tieling; see Figure 5.1) were fixed at the following amounts: coolies, salary per day: 60 *sen*; pork, per 1½ pounds: 20 *sen*; chickens, according to size: 60–90 *sen*; eggs, each: 2 *sen*.²⁴ These examples are telling insofar as Satō’s salary would certainly have guaranteed his basic survival but not made him a rich man. Indeed, even a coolie could earn half his monthly allowance for a full day’s work, i.e. six times the value of the 10-*sen* note. In any case, it seems likely that it was not the value of the money itself that caused Satō’s unrest. Rather, it may have been caused by the potentially uneasy social interactions that were to be expected when mutual trust was threatened by the suspicion of theft in places as crowded as army barracks.

On August 7, 1905, Satō was admitted to the cantonment hospital (*shaei byōin* 舍營病院) at Qingyunpu. The rustic building had originally been established as a field hospital (*yasen byōin* 野戰病院) in close proximity to the front line, and was immobilized afterwards. Named after a small Chinese village, the hospital was located south of present-day Changtu and north of Tieling.²⁵ Satō was examined by military doctors in this hospital, but they did not detect any serious physical disorders. However, since Satō was still deemed to be suicidal, he was sent back to Japan via the established evacuation routes. After having traveled to the south of the Liaodong 遼東 Peninsula, he boarded a ship in Dalny that made passage to Hiroshima.

The diagnosis that Satō would receive in Japan was very much dependent on the division to which he was attached, because this determined the destination hospital to which he was going to be transferred. While patients of the 5th Division were cared for in Hiroshima, those of the 4th Division were sent to Ōsaka, and those of the 1st to Tokyo (see Figure 5.1 for the location of the divisions). Although most mental health patients who returned from the front probably never saw a psychiatrist because most of the treatment was in the hands of military doctors, there were good chances that they would be treated by Araki, Shimamura, or Kure in Hiroshima, Ōsaka, and Tokyo, respectively. Out of

22 William Grant Macpherson, ed., *The Russo-Japanese War: Medical and Sanitary Reports from Officers Attached to the Japanese and Russian Forces in the Field* (London: Printed for H. M. Stationery off., by Eyre / Spottiswoode, 1908), 388, 511–512.

23 Edward J. McClerand, “Report of Lieutenant-Colonel McClerand, First Cavalry,” in *Reports of Military Observers Attached to the Armies in Manchuria during the Russo-Japanese War*, 5:145.

24 McClerand, 94.

25 Kuhn, “Report of Major Joseph E. Kuhn, Corps of Engineers,” 102–103.



Figure 5.2: Japanese railway lines and headquarters of divisions in 1904

the 211 patients under Araki's care in the reserve hospital in Hiroshima, most were diagnosed with melancholia (28%), neurasthenia (21%), and mania (17%).²⁶ Shimamura, who was working in Ōsaka, reported that he mainly saw cases of *amentia* (a form of acute mental confusion) among his 23 patients.²⁷ Kure, on the other hand, diagnosed most of his 134 mental disease patients with dementia praecox (49%), traumatic psychosis (18%), and manic-depressive insanity (16%), but did not use the diagnoses of melancholia and mania.²⁸

This state of affairs was further complicated when the patients moved from one hospital to another. Most patients began their journey on the Japanese mainland at the reserve hospital of Hiroshima. According to Araki's patient records, half of his patients were transferred to other reserve hospitals after having been released from Hiroshima. When the data from the individual records is brought together, it appears that one patient was transferred to Kokura 小倉, four to Kumamoto 熊本, nine to Zentsuji 善逸寺, seven to Himeji, thirteen to Ōsaka, seven to Kanazawa 金澤, nine to Nagoya 名古屋, thirty-five to Tokyo, eleven to Sendai 仙臺, and eight to Hirosaki 弘前.²⁹ Most patients were transported by train, and those patients who were transferred to reserve hospitals in northern Japan (like Sendai or Hirosaki) must also have passed through Ōsaka and Tokyo (see Figure 5.2).³⁰ When the patients traveled, their patient files traveled with them. The files were subsequently expanded and re-scripted by the physicians who were entrusted with the care of mentally ill patients. That is why a diagnosis made by Araki in Hiroshima could be altered when the patient passed through Ōsaka and was examined by Shimamura. If the patient's destination was the reserve hospital in Hirosaki in the far north of Japan (near Aomori 青森), he would additionally have to pass through Tokyo, where his diagnosis might be changed again by Kure.

26 Araki Sōtarō 荒木蒼太郎 [Araky, S.], "Beobachtungen über psychische und nervöse Krankheiten im japanisch-russischen Kriege 1904/1905" [Observations on Mental and Nervous Diseases during the Russo-Japanese War 1904–05], *Klinik für psychische und nervöse Krankheiten* 2, no. 4 (1907): 653.

27 Shimamura Toshiichi 島村俊一, discussion following Araki's talk on War Psychoses, *Dai nikai Nihon rengō igakkai kaishi*, 1907, 211.

28 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 8. Apart from mental diseases, Kure also reported 255 cases of what he diagnosed as "nervous diseases after physical trauma" (Kure Shūzō, 8–9). See section 2.2 for a detailed discussion of Kure's approach of classifying mental disorders and section 4.1 for Araki's approach.

29 Araki Sōtarō 荒木蒼太郎, "Seneki ni insuru seishinbyō ni tsukite" 戦役ニ因スル精神病ニ就キテ [On Psychoses Caused by the War], *Okayama igakkai zasshi* 18, no. 195 (1906): 137–216.

30 This is a detailed view of Map 1, "Sketch Map of the Theatre of War", 1904 published in General Staff, War Office, *The Russo-Japanese War*. I have placed the full view of the map in the lower right corner for reference.

5.2 Hiroshima: Melancholic Satō

It was only in the insanity ward of the Hiroshima Reserve Hospital that Satō's behavior and condition were first interpreted by a trained psychiatrist. Araki had volunteered to offer his services as psychiatrist and was employed as assistant medical attendant in the reserve hospitals of Hiroshima and Himeji.³¹ After the war, he compiled a report that documented his experiences in these hospitals. It was published in the in-house journal of his home institution and, next to 199 other case histories, contained a description of Satō's case.³² In 1907, when Araki went to Germany for further research in psychiatry and neurology, he also published a German version of his article in a local German journal.³³ In this version, eighty-nine of the original 200 case histories are reproduced in a shortened form and different arrangement (see also section 7.1). Since not only the total number but also the numbering of cases differs from one article to the other, they first needed to be matched. In the absence of the patients' names or any other unique markers, the matching cases can only be identified by their rather vague titles and their content. In the case of the thirty-one-year-old military engineer Satō, this was fairly easy, because there are no more than six military engineers in Araki's case collection, and only one of them is thirty-one years old.³⁴ It follows that case 31 (*dai sanjū ichi rei sanjū ichi sai kōbei* 第三十一例三十一歳工兵) from the Japanese version corresponds to case 65 (*Fall 65, 31 jähriger Pionier*) in the German version (see also Table 1 in the appendix).³⁵

According to his German article, Araki worked in the reserve hospitals twice a week.³⁶ In Hiroshima, there were special wards for mental patients in the sections of Hakushima 白島分院 and Motomachi 基町分院.³⁷ These were ordinary ward buildings divided

31 Rikugunshō 陸軍省, ed., *Rikugun eisei kinmu hōjoin kyōka no ken* 陸軍衛生勤務幫助員許可の件 [Permitting Employment of an Assistant in Sanitary Service to Army] (April 1905), accessed June 1, 2016, JACAR: C03027948700, <https://www.jacar.archives.go.jp>.

32 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite."

33 Araki Sōtarō 荒木蒼太郎, "Beobachtungen."

34 In fact, according to Western age reckoning, Satō was 29 years old in August 1905, as he was born in July 1876. Even by East-Asian age reckoning he was only 30 years old, not 31. See also footnote 59 on page 157. In the large group of infantry soldiers (84 cases), matching the corresponding cases was more difficult as most of them were between 22 and 25 years old.

35 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 157; Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 656–657.

36 Araki Sōtarō 荒木蒼太郎, 625.

37 Tabata Yukie 田端幸枝, "Kure Shūzō ga hōmon shita Nichiro sensō no rikugun Hiroshima yobibyōin no seishinka iryō kono 2 呉秀三が訪問した日露戦争時の陸軍広島豫備病院の精神科医療その2: Nichiro sensō zengo no seishin byōshitsu no hensen 日露戦争前後の精神病室の変遷" [Psychiatric Care in the Military Reserve Hospital of Hiroshima Visited by Kure Shūzō (Part 2): The Insane Ward Before and After the Russo-Japanese War], *Seishin igakushi kenkyū* 13, no. 1 (2009): 71 (Abstract of conference talk).

into barred padded cells.³⁸ When Satō arrived in Hiroshima on August 21, he was confined to such a cell and was cared for by Red Cross nurses and military sick attendants before Araki first examined him six days later. In his short report, Araki first gave a brief summary of Satō's condition before the latter was admitted to Hiroshima:

[...] 三十八年八月初旬昌圖ニ於テ發狂シ、沈鬱、自咎、過失アリトナシ、自殺ヲ企テ、夜間逃走シ、語ル所前後符合セズ、八月七日慶雲堡舍營病院ニ入リシ以來常ニ死ヲ欲シ、夜間逃走セントシ、不眠、頭重、眩暈、顔面蟻走感覺、眼火、耳鳴アリ、食欲、便通ハ常ノ如シ、八月二十一日廣島豫備病院ニ收容セラル [...] ³⁹

He got mentally ill in the first week of August 1905, while in Changtu. He was depressed, made self-accusations and acted as if he had made a terrible mistake. He tried to commit suicide and to escape at night. His speech was incoherent. On August 7, he was admitted to the cantonment hospital at Qingyunpu. Since then, he constantly wished to die and to escape at night. He suffered from lack of sleep, headaches, heaviness in the head, nausea, a tingling sensation on his face, blurred vision, and buzzing in the ears. Appetite and bowel movement were normal. He was sent to the rear and admitted to the Hiroshima reserve hospital on August 21.

It is clear that the information concerning the early stage of Satō's illness was known to Araki from the patient file that the medical personnel had compiled in the various hospitals in Manchuria. As these original records are no longer available, it is difficult to estimate how Araki handled and transformed the information. Araki's description begins with the statement that Satō's mood was depressed (*chin-utsu* 沈鬱). *Chin-utsu* is a medical term with connotations of pathology.⁴⁰ It was widely used in nineteenth- and early-twentieth-century psychiatric literature to denote depression, which was considered the main symptom of melancholia. In the German version, Araki used *Depression*, which was his most common translation of *chin-utsu*. He also often used the adjective form *depressiv* and, in some rare cases, *schwermütig* as a synonym. He never used the term "melancholic" or "melancholy" to describe a patient's mood or character. This term was reserved for the designation of the illness.

However, it is important to note that there was no generally binding terminology at the time. Army doctors, Red Cross attendants, and psychiatrists did not share the same

38 Lynch, "Report of Maj. Charles Lynch, Medical Department, General Staff, U. S. Army, Observer with the Japanese forces in Manchuria," 310.

39 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 157.

40 The pathological connotation of *chin-utsu* primarily derives from the original meaning of *utsu* 鬱 (constrain, stagnate), which is one of the technical terms in Traditional Chinese Medicine. Eventually, *chin-utsu* became part of everyday language in modern Japanese, but the exact timeline of this process has not yet been researched.

medical vocabulary when it came to treating mental disorders. In the report of the 74th Relief Detachment (*kyūgo ban* 救護班), which cared for the patients in the insane ward of the Hakushima section in Hiroshima, melancholia is referred to as *utsu-yū kyō* 鬱憂狂, whereas Araki used *chin-utsu kyō* 沈鬱狂.⁴¹ It is possible that an army doctor or medical attendant in Manchuria would have used *chin-utsu* to describe Satō's state of mind, but they might just as well have chosen a more generally used expression to indicate sadness or despondent mood. Araki himself occasionally used the less technical *yūshū* 憂愁 [melancholy, gloomy], *hiai* 悲哀 [sorrowful, sad], or *urei* 愁 [sorrowful, sad], especially when referring to a patient's conduct or facial expression.

In light of these fluctuating terminologies, Araki's use of the term *chin-utsu* did not necessarily coincide with the original description, but might already have been a re-adjusted rendering of the original medical record to support his own diagnosis of melancholia (*chin-utsu kyō*). In any case, even if he had taken certain liberties and paraphrased the original, it is very unlikely that the patient's mood would not have been mentioned in the patient file at all. However, it should already be noted here that this particular symptom was dropped from the medical history of the patient in the account of Kure, who treated the same patient in Tokyo five days later.

In Araki's classification system, "depressed mood" was a fundamental symptom of melancholia. This view is consistent with the discussion of melancholia in his textbook, which was published in the same year (1906) as his article on mental illness in the Russo-Japanese War.⁴² In the German version of his article, the term *chin-utsu kyō* 沈鬱狂 was always rendered as *Melancholie*, and in Satō's case, this diagnosis was followed by the additional note "*Selbstmordversuche*" [suicide attempts]. This addition, missing in the Japanese original, seemed to represent the main justification of the diagnosis.⁴³ Apart from this note, the German version did not provide any new information about Satō's condition.

41 Nihon Sekijūjisha 日本赤十字社, ed., *Meiji sanjūshichi-hachi nen seneki Nihon Sekijūjisha kyūgo hōkoku* 明治三十七八年戦役日本赤十字社救護報告 [Report on the Sanitary Assistance Provided by the Japanese Red Cross Society during the War in 1904–05] (Tōkyō: Nihon Sekijūjisha, 1908), 646. This relief squad of the Red Cross Society came from Wakayama and arrived in Hiroshima on June 25, 1904. They took care of more than 130 mental health patients from November 1904 to September 1905 (Nihon Sekijūjisha, 644–645). For some visual impressions of the working conditions of the Japanese Red Cross during the war, see (Hashimoto Kyūjirō 橋本忠次郎, ed., *Nichiro sensō Nihon sekijūjisha kyūgo shashinchō* 日露戦争日本赤十字社救護写真帖 [Photographs Showing the Work of the Red Cross Society of Japan during the Russo-Japanese War], vol. 2 [Tōkyō: Nihon sekijūji hakkōjo, 1906], not numbered).

42 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite"; Araki Sōtarō, *Seishin byōri hyōshaku*.

43 There are mainly two different kinds of melancholia-cases in Araki's report. First, those specified as suicidal and second, those characterized as suffering from delusions of self-accusation (Versündigungswahn). In other cases, when the patient was suffering from various diseases (colitis, tuberculosis, or syphilis), these were given in brackets after the main diagnosis and indicate a possible cause of illness (cases 16, 17, and 43).

Whereas the first part of Satō's case history contained at least a few narrative elements, Araki's own observations were simply presented in the form of a list of symptoms:

初診 八月二十七日、沈鬱、聯合抑制、音聲小、應答甚ダ不充分
ニシテ片々斷裂シ、連續スル談話ヲナサズ、語ル所極メテ
單簡ナリ、食欲振ハズ、睡眠十分ナラズ、自殺ヲ欲ス、

診断 沈鬱狂 [...]

經過 九月一日東京豫備病院ニ轉送セラル、⁴⁴

Status praesens:⁴⁵ August, 27: Depression, inhibition of associations, low voice. His response to questions is very poor. He speaks in a clipped manner. His speech is incoherent and his answers extremely simple. Absence of appetite, bad sleep, he wishes to kill himself.

Diagnosis: Melancholia.

Further developments: Transferred to the Tokyo Reserve Hospital on September 1.

There are two relevant aspects for Araki's framing of Satō's case as melancholic that can be observed from this short description. The first has to do with the similarity of the words (for the main symptom and disease name), and the second with the sequence of symptoms. Araki began his own enumeration of symptoms with depression (*chin-utsu* 沈鬱), thereby consciously echoing the structure of Satō's anamnesis. He constructed a case history that convincingly led to a diagnosis of melancholia, as it relied on about the same words for the description of symptoms (*chin-utsu*) as for the diagnosis (*chin-utsu kyō*). The importance of the order of symptoms becomes obvious when it is compared to the description of cases of neurasthenia (forty-four cases), which was Araki's second most common diagnosis after melancholia (fifty-nine cases). Although "depressed mood" was also considered to be a characteristic symptom of neurasthenia,⁴⁶ Araki never started the description of a neurasthenic's observation with this symptom. Usually, he began these cases with "headache," "forehead pain," or "vertex pain." This manner of arranging symptoms suggests that in Araki's structure, symptoms at the top of the list were weighted more heavily and were closer related to the diagnosis.

The brevity of Araki's report leaves it open how he actually observed Satō's depressed mood, but from his other melancholia cases it is evident that he usually paid careful attention to a patient's facial expression. The phrase most commonly used in the text was

⁴⁴ Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 157.

⁴⁵ "Status praesens" is the term used by Araki in the German version. It was also common in contemporary English texts and referred to the description of the patient's condition at initial observation.

⁴⁶ See the general symptomatology of *neurasthenia* in Araki's article Araki Sōtarō, 146. The subject of *neurasthenia* will be discussed in another part in more detail.

ganyō taishū 顔容帶愁 [face marked by sadness] and variations of this expression. Sometimes, Araki used verbs which indicate visibility and, by implication, the act of observing. These were mainly *shimesu* 示ス [show, indicate] and *hyōji su* 表示ス [show, express], as in *ganbō hiai o shimeshi* 顔貌悲哀ヲ示シ [his face showed sadness].⁴⁷ In a few rare cases, depression itself (not just sadness) was visible on the face: *ganyō chinutsu o hyōji shi* 顔容沈鬱ヲ表示シ [his face showed depression].⁴⁸

Occasionally, he recorded when a patient was sighing, crying, or brooding over some real or imagined worry, but in Satō's case, there is no such detailed description of direct expressions of mood. It could, however, be argued that Satō's suicide attempts were interpreted as an indirect sign and a result of his mood, a causal relation also suggested in Araki's textbook.⁴⁹ Even if Satō showed any visible signs, Araki chose to subsume most of them under the category of "depression" in his report. The only observable expression of depressed mood directly recorded by Araki was Satō's low voice. It may be assumed that Araki's technique of note-taking and case-writing was guided by certain patterns of perception, where facial expressions and other directly observable markers of disturbed mood were already translated into technical terms at an early stage of the diagnostic process.

On the whole, there was a strong emphasis on the patient's manner of speaking.⁵⁰ The "inhibition of associations" (*rengō yokusei* 聯合抑制) is a symptom that describes a specific disturbance of the train of thought.⁵¹ In theory, it meant that the patient's mental ability to perceive external impressions, to link one idea to another, and to physically react to the impression was markedly retarded. Of course, none of these mental processes was directly observable. In practice, "inhibition of associations" referred to a patient's slowness in speaking and answering the doctor's questions. Other observations, such as "incoherent speech" and "simple answers," served to reinforce the idea that Satō's thought process was disturbed. Disturbed speech then became a direct manifestation of disturbed thought. At this point, Satō's case already contained two of the necessary symptoms for a melancholia diagnosis: depression and inhibition of associations.

At the end of his observation, Araki mentioned a few symptoms that he generally treated as "physical," namely, appetite and sleep. These were routinely mentioned because they affected a patient's physical condition and sometimes required medical intervention (such as forced feeding). In any case, Araki did not necessarily make a direct connection between Satō's appetite and his diagnosis, an aspect that gained significantly in

47 See case 41 in Araki Sōtarō, 161.

48 See case 42 in Araki Sōtarō, 161. For a short discussion of physiognomy as a means of diagnosis in psychiatry see also Arnold I. Davidson, *The Emergence of Sexuality: Historical Epistemology and the Formation of Concepts* (Cambridge and London: Harvard University Press, 2004), 47–52.

49 Araki Sōtarō, *Seishin byōri hyōshaku* 147.

50 On the role of "disturbed speech" as a marker of insanity see especially Wübben, *Verrückte Sprache*, 9, 33–40.

51 *Rengō yokusei* is referred to as "Assoziationshemmung" in the German version.

importance in Kure's report. Araki's rather short description and some of the discrepancies with Kure's report might, in part, have been caused by the circumstance that he did not get the chance to observe Satō's condition for a long period, as he only saw him once before the latter was transferred to Tokyo.⁵² On that day, August 27, 1905, Araki examined at least seven other patients in the insanity ward of Hiroshima.⁵³ His attention was, therefore, not restricted to Satō's case, and he was unable to observe the course and outcome of the condition. In general, he noted that most patients seemed to recover from melancholia after a few months.⁵⁴ However, Araki's view was not the final verdict on Satō's condition. When Satō was admitted to the Tokyo Reserve Hospital a few days later, his case history was substantially rewritten, and his prognosis worsened dramatically.

5.3 Tokyo: Deranged Satō

The journey from Hiroshima to Tokyo usually took about two days and one night, and was made in stages. The first night was spent in Ōsaka, about twelve hours' journey from Hiroshima by train. The patients travelled in hospital clothing and were housed for the night by being billeted in inns and houses in the neighborhood of the railway station. On arrival in Tokyo, stretcher parties, ambulance rickshaws, and ordinary rickshaws carried the patients to the hospitals.⁵⁵

When Satō was admitted to Tokyo on September 1, he came under Kure's care. Kure's collection of case histories had a character much different from Araki's, as the Ministry of War had ordered him to compile the official report on mental illness in the army.⁵⁶ Before starting his work in the reserve hospitals of Tokyo in January 1905, he was sent to Hiroshima to inspect the insane wards there and to ensure that they met modern standards.⁵⁷ Kure's report can therefore be considered to represent the authoritative view on mental illness in the Russo-Japanese War.

52 From the dates given as the date of first examination (*shoshin* 初診) in the 200 cases of the Japanese version, one can conclude that he worked in Himeji on Wednesdays and in Hiroshima on Sundays. As Satō was transferred to Tokyo on the next Friday after his examination, Araki could not have seen him more than once.

53 According to his records, two among these seven were diagnosed with *melancholia*, one with *mania*, and four with *neurasthenia*.

54 See Araki's general symptomatology of melancholia, Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 142–143.

55 Macpherson, *The Russo-Japanese War*, 354.

56 Rikugunshō, *Meiji sanjūshichi-bachinen sen'eki rikugun eiseishi* 6. In the preface of the chapter on mental illness, it is explicitly stated that Kure composed his article for the army's sanitary report.

57 Tabata Yukie 田端幸枝, "Kure Shūzō ga hōmon shita Nichiro sensō no rikugun Hiroshima yobibyōin no seishinka iryō kono 1: Rikugun Hiroshima yobibyōin no gaiyō" 呉秀三が訪問した日露戦争時の陸軍広島豫備病院の精神科医療その1: 陸軍広島豫備病院の概要 [Psychiatric Care in the Military Reserve Hospital of Hiroshima Visited by Kure Shūzō (Part 1): Overview of the Military Reserve Hospital of Hiroshima], *Seishin igakushi kenkyū* 13, no. 1 (2009): 70. The oldest military hospitals

His report also served a didactic purpose. Unlike Araki, who gave the diagnosis at the end of a case history as the result of the anamnesis and his own medical evaluation, Kure always put it at the beginning of a case. In this writing mode, the individual case was turned into the illustration of an illness with general characteristics. In this context, Satō's case was merely one example of the manifold manifestations of *catatonia*. The didactic function of the text also explains the confidence with which Kure presented his diagnostic judgment. While Araki sometimes expressed doubts about his classification and openly stated that his results were of a preliminary nature, there was no trace of uncertainty in Kure's report.⁵⁸ His evaluation was presented as definite and unambiguous:

病名 緊張病

既往症 生来壯健ナリ、飲酒喫煙ヲ好ム、沈著快活ニシテ業務ニ熱心ナリ明治三十八年九月 [sic!] 清國昌圖ニテ軍用手票十錢ヲ拾ヒ最初自分ノ遺失セルモノトテ懷中セシモ後チ自分ノモノニアラヲ [ザ] ルヲ知り、之ヲ戰友ニ問フモ遺失者無ク戰友ハ自分竊取ヲ疑フト思ヒ自殺ノ企圖セントシ又夜間戸外ニ逃走セルコトアリ談話ハ要領ヲ得ス
開原、奉天、大連等兵站病院ヲ經テ後送セラレ九月一日戸山分院ニ入ル。⁵⁹

Diagnosis: Catatonia

Anamnesis: The patient had a healthy constitution, but was fond of alcohol and smoking. He was of a calm and peaceful disposition and fulfilled his duties eagerly. In [August] 1905,⁶⁰ while in Changtu, China, he found a 10-*sen* war-note. At first, he thought that it was money he

in Hiroshima had already been constructed during the First Sino-Japanese War (1894–1895). The insane wards were ordinary ward buildings, not different from other sections in the hospital. During the Russo-Japanese War, these wards were turned into specialized wards for the insane (Tabata Yukie, “Kure Shūzō ga hōmon shita Hiroshima yobibyōin 2,” 71).

58 It should be noted that Araki discussed the subject of uncertainty only in his German version (Araki Sōtarō 荒木蒼太郎, “Beobachtungen,” 625, 668).

59 Case 28 (first-class soldier Satō of the corps of engineers of the reserve army, born July 1876) in Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 85–86. Both Araki and Kure use East Asian age reckoning (also in their German texts), according to which a person is one or two years older than in Western age reckoning.

As with Araki's quotes, I have reproduced the Japanese text in its original form without converting characters into their modern equivalents (*zu* 圖 instead of *zu* 図). I have also left the kana unmodified. In this edition, no *dakuten* (a diacritic sign used to indicate voiced consonants in kana) are used. Context and syntax provide sufficient clarity to identify these places (for example, *yōryō wo esu* 要領ヲ得ス should be read as *yōryō wo esu* 要領ヲ得ズ).

60 Although it is stated in the Japanese text that the events took place in September, it must be a mistake because Satō was admitted to Tokyo on September 1 (see end of quote). I follow Araki's description, who states that it was the first week of August (see Araki's report on page 152).

himself had lost, so he put it in his pocket. Later, he realized that it was not his own. Although he asked his comrades about it, the real owner could not be found. He thought that his comrades suspected him of stealing. He attempted suicide and sometimes tried to run away at night. His speech was incomprehensible.

After passing the line of communication hospitals of Kaiyuan, Mukden, and Dalny,⁶¹ he was sent to the rear and admitted to the Toyama branch hospital on September 1, 1905.

Kure gave a more detailed account of the circumstances of Satō's experiences in Manchuria. He might either have obtained this information from the patient file or by questioning his patient. More important, however, is the fact that he chose to include this story in his version of the patient's medical past, which seems to be related to his diagnosis, rather than an obsession with details. Indeed, while Araki summarized the *io-sen* episode using abstract expressions such as "self-accusations" and "terrible mistake," Kure actively linked the manner of Satō's behavior to catatonia. To understand how exactly he achieved this, one must turn to the theories associated with this diagnosis. Catatonia was considered to be an incurable form of mental illness that invariably led to mental enfeeblement. However, the "true art of diagnosis" as it had been propagated by Kraepelin (see page 47) was to recognize catatonia and other forms of dementia praecox *before* mental deterioration was yet observable. These early signs, which allowed a skilled psychiatrist to make prognostic assessments by differentiating forms of melancholia that would lead to recovery from those that would lead to mental deficiency, were called "catatonic signs."

Apparently, Kure considered himself to be equipped with this diagnostic skill when he remarked in the introduction to his report that more than half of the melancholias witnessed by other psychiatrists in wartime actually belonged to the categories of hebephrenia and catatonia (both being forms of dementia praecox).⁶² He did not exclusively refer to Araki's report when he criticized the melancholia interpretation but listed him among other physicians who noticed a prevalence of this illness in soldiers.⁶³ Nor did he mention Araki in his case histories, eliding the latter's diagnosis even in cases where he quoted from his report literally. Satō's re-evaluation as a catatonic patient is therefore hushed up in Kure's account, and his medical past is notably re-scripted to reveal "catatonic signs."

Indeed, if one follows contemporary textbook descriptions of dementia praecox, Kure's detailed portrayal of the *io-sen* episode is very much part of his catatonia interpretation. In fact, among those symptoms which were recognizable at an early stage, the patient's "defective judgment" and the resulting "irrationality" (*fugōri* 不合理)

⁶¹ For further information on the place names, see footnote 9 on page 143.

⁶² Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 11.

⁶³ Kure Shūzō, 10. Kure's general critique of German and Russian authors will be discussed in more detail in section 7.2.

and “queerness” (*kii* 奇異) of his delusions were considered typical.⁶⁴ In this train of thought, not only was the presence of delusions seen as pathological, but their content was evaluated in relation to some implied, but never explicitly articulated, standard of “rationality” as well.

Because the objective value of the note that Satō had found was not very high, it is safe to assume that Kure’s “common sense” approach made Satō’s suicidal behavior seem highly irrational. His otherwise calm and peaceful disposition, which was noted by Kure at the beginning of the case history, also made his actions appear more extreme. Even the statements about Satō’s previous health and well-being had diagnostic value for Kure. They allowed for a differentiation between dementia praecox, which is a form of dementia that occurs in youth, and its congenital forms. The incoherence of speech also nicely fitted Kure’s catatonia interpretation, but many other symptoms listed in Araki’s version of the anamnesis were deleted from his account.

For instance, any reference to Satō’s mood is conspicuously absent, illustrating the fact that Kure’s narrative construction and all narrative constructions of case histories involve the process of selection.⁶⁵ By omitting the symptom of depression, Kure deliberately shifted the focus from the “affectivity” of Satō’s behavior to its “irrationality.” Although depressed mood was also a common symptom in the early stages of catatonia, it was not essential to its diagnosis. Consequently, other aspects of Satō’s behavior were more prominently stressed. These aspects were then further elaborated in Kure’s personal observation of Satō, reinforcing their significance and supporting the catatonia interpretation:

現在症 指南力不良、記憶正カラス、観念ノ経過遅滞シ幻聴アリ、佐藤○太郎（自分姓名）ハ放火セリ、親ノ死亡時金五圓ヲ誤魔化セリ等ノコト聴エ、又居村ニ山林ノ事件アリトカ、父カ病氣ナリトカ思ハレ、犯罪ノ覺ナキニ處罰セラルルカ如クニ信ジ、自殺念慮アリ井戸ニ投身セントセルコトアリ、感情沈鬱性ナリシガ後昏迷状態トナリ。問フモ目ヲ閉キテ答ヘス食事ハ人ノ目前ニテナサス人居ラヲ [ザ] レハ食ス。胸腹部ニ異常ナク瞳孔反應存シ、膝反射減弱ス。⁶⁶

Present symptoms: Orientation not good, memory impaired. The train of thought is slowed and he has acoustic hallucinations. He is

64 See the general symptomatology of dementia praecox as it was taught by Kure at Tokyo Imperial University in Ishida Noboru 石田昇, *Shinsen seishinbyōgaku* 新撰精神病学 [New Psychiatry] (Tōkyō: Nankōdō, 1906), 74. The point is further reinforced in the corresponding sections of Kraepelin’s sixth edition of his *Psychiatrie* (Kraepelin, *Klinische Psychiatrie*, 141) and in the American translation of this textbook (Diefendorf, *Clinical Psychiatry*, 157).

65 Guenter B. Risse and John Harley Warner, “Reconstructing Clinical Activities: Patient Records in Medical History,” *Social History of Medicine* 5, no. 2 (1992): 190.

66 Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 86.

hearing that Satō [...] tarō (his first and family name) has set a house on fire, the time of death of his parents, that he has embezzled 5 *yen*. He thinks that there has been an accident in the woods of his native village, that his father became ill. He believes that he will receive a punishment, even though he is not aware of having committed any crime. He has suicidal thoughts and has tried to throw himself into a well. In the emotional attitude there was at first depression, while later he was in a stuporous condition [a state of mental and physical inertness]. When questioned, he closes his eyes and does not answer. He does not eat when other people are watching. When no people are there, he eats. No anomalies in chest and abdomen, pupillary reaction is present, loss of tendon reflexes.

Kure began his observation with statements on the field of what was generally referred to as “intellectual capacity.” To evaluate whether orientation and memory were affected, the patient had to answer a series of questions. The catalogue of questions designed to test someone’s orientation usually included inquiries about a patient’s name, occupation, and place of residence as well as questions about their surroundings and their conception of the time of week, month, and year.⁶⁷ Similarly, the questions designed to test a patient’s memory ranged from asking about family history to queries regarding geography, history, and religion.⁶⁸ Answering a certain number of these questions incorrectly was interpreted as an impairment of mental elaboration.

Another early symptom of catatonia was “slowness of the train of thought.” Like deficiency in mental capacity, it was only observable through interrogation, but instead of evaluating the accuracy of answers, it referred to the response time a patient required to answer the doctor’s questions. According to textbook descriptions of catatonia, neither the impairment of intellectual capacity nor retardation of the train of thought were essential to the diagnosis, but the presence of acoustic hallucinations, closely linked to the symptom of delusions, could be indicative of catatonia.⁶⁹

67 Kure Shūzō 呉秀三, *Seishinbyō shinsatsubō* 精神病診察法 [Methods of Diagnosing Mental Illness] (Tōkyō: Chiryō gakusha 治療学社, 1908), 9. According to the preface, this book is mainly based on Sommer’s *Textbook on Examination Methods in Psychopathology* (on Sommer, see footnote 93). This textbook provides the physician with many practical instructions and lists of questions.

68 Kure Shūzō, 16–25.

69 In the textbook description, acoustic hallucinations are stressed as the most prominent form of hallucinations, followed by hallucinations of sight, touch, smell etc. (Ishida Noboru, *Shinsen seishinbyōgaku* 72). This view is consistent with Kraepelin’s textbook (Kraepelin, *Klinische Psychiatrie*, 155). Contrary to a seemingly widespread presumption, Kraepelin, the founding father of *dementia praecox*, did not emphasize hallucinations as a key symptom, nor did Eugen Bleuler (1857–1939), who is commonly believed to have further developed Kraepelin’s disease concept into *schizophrenia*. According to Hacking, it was only after Kurt Schneider (1887–1967), in an attempt to operationalize the concept, put auditory hallucinations at the top of “first-rank-symptoms,” that they almost became “a sine qua non of schizophrenia”

By picking up the subject of Satō's delusions already highlighted in the anamnesis ("He thinks that there has been [...]"), Kure once again put the focus on their content and so not only re-enforced his interpretation but additionally pointed to the lack of coherence among the various delusions. By simply listing the different subjects of Satō's fears (illness of father, fire in the woods, unjust punishment), he created an impression of inconsistency and randomness. In his general discussion of the main symptoms of catatonia observed in Tokyo's reserve hospitals, Kure referred to this kind of delusion as "unsystematized" (*keitōteki narazaru mōsō* 系統的ナラサル妄想),⁷⁰ an attribute that was also echoed in textbook descriptions of catatonia.⁷¹

Directly subsequent to the enumeration of Satō's diverse delusions, Kure mentioned the presence of suicidal thoughts. This structure suggests an affinity between delusions and suicidal propensity, an aspect entirely absent from Araki's report. Araki's account, quite in contrast, suggests a connection between despondent mood and suicide.⁷² Kure's active recontextualization of the suicidal propensity as a result of "irrational delusions" completely alters the interpretation of Satō's mental state. It once again shifts the focus from an illness characterized by "affectivity" and "self-centeredness" to an illness defined by the patient's "irrationality." Although not explicitly pointed out within Satō's case history, the causal relationship between delusions and suicide is more clearly articulated in another part of Kure's report. There are a few references to Satō's case in Kure's general discussion on catatonia, which provide additional information on how Kure categorized and evaluated some of Satō's symptoms. Kure noted that, within a group of eight catatonic patients who did not exhibit symptoms of agitation but had undetermined and unsystematized delusions, there were three patients with delusions of self-accusation (*zaigō mōsō* 罪業妄想), of which two had suicidal thoughts resulting from these delusions (*sono kekka jisatsu no nenryo ari* 其結果自殺ノ念慮アリ). He then further explained that one of these two patients had tried to throw himself into a well (*ichinin wa ido ni tōshin sen to seri* 一人ハ井戸ニ投身セントセリ), which is a direct reference to Satō's case.⁷³

(Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* [Princeton: Princeton University Press, 1998], 114). I do not agree with Hacking that Kraepelin emphasized "flat affect." At least during this period, Kraepelin de-emphasized all forms of affect in *dementia praecox* in favor of his "significant signs" (see the discussion in chapter 2). However, I find Hacking's portrayal of the rise and fall of hallucinations as a key symptom of schizophrenia convincing in general.

70 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 68.

71 Ishida Noboru, *Shinsen seishinbyōgaku* 74–75. See also Kraepelin, *Klinische Psychiatrie*, 141.

72 On the relation between melancholia and suicide in Victorian England, see Åsa Jansson, "From Statistics to Diagnostics: Medical Certificates, Melancholia, and 'Suicidal Propensities' in Victorian Psychiatry," *Journal of Social History* 46, no. 3 (2013): 716–731. For a discussion of medicalization of suicide in Japan, see Di Marco, *Suicide in Twentieth Century Japan*. An innovative, poetic, and literary approach focusing on the various forms suicide notes can take and serve can be found in Kirsten Cather, *Scripting Suicide in Japan* (Berkeley: University of California Press, 2024).

73 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 68. Even without the indication of a name or case number, one can easily match the passages from the general discussion

Based on the statements in the general discussion, it thus follows that Kure definitely saw a causal relationship between Satō's delusions and his suicide attempts, and that he furthermore categorized these delusions as "delusions of self-accusation."

Only towards the end of his report did Kure eventually concede that Satō had, indeed, been depressed at an early stage of the illness, but he instantly undermined the significance of affectivity by pointing to its transient nature. This newly introduced temporal dimension is completely absent from Araki's account. Whereas Araki reported that the depressed mood was observed simultaneously with the absence of appetite and bad verbal response, Kure attributed these symptoms to two different stages of Satō's illness. He thereby suggested that there was a change in the emotional attitude of the patient, who was depressed at first but later became inert and unapproachable.⁷⁴ Although such a progression of symptoms is contradicted by Araki's account, who observed them all on the same day, Kure's choice in favor of the catatonia interpretation committed him to reporting a certain development in Satō's condition, because the element of progress was crucial to the diagnosis.⁷⁵

After having dismissed depressed mood as a minor episode in the course of the illness, Kure immediately proceeded to his most powerful argument in favor of catatonia: his description of Satō's behavior when questioned or given meals. He observed that Satō used to close his eyes when questioned and refused to eat when people were watching him. Unlike Araki, who merely noted the fact that Satō did not respond well to questions and did not eat, Kure paid attention to the manner in which Satō expressed his refusal to cooperate. Thus, Kure psychologized these actions and interpreted them as "catatonic signs" belonging to the category of "negativism" (*kyozetsushō* 拒絶症).⁷⁶

Negativism was another technical term (still used in present-day psychiatry) that in theory referred to a patient's mental activity, but in practice was only observable in his movements and actions. Supposedly resulting from a diminished susceptibility of the

with the corresponding case history by process of elimination and by comparing the list of symptoms in both sections.

74 In the case of Satō, there is no indication of the duration of his treatment in Tokyo, but a survey of Kure's other cases reveals that his patients were hospitalized for about a month on average.

75 Both Karl Ludwig Kahlbaum and Kraepelin (the main promoters of the concept of *catatonia*) considered the presence of a typical course a necessary criterion for a conclusive *catatonia* diagnosis (Wübben, *Verrückte Sprache*, 71).

76 Kure's categorization of such behavior as "negativism" is also expressed in his general discussion (Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 68). It also becomes clear from other cases that in practice, Kure used to equate refusing food with "negativism" without even observing the patient personally. In the case of the superior soldier Hamada, the medical record says that he had been "cheerful, talked and laughed to himself, and refused food" 快楽性ニシテ獨語獨笑シ、食事ヲ拒ミ (Kure Shūzō, 120–121) when he was 16 years old. However, in his general discussion, Kure summarized the patient's symptoms as "became cheerful, talked and laughed to himself, and showed negativism" 快楽性トナリ獨語獨笑拒絶症等アリ (Kure Shūzō, 112). See case 48 (superior soldier Hamada of the corps of engineers, born 1883) in Kure Shūzō, 120–121.

faculty of volition, “negativism” denoted the involuntary suppression and subsequent reversal of impulses in reaction to external stimuli. According to this mechanistic definition, “negativism” was not triggered by voluntary opposition but was the expression of a morbid functioning of a mental faculty. However, the distinction between pathological and normal opposition was dependent on the physician’s assessment of its “appropriateness” in relation to a given situation. That such judgment calls are complicated in nature is evident, as sociological research into the doctor–patient relationship has shown.⁷⁷ Their reification as diagnostic primary facts should be considered with extreme care.

With regard to the medical practice of diagnosis, the introduction of “negativism” significantly altered the patient’s observation by the doctor. Its abstract character obscured the underlying logic of equating a person’s mental functioning with his physical reaction to the medical setting. It also masked the involvement of social norms in guiding the physician’s gaze and medical judgment. Satō’s reinterpretation as a catatonic patient was, therefore, not due to a sudden change of his symptoms, but rather relied on a reinterpretation of his behavior. This reinterpretation was mediated through the introduction of new interpretative patterns (such as the concepts of “negativism”) that effectuated a change in the doctor’s mode of seeing. Although Kure reported almost the same symptoms as Araki, he imbued them with different meanings and reconfigured their interrelations.

In the text, the transformation of meaning was accomplished through a number of structural and stylistic modifications. Compared to Araki’s account, one finds the order of symptoms rearranged. Some symptoms are emphasized by being discussed in minute detail (hallucinations, irrational thoughts); others are marginalized by being mentioned merely in passing (depressed mood, inhibition of associations). To illustrate Satō’s disordered state of mind, Kure employs a narrative device reminiscent of an interior monologue. Satō’s various thoughts and fears are hereby presented collectively without any context or coherence, suggesting a lack of coherence in Satō’s train of thought. Furthermore, the rearrangement of symptoms unravels the close connection between suicide and depressed mood—found in Araki’s text—and re-links suicide to irrationality. Likewise, the “absence of appetite” is de-contextualized from the domain of physical symptoms to become a main indicator of a dysfunctional mental faculty. All of these structural moves reconfigure Satō’s initial characterization as a melancholic patient to present him as exemplarily catatonic.

Satō’s case has served as an exemplary illustration to show how a diagnosis of melancholia was first deconstructed and then replaced with catatonia. However, on its own, it cannot give a full picture of the disintegration and vanishing of melancholia. Although Kure himself stressed the fact that most of the so-called melancholias belonged into the

77 Roy Porter, “The Patient’s View: Doing Medical History from Below,” *Theory and Society* 14, no. 2 (1985): 175–198.

category of dementia praecox, a detailed examination of his case records reveals a more differentiated approach. Indeed, the patients who were originally diagnosed with melancholia by Araki were not all systematically re-diagnosed with dementia praecox by Kure. Rather, some of them were re-conceptualized as cases of manic-depressive insanity. Tracing the rationale behind the division that eliminated melancholia from the psychiatrist's conceptual toolbox and provided melancholics with new medical identities is the subject of the next chapter.

6 New Modes of Observation & the Psychologization of Opposition

The analysis of patient files that contain conflicting diagnoses is not only pertinent to analyzing modes of observation and writing, but it is also ideal to demonstrate the changes in perception that allowed the re-conceptualization of melancholia as either manic-depressive insanity or dementia praecox. As we have seen in chapter 5, Satō's melancholia was reinterpreted as dementia praecox, which suggests that the relationship between these two conditions was, in fact, closer than it is usually assumed to be. Even though one of them was defined as a temporary affliction and the other as an incurable, permanent illness, it was still possible for Kure to rewrite Satō's melancholia as dementia praecox.

As it happens, patients do not usually come with an “*incurable*” tag pasted across their foreheads, and unlike other states of mind such as sadness or fear, incurability is not a trait that doctors are traditionally used to recognizing by observing their patients' appearance and behavior. We also need to consider that the observation period in Japan's military hospitals was very short and that doctors did not have the luxury of drawing their conclusions from long-term records. In fact, the wartime setting often required an ad hoc diagnosis immediately upon admission. This situation was very similar to the conditions Kraepelin faced in Heidelberg when he had to decide whether a new patient should remain in the (constantly overcrowded) teaching hospital or be transferred to a long-term hospitalization facility for incurable patients. I will therefore draw upon the analysis from chapter 2 and show how the new system of “significant signs” propagated by Kraepelin was applied in practice in the Japanese setting.

Indeed, upon matching and examining Araki's and Kure's case histories, several other cases of conflicting diagnoses (other than Satō's) come to light, which allow the articulation of a more nuanced view of the relationship between the contemporary perception of melancholia and dementia praecox. In this chapter, I will demonstrate that at the time of the Russo-Japanese War, Araki's melancholia and Kure's dementia praecox were overlapping disease concepts. Thus, the two physicians could apply them to the same group of patients by emphasizing different criteria of illness identification. When examining medical literature from this period, one should, therefore, not treat these terms as if they

represented distinct disease entities and referred to different patient populations. In fact, not even the use of the same medical term implied a shared understanding of its meaning.¹

From a comparison of Kure's and Araki's cases, it can be observed that one effect of Kure's new diagnostic scheme was that several previously inconspicuous clinical signs (gestures, movements, attitudes) had suddenly been ascribed diagnostic value and thereby changed modes of observation. In cases that have been observed both by Kure and Araki, I will examine the changes in observation by focusing on three spheres of mental functioning, namely, affect, cognition, and volition. In focusing on these three categories, I enter into dialogue with Radden and Shorter, who have argued that the emergence of Kraepelin's disease concept of manic-depressive insanity was a result of "lumping mood disorders together."² Re-examining the case histories according to this tripartite division allows me to demonstrate that this was not the case and to propose an alternative explanation. Thus, the structure of this chapter suits my aim of making a historical argument on the genesis of the psychiatric concepts of manic-depressive insanity and dementia praecox. However, this is not to imply a division of mental faculties (as such) nor to suggest that the historical actors Kure and Araki actively used this subdivision as analytical categories. On the contrary, I will show that it was precisely the rejection of a division into affective and cognitive disorders that characterized Kure's approach.

6.1 Affect: Tears and Withdrawal

Although medical historians often characterized Kraepelin's manic-depressive insanity as an "affective disorder," there is little evidence in Kure's cases that "affect" actually played a decisive role in the diagnosis of his manic-depressive patients.³ The cases of Akiyuki 秋元 and Hibara 檜原, two of Araki's melancholic patients who were subsequently re-diagnosed with manic-depressive insanity by Kure, serve to illustrate the transformation process that provided them with new medical identities.⁴ When their medical records are

1 This has been the most common approach to analyzing these historical texts. It is characterized by the absence of a contextualized examination of medical categories, an ignorance of their use in practice and their notoriously unstable meanings. The shortcomings of such studies become even more apparent when the analysis is limited to statistical data. Although acknowledging the limitations of his approach, Paul Wanke's assessment that at the time of the Russo-Japanese War, Russian military psychiatry was in a state of confusion is entirely based on statistics issued by different psychiatric hospitals (Wanke, *Russian/Soviet Military Psychiatry 1904–1945*, 20).

2 Shorter, *What Psychiatry Left Out of the DSM-5*, 167; Radden, "Lumps and Bumps," 131.

3 The representation of *manic-depressive insanity* as an "affective disorder" is the most common way of portraying the illness. See for example: Schmidt-Degenhard, *Melancholie und Depression*; Jackson, *Melancholia and Depression*; Berrios, "Melancholia and Depression during the 19th Century"; Hoff, *Emil Kraepelin und die Psychiatrie als klinische Wissenschaft*; Radden, *Moody Minds Distempered*; Somogy Varga, "From Melancholia to Depression: Ideas on a Possible Continuity," *Philosophy, Psychiatry, & Psychology* 20, no. 2 (2013): 141–155; Shorter, *What Psychiatry Left Out of the DSM-5*.

4 For Araki's data on Akiyuki see case 19 (23-year-old transport soldier) in Araki Sōtarō, "Seneki ni insuru

compared to Satō's case, the rationale behind Kure's differentiation of manic-depressive insanity and dementia praecox becomes more clearly visible. In fact, the plurality of complementary cases shows that Kure's gaze was guided by other determinants than the division of "affective" and "cognitive" symptoms.

Akiyuki had joined the Army in 1903, when he was twenty years old. During the spring of 1905, when most of the battles of the Russo-Japanese War had already been fought, he was stationed in Xiafeidi 下肥地, a small village in Liaoning province in Manchuria, where he worked as a transport soldier (*yusotsu* 輸卒).⁵ On May 30, while on duty, Akiyuki experienced physical weariness and discomfort. At first, he ignored these symptoms, but when his condition got worse on the following day, he asked for a medical examination.

Araki recorded that Akiyuki seemed to be in a stuporous condition and could not give intelligible answers during the examination. In his article, Kure supplied the additional information that it had become apparent upon examination that Akiyuki was drunk, reeked of alcohol, and was muddle-headed, so that his comrades had to be questioned in his stead.⁶ They assured the medical personnel that Akiyuki was mentally ill (*seishin ni ijō ari* 精神二異常アリ) and was apparently also experiencing hallucinations (*genkaku* 幻覚). He was known for his habit of sneaking into the neighboring villages in the evenings, was restless at night, and used to talk in his sleep.

Apart from the alleged "facts," this episode illustrates the involvement of third parties in identifying abnormal behavior and interpreting it as mental illness. Comrades, commanding officers, or the military police (*kenpei* 憲兵) often acted as mediators or complainants who initiated a person's commitment to a hospital.⁷ However, it seems that in

seishinbyō ni tsukite," 153. There is no corresponding German version. As in all other instances, the name and date of birth of the patient is only mentioned in Kure's records, cf. case 36 (transport soldier Akiyuki of the transport unit [peasant], born February 1883) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 101–102.

For Araki's data on Hibara see case 27 (25-year-old transport soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 156. There is no corresponding German version either. For Kure's data on Hibara see case 38 (transport soldier Hibara [peasant], born May 1881) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 102–103.

5 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 153; Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 101–102.

6 Kure Shūzō, 101. Kure also mentioned that Akiyuki's father was known as a heavy drinker (*taishuka* 大酒家) and that the patient himself was fond of alcohol and was used to drink about 1.5 pints i.e. roughly 1 liter (*go gō* 五合) at a time.

7 In Araki's and Kure's case histories, these mediators were rarely named or even mentioned. Their involvement sometimes became apparent in the patient's fear of being arrested by the military police or when the patient record contained information about some offense or criminal behavior (absence without leave, desertion, theft, and others). The role of mediators, complainants, and family members in the process of hospitalization has been explored in Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961), 136–144. On the role of the family in the Japanese mental health system see Suzuki, "The State, Family, and the Insane in Japan, 1900–1945."

Akiyuki's case, none of these reported symptoms and anomalies had prompted the medical authorities in Manchuria to commission his transfer to a specialized hospital. It was only when he complained of diarrhea and abdominal pain (identified as colitis by Araki) on the 10th that he was immediately sent back to Japan along the established evacuation routes. After having passed Tieling, Liaoyang, and Dalian, he arrived in Hiroshima on Thursday, June 29, and was examined by Araki on the following Sunday, when he was on duty at the hospital. Araki's assessment proved rather short:

初診 七月二日、聯合作用抑制ノ状アリ、應答甚ダ不十分ナリ、

診断 鬱躁狂

経過 七月八日東京豫備病院二轉送セラル、⁸

Status praesens: July 2: Inhibition of associations, responds very poorly to questions.

Diagnosis: Melancholia.

Further Developments: Transferred to the Tokyo Reserve Hospital on July 8.

In his version of the anamnesis, Araki noted that Akiyuki had been depressed (*chinutsu* 沈鬱), inhibited (*yokusei* 抑制), and that he had hallucinated (*genkaku ari* 幻覺アリ) and talked to himself at night (*yakan dokugo wo nashi* 夜間獨語ヲナシ) when he was being examined in Manchuria. Unlike Kure, Araki did not mention the influence of alcohol as a possible cause for the hallucinations and self-talk, but Kure would later interpret them as *delirium* (*sengo* 譫語). When Araki examined the patient at Hiroshima, he seems to have focused on Akiyuki's verbal response and made his diagnosis based on his slow and unintelligible way of speaking, which to him suggested an inhibition of mental and physical processes. As for Kure, his observations were far more detailed:

病名 鬱憂状態

既往症 [...] 鐵嶺遼陽大連等ノ兵站病院ヲ經テ七月十日渋谷分院ニ收容セラル。

On the role of the police see Catharine Coleborne, "Passage to the Asylum: The Role of the Police in Committals of the Insane in Victoria, Australia, 1848–1900," in Porter and Wright, *The Confinement of the Insane*, 129–148. A more recent study is the article of Nellen and Suter who examined the role of the police and its informants—the innkeepers of the city of Basel—in the process of identifying, relaying, and processing cases of mental illness around 1900 (Nellen and Suter, "Unfälle, Vorfälle, Fälle").

⁸ Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 153. Araki's use of punctuation marks is often inconsistent. He used the Japanese *tōten* “、” both as a comma and as a full stop, but sometimes did not indicate the end of a sentence at all.

現在症 顔貌沈鬱状ヲ呈シ舌震顫アリ、痛覺少シク鈍麻シ、胸腹部ニ異常ナキモ心悸亢進アリ、胃部壓痛アリ下痢アリ粘液状ニシテ血液ヲ混ス、倦怠及ヒ食思不振ヲ告フ。沈鬱シ寡言ニシテ應答明瞭ナラス記憶不良ニシテ舉動不活潑ナリ。體格營養共ニ中等ナリ、顔貌沈鬱状ヲ呈シ舉動緩慢ナリ、頭蓋異常ヲ認メス、瞳孔左右同大ニシテ光線反應存シ、舌震顫アリ、腱反射亢進セリ。應答甚タ遲滯シテ簡單ナリ、時ニ答ヘサルコトアリ強テ問ヘハ流涕ス、病覺ナク、追想不良ナリ、寢臺上ニアルモ茫然トシ或ハ室隅ニ蟄伏シ、時々食事セス、之ヲ強テ勸ムルトキハ涕泣ス、明治三十八年八月十三日兵役免除退院ス。

Diagnosis: Depressed state [of manic-depressive insanity].

Anamnesis: [...] After having passed through the line of communication hospitals of Tieling, Liaoyang, and Dalian, the patient was admitted to the Shibuya branch-hospital on July 10.

Present symptoms: His facial expression indicates a depressed state. Tongue tremor as well as a minor reduction of the sense of pain is present. There are no anomalies in chest and abdomen except for cardiac palpitation. He has pressure pain in the gastric region and diarrhea with mucinous stool mixed with blood. Complains about fatigue and loss of appetite. The patient is depressed and silent, answering questions unassertively. His memory is impaired and his movements sluggish. Physical state and nutritional condition are average. His facial expression indicates a depressed state, the movements are slow. No abnormalities of the cranium detectable. Pupils are of equal size and pupillary reaction is present. Tongue tremor, tendon reflexes increased. He answers slowly and in simple words, sometimes not giving an answer at all. When pressed to talk, he cries. He has no insight into his condition and his memory has become corrupt. When he is in bed, he is absent-minded. Sometimes he holes up in a corner. Occasionally, he does not eat and when encouraged emphatically, he cries. On August 13, he was exempted from military service and discharged from hospital.

9 Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 101–102.

It is clear from this description that Kure tried to come to a conclusive diagnosis by excluding unlikely diagnoses and by conducting a series of medical tests. He auscultated Akiyuki's chest, palpated his stomach for pains in the abdomen, and had his stool tested. He examined his skull for signs of degeneration, tested his pupillary response to light, and checked his tongue and his tendon reflexes. Most of these physical examinations were aimed at excluding physical ailments and several serious neurological diseases or brain lesions.

Furthermore, he evaluated his facial expression and tested his memory and his verbal response. He observed the flow of his movements and his activities in the hospital, paying special attention to Akiyuki's sleep and appetite. The extent to which Kure tested Akiyuki for "negativistic" behavior, probing how he would react when pressured to talk or eat, is telling of the importance that he ascribed to this "symptom." Had Akiyuki given in to the pressure with a sudden movement or some unexpected remark, his actions could immediately have been interpreted as signs of "negativism," as in Satō's case (on page 162). However, since he reacted with tears and restraint, Akiyuki's passive behavior was read as a sign of inhibition instead. Whereas Satō averted his eyes when questioned and refused to eat when watched, Akiyuki apparently did not show such signs of opposition and reluctance.

Through his series of tests, Kure had ruled out "negativism" and with it the possibility of interpreting Akiyuki's condition as dementia praecox. Other signs, such as his depressed appearance, slow replies, and sluggish movements strengthened Kure's manic-depression interpretation. However, what turned Araki's melancholic patient into a manic-depressive patient in Kure's eyes was the combination of inhibition and disturbed affectivity with the absence of any behavior that he could interpret as catatonic. As Satō's and Akiyuki's cases exemplify, this chiefly concerned the patient's reaction to the medical examination and the medical setting in general. According to this logic, which still has some significance in present-day diagnostic practice, patients who cooperate or resign can be put in a different medical category from those who resist treatment.

The comparison of Satō's and Akiyuki's cases also shows that, in Kure's differentiation scheme between manic-depressive insanity and dementia praecox, "affective" symptoms were definitely less decisive than the presence or absence of "catatonic" signs, which indicated a dysfunction of the volitional impulse to Kure. In his general discussion of depressed and exalted states among the patients from the Russo-Japanese War, he noted that depressed states were not restricted to manic-depressive insanity. As for patients who exhibited alternate states of exaltation and depression, he even noted that most of them were suffering from dementia praecox, rather than manic-depressive insanity.¹⁰ This approach to affective disorders was also reflected in Kure's case histories: among the twenty-nine dementia praecox patients, only four were explicitly recorded as having flat affect (*kanjō*

¹⁰ Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 45.

donma 感情鈍麻), four were characterized as having changing moods (*kanjō henkansei* 感情變換性), and five others were referred to as depressed (*chinutsu shi* 沈鬱シ).¹¹

Other behavior patterns than “negativism” that were ascribed high diagnostic relevance in Kure’s scheme were those related to speech. In Satō’s case, disturbed speech was associated with disturbed thought, but Satō also showed other cognitive disorders (delusions) and exhibited behavior that Kure interpreted as a dysfunction of volition (negativism). It is therefore plausible that Kure’s catatonia diagnosis should have rested more upon these other symptoms and that the presence of incoherent speech had not been deemed to be equally decisive.

The relevance of speech for diagnostic judgment is more prominent in another case. On the same day that Satō was admitted to the Hiroshima hospital, another patient who had been reported to show incoherent speech was hospitalized in Tokyo. Hibara, like Akiyuki, was a transport soldier who had been stationed in Manchuria in the summer of 1905. He had been known as a quiet and diligent worker, but on August 4, he suddenly approached the platoon leader and proclaimed that no matter how hard they would punish him, he just could not observe public order and military discipline.¹² When he was asked why he should say this, he remained silent and did not answer. On another occasion, he had claimed that he was a hindrance on the road the Army was supposed to pass.¹³

Araki reported that Hibara had given unintelligible answers (*ōtō yōryō wo ezu* 應答要領ヲ得ズ), had been depressed (*chinutsu* 沈鬱), had refused to eat, and had had trouble sleeping in Manchuria. On the 6th, he had been admitted to the line of communication hospital at Fushun 撫順, and after passing through Liaoyang and Dalian, he had reached Hiroshima on August 17.¹⁴ By the time Hibara was examined by Araki on the 20th, his symptoms seemed to have improved:

初診 八月二十日、著シキ精神病徴ヲ認メス、

診断 沈鬱狂—現時ハ治セリ、[...]

経過 發狂後一ヶ月以内ニシテ治セリ—八月二十一日東京豫備
病院ニ轉送セラル、¹⁵

Status praesens: August 20: No prominent symptoms detectable.

Diagnosis: Melancholia—now already cured. [...]

11 In fourteen cases the mood was not mentioned. Also note that Kure’s report only provides twenty-nine case histories for his sixty-five dementia praecox patients.

12 This incident is described in Kure’s report, see Kure Shūzō, 101–102. In Araki’s version, the episode is not mentioned, but both Araki and Kure noted that Hibara suffered from a headache two days prior to the event and was depressed and taciturn afterwards (Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 153).

13 Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 101–102.

14 Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 156.

15 Araki Sōtarō, 156.

Further Developments: Recovered within a month after the illness broke out—transferred to Tokyo Reserve Hospital on August 21.

It becomes apparent from Araki's diagnosis and the outlook he noted under the rubric "further developments" that when Hibara was transferred to Tokyo on the day after the examination, Araki believed him no longer to be ill. However, based on the reported symptoms and quite possibly due to the automated conviction that no healthy soldiers were ever admitted into hospital care, he diagnosed Hibara's former condition as melancholia. Kure, on the other hand, went even further and not only re-diagnosed Hibara with manic-depressive illness but, in doing so, returned him to his original role as a sick man:

病名 鬱憂状態

既往症 [...] 遼陽、大連等ヲ経テ八月二十一日東京豫備病院ニ收容セラル。

現在症 體格榮養共ニ中等ナリ、憂愁ノ色面ニ露ハル、瞳孔散大シ舌ニ白苔アリ、脈搏頻數ニシテ百二十至ナリ、心悸亢進ノ他ニ胸部ニ異常ナシ、膝蓋腱反射亢進ス。倦怠頭痛ヲ告フ。

言語明瞭應答確實ナルモ感情沈鬱シ、恐怖心ヲ有シ、被害罪業妄想アリ、自分ハ罪惡ノ為メニ死刑ニ處セラルルトカ、他人カ自分ヲ咀フトカ、或ハ郷里ニ歸レハ村民ニ復仇ノ念アリテ己ニ危害ヲ加フルトカ、又ハ舊師（劍術）ノ娘ヲ娶リ離縁セルタメ怨マレ、其為メニ暗殺セラレントスルトカ又ハ父ハ區長ニシテ村民ニ嚙サレテ職務上ノ失策ヲナシ村ノ者カ訴訟ヲ起シ、為メニ家ニモ歸レス等ト語レリ。明治三十四年十月二十七日兵役免除退院セリ。¹⁶

Diagnosis: Depressed state [of manic-depressive illness].

Anamnesis: [...] After having passed through Liaoyang and Dalian, the patient was admitted to the Tokyo Reserve Hospital on August 21.

Present symptoms: Physical and nutritional state are average. Sadness is clearly shown on his face. The pupils are of equal size and the tongue is furred. He has a frequent pulse reaching 120 beats. Except for cardiac palpitation, there are no anomalies in chest and abdomen. He has increased tendon reflexes and complains about weariness and headache.

¹⁶ Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 102–103.

He speaks clearly and gives accurate answers, but his mood is depressed. He is anxious and has delusions of persecution and self-accusation:¹⁷ He says that he will be sentenced to death for some crime, or [he says that] others have cursed him. [He says that] should he return to his native village, the townspeople would surely harm him driven by thoughts of revenge, or they would treacherously murder him because they got angry when he got divorced from the daughter of his former teacher (a fencing master). Or else [he says that] his father, the mayor of the village, would commit some disciplinary offense at the instigation of the villagers and that thereupon a lawsuit would be raised against him, so that Hibara would not be able to return to his family. On October 27, 1901 [1905], he was exempted from military service and discharged from the hospital.

According to Kure's observations, Hibara neither recovered from melancholia nor ever suffered from it in the first place. But Kure also observed that there were no longer any anomalies in Hibara's way of talking. For Araki, for whom the presence of slowed speech (indicating inhibition) had played an important role in diagnosing melancholia, this change in the patient's condition had been crucial. Kure, on the other hand, based both his conviction that the patient was indeed mentally ill and his actual diagnosis on two completely separate symptoms. Thus, he explicitly noted Hibara's depressed look and paid great attention to his miscellaneous fears and worries, which in his observation he interpreted as delusions.

Furthermore, in Kure's opinion, the illness had already begun in 1901, because in that year Hibara had become extremely anxious and had started to develop delusions of self-accusation after a quarrel with a friend. This information is completely missing from Araki's report, and it is quite likely that Kure learned about it from Hibara himself during the latter's lengthy stay at the Tokyo hospital. Moreover, it is possible that what Kure identified as delusions after an observation of more than two months had not been readily observable in Hiroshima at all, where Hibara had only stayed for five days. It could also be the case that what Kure perceived as delusions, Araki merely interpreted as worries and fears.

17 In the German version of Kure's general discussion, both *bigai mōsō* 被害妄想 and *tsuiseki mōsō* 追跡妄想 are translated as "Beeinträchtigungswahn" (Kure Shūzō 呉秀三, "Über die im japanisch-russischen Krieg beobachteten Geistesstörungen" [On Mental Disorders Observed during the Russo-Japanese War], *Neurologia* 4 [1913]: 16, 26, 28), although the former literally means "delusions of harm" or "delusions of control" and the latter "delusions of persecution." Similarly, *higaiteki* 被害的 is sometimes translated as "persecutorisch" (persecutory) and sometimes as "beeinträchtigend" (impairing). It seems that Kure used these terms interchangeably. However, he clearly preferred *bigai mōsō* and seems to have referred to *tsuiseki mōsō* only as a subtype of the former. In English, I translate both terms as "delusions of persecution," as this is the more common expression in modern day usage as well as in contemporary English texts (as for example in Diefendorf, *Clinical Psychiatry*).

Be that as it may, for Kure, a previous occurrence of a depressed phase clearly fitted the conceptual profile of manic-depressive illness, which was characterized by its recurrent nature. This was the fundamental difference between Kraepelin's conception of manic-depressive insanity and dementia praecox. Whereas the former was characterized as recurrent (*periodisch*), the latter was seen as the expression of a debilitating process (*Verblödungsprozess*). This notion had already been introduced by Kraepelin at the Heidelberg Conference of 1896 (see section 1.1). Here, he had explicitly stated that there could never be a periodic catatonia.¹⁸ In any case, in Kure's diagnostic scheme, indications of a recurrent or periodic course of an affliction were more decisive for his diagnosis than the presence of affective disorders, which were to be found in many forms of mental illness.

6.2 Cognition: Foxes and Electricity

Another aspect that becomes clear from Hibara's case is that for Kure, the division of manic-depressive illness and dementia praecox did not rest upon the presence or absence of "cognitive disorders." Delusions were considered to be cognitive symptoms, and just like "affective disorders," they were not restricted to any particular mental illness. Among Kure's cases, forty-one patients had exhibited delusions, and he had divided them up into the following groups: twenty-six cases of dementia praecox, nine of *manic-depressive illness*, two of *general paresis*, two of *epileptic psychosis*, one of *hysterical psychosis*, and one of *psychosis after an infectious disease*.¹⁹ Considering the total number of cases for the two illnesses (sixty-five of dementia praecox, twenty-two of manic-depressive illness), it appears that about 40% of the patients in both groups suffered from delusions.

In Kure's collection of cases, the different kinds of delusions were not unswervingly linked to particular illnesses. Delusions of persecution, for instance, appeared both in patients diagnosed with dementia praecox and in patients diagnosed with manic-depressive illness. Likewise, delusions of self-accusation were equally common in both illnesses. These rather fluid mechanics become obvious in the following couple of cases that deal with patients who suffered from distinctly Japanese visitations, but were diagnosed with a whole range of different diseases by Kure and Araki. In fact, all four patients believed themselves to be harassed by foxes (*kitsune* 狐) or raccoon dogs (*tanuki* 狸), vicious creatures that have long been associated with mischief and manipulation in Japan.²⁰

18 Kraepelin, "Ziele und Wege der klinischen Psychiatrie," 843.

19 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 42.

20 There is a German monograph on the topic of fox-possession published shortly after the Russo-Japanese War: Erwin von Bälz, *Über Besessenheit und verwandte Zustände: Auf Grund eigener Beobachtungen* [On Possession and Similar States: Based on Personal Observations], Separatdruck aus der "Wiener Medizinischen Wochenschrift" Nr. 18 bis 22. 1907 (Wien: Moritz Perles, k. und k. Hof-Buchhandlung, 1907). The phenomenon of possession has already been studied extensively by Japanese historians and anthropologists. See for example the works of Kiyoshi Nozaki, *Kitsuné: Japan's Fox of Mystery, Romance & Humor*

On the one hand, Kure diagnosed the thirty-one-year-old soldier Chiba 千葉 with catatonia.²¹ He had tried to commit suicide because he believed he was possessed by a fox, and during his examination, he had insisted that since “it was a shameful thing for a soldier of the Japanese Army to be fooled by such creatures, he would rather kill himself.”²² On the other hand, Corporal Kibashi 木橋 was diagnosed with the depressed state of manic-depressive illness.²³ He suffered from the nagging worry that his tea might have been poisoned and also constantly sensed the presence of a dog or racoon dog.²⁴ However, he proved “unable to tell exactly which of the two creatures it was.”²⁵

There were also some cases that involved foxes among Araki’s patients. For instance, one patient was diagnosed with mania because he felt an anxiety that was caused by the belief that he had seen foxes passing in front of the army’s lodgings.²⁶ In his analysis, Araki had interpreted this as a sign of false perception (*mōkaku* 妄覺).²⁷ Another case involved a patient who had been suffering from typhus and had afterwards developed psychotic symptoms.²⁸ He was convinced that foxes and cats entered his belly through his feet at night and rose to his throat to choke him. Araki diagnosed this patient with hallucinatory insanity (*mōkakukyō* 妄覺狂) and referred to this particular type of delusion as “delusions of possession” (*hyōi mōkaku* 憑依妄想).²⁹

(Tōkyō: The Hokuseido Press, 1961); Okada Yasuo 岡田靖雄, “Kitsune tsuki kenkyūshi: Meiji jidai o chūshin ni” 狐憑き研究史：明治時代を中心に [History of Studies on Fox Possession: Focusing on the Meiji Period], *Nihon ishigaku zasshi* 29, no. 4 (1983): 368–391; Okada Yasuo 岡田靖雄, “Tsukimono no geshōron: Sono kōzō bunseki” 憑きものの現象論：その構造分析 [The Phenomenology of Possession Symptoms: An Analysis of Their Structure], *Nihon ishigaku zasshi* 44, nos. 1;3 (1998): 369–384; Shegeyuki Eguchi, “Between Folk Concepts of Illness and Psychiatric Diagnosis: Kitsune-tsuki (Fox Possession) in a Mountain Village of Western Japan,” *Culture, Medicine, and Psychiatry* 15, no. 4 (1991): 421–451; Hyōdō Akiko, *Seishinbyō no Nihon kindai* Watarai Yoshiichi, *Meiji no seishin isetsu* 95–153.

- 21 Case 16 (first-class soldier Chiba of the infantry corps of the reserve army, born July 1874) in Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 79–80.
- 22 “日本軍人力獣類ニ憑カルルカ如キハ耻辱ナリ寧口自殺スルニ如カス” (Kure Shūzō, 79–80).
- 23 Case 41 (corporal Kibashi [train conductor] of the corps of engineers, born January 1880) in Kure Shūzō, 104.
- 24 Kure Shūzō, 104.
- 25 “何レカ狸カ犬カ分カラス” (Kure Shūzō, 104). In a case of *epileptic psychosis*, it was not the patient, but the people in the neighbourhood (*kinrin* 近隣) who considered him to be possessed by a fox (*kit-sunetsukisha* 狐憑者) when the patient was 16 years old (Kure Shūzō, 112). This refers to case 48 in Kure Shūzō, 120–121, see footnote 76.
- 26 Case 56 (22-year-old infantry soldier) in Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 165–166.
- 27 Araki Sōtarō, 165–166.
- 28 Case 132 (28-year-old infantry soldier) in Araki Sōtarō, 191. There is a corresponding German version, see Fall 20 (28 jähriger Infanterist) in Araki Sōtarō 荒木蒼太郎, “Beobachtungen,” 635–636.
- 29 In the German version, *hyōi mōkaku* was translated as “Besessenheitswahn” (Araki Sōtarō 荒木蒼太郎, 636). Araki had had some previous experience with spirit-posessions when he investigated such cases in Tokushima prefecture (Araki Sōtarō 荒木蒼太郎, “Tokushima-ken no Inugami-tsuki oyobi Tanuki-tsuki ni tsukite” 徳島縣下ノ犬神憑及ヒ狸憑ニ就キテ [On Dog-Spirit Possession and Racoon-Dog

As opposed to the fairly common but rather unspecific fox sightings, patterns that were qualified as *systematized delusions* were rather rare. In fact, there was only one patient in Kure's report who exhibited pronounced delusions that focused on one particular theme over a longer period of time. Unlike the patients who attributed their conditions to mystical creatures from Japanese folklore, Sergeant Major Sutō 須藤 was haunted by a more modern phenomenon: electricity.³⁰ Indeed, his preoccupation with electricity was so prominent that both Araki and Kure saw it as a defining element of his condition.

Sutō had arrived in Manchuria on August 4, 1904. Due to overwork and poor hygienic conditions, he had become exhausted, and in the summer of 1905 he suffered from weariness, headache, nausea, heaviness in the head, and bad sleep. He had continued to work, but when his symptoms became worse at the beginning of July, he was finally examined and deemed unfit for duty.³¹ Hence, he was sent to the rear and passed through Hiroshima, where he was first examined by Araki:

Possession in Tokushima Prefecture], *Okayama igakkai zasshi* 12, no. 124 [1900]: 121–130; Araki Sōtarō 荒木蒼太郎, “Tokushima-ken no Inugami-tsuki oyobi Tanuki-tsuki ni tsukite” 徳島縣下ノ犬神憑及ヒ狸憑二就キテ, shōzen 承前 [On Dog-Spirit Possession and Raccoon-Dog Possession in Tokushima Prefecture (Continued)], *Okayama igakkai zasshi* 12, no. 125 [1900]: 24–37. In this study he drew on the theories of Max Dessoir (1867–1947) to account for symptoms of depersonalization and memory loss in some of the patients. Araki's explanation strategy was a rare attempt to include the patient's personal experience into the interpretation of the phenomenon: He assumed that these people experienced a splitting of the personality (*jinsei bunretsu* 人性分裂) as a result of some triggering exciting cause. He then explained the symptoms associated with possession by suggesting that the idea of spirit possession that was present in their subconscious (*ka-ishiki* 下意識) gained prominence when the subconscious part of the mind gained control (*shuken wo nigiri* 主權ヲ握リ). When the person returned to his former self, he or she had no memory of the incident (Araki Sōtarō, 37). Please note that although *bunretsu shō* 分裂症 is the present Japanese translation term for *schizophrenia*, this concept only emerged around 1907 and had a completely different meaning, originally referring to “a splitting of mental faculties.” Max Dessoir relied on the works of Pierre Janet (1859–1947), Wilhelm Wundt, William James (1842–1910), Hugo Münsterberg, and others (Max Dessoir, *Das Doppel-Ich* [The Double-Ego] [Leipzig: Ernst Günthers Verlag, 1896]), but did not mention Freud. Although Freud popularized the idea of the subconscious, he did neither invent it, nor was he the only scholar interested in hypnotism and the interpretation of dreams in the 19th century, see Henri F. Ellenberger, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* (New York: Basic Books, 1970); Andreas Mayer, *Mikroskopie der Psyche: Die Anfänge der Psychoanalyse im Hypnose-Labor* [Microscopy of the Psyche: The Beginnings of Psychoanalysis in the Hypnosis-Laboratory] (Göttingen: Wallstein, 2002). Araki's study is also mentioned in Susan Burns' article, but Araki is referred to as “Aragi” (Susan L. Burns, “Constructing the National Body: Public Health and the Nation in Nineteenth-Century Japan,” in *Nation Work: Asian Elites and National Identities*, ed. Timothy Brook and Andre Schmid [Ann Arbor: University of Michigan Press, 2000], 39).

30 Case 79 (32-year-old non-commissioned officer of the artillery) in Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 173–174. There is no corresponding German version. Kure's data on Sutō is to be found in case 29 (sergeant-major Sutō [government official] of the artillery corps, born January 1873) in Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 86.

31 Kure Shūzō, 86.

初診 七月二十三日、顔容憔悴、貧血、頭重、時々頭痛、時トシテハ全頭ニ電氣ヲ通ゼラル、ノ感覺ヲナスアリ —— 異常感覺 —— 不眠、夜間種々ノ聲ヲ聞ク、自ラ謂ヘラク、是レ聴覺ノ甚ダ過敏ナルニヨルト、精神不快ニシテ、食欲振ハズ、談話序次アリ、聯合抑制ヲナスコト著シカラズ、

診断 妄覺狂 [...]

経過 七月二十四日東京豫備病院ニ轉送セラル、³²

Status praesens: July 23. Gaunt face, anaemic, [complains about] a heaviness in the head, at times headaches. Sometimes he has a feeling as if electricity is conducted through his whole head—paraesthesia. He does not sleep and hears all sorts of voices at night. He himself thinks that it is because of this hypersensitivity of hearing that he has become mentally unstable. Loss of appetite. His speech is coherent, inhibition of associations not very prominent.

Diagnosis: Hallucinatory insanity [...]

Further Developments: Transferred to Tokyo Reserve Hospital on July 24.

Araki's observation did not mention delusions but interpreted Sutō's experiences as a case of false perception of which the patient was painfully aware. In the anamnesis, Araki had mentioned that Sutō seemed to have suffered from acoustic hallucinations (*genchō* 幻聴) since the medical examination in Manchuria.³³ This statement is followed by a question mark in Araki's text, indicating that the information available from Sutō's medical record was not conclusive in this regard. During the examination in Hiroshima, Araki seems to have attached some importance to Sutō's own assessment of his condition. That he interpreted Sutō's description of an electricity-like sensation as paraesthesia (a particular disturbance of skin sensation) shows that Araki was inclined to ascribe the condition to a physical cause. From this point of view, Sutō's fears and worries were secondary symptoms that resulted from the patient's demand to explain his experience. With the added observation that the patient's speech was coherent and his thought process little affected, his diagnosis of hallucinatory insanity seems convincing.

Hallucinatory insanity, also referred to as *Amentia* in the German version of Araki's article, was characterized as an illness that could lead to full recovery.³⁴ In the general remarks on his experience with this illness during the Russo-Japanese War, Araki noted

³² Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 174.

³³ Araki Sōtarō, 173.

³⁴ Araki Sōtarō, *Seishin byōri hyōshaku* 180.

that most cases of hallucinatory insanity tended to improve.³⁵ However, diametrically opposed to Araki's rather favorable prognosis, Kure identified signs of a beginning mental deterioration which put Sutō's case within the broader category of dementia praecox:

病名 妄想性癡呆 [...]

既往症 明治三十八年七月三十日東京豫備病院本病ニ転送セラル。

現在症 體格榮養中等度ナリ、胸腹臟器ニ異常ナク、脈搏九十至、體溫常、舌白苔アリ、手指震顫アリ膝反射亢進ス。頭痛眩暈胸内苦悶、不眠等ヲ告フ。

記憶普通幻覺アリ幻視トシテハ人或ハ蛇ヲ見、幻聽トシテハ已ヲ嘲弄スルカ如キ声ヲ聽キ重ニ女声ナリ、妄想ハ被害妄想及ヒ電氣妄想ニシテ何者カ自分ヲ罪ニ問ハントスルカ如ク思ヒ、又ハ電氣ヲ掛ケテ自分ヲ苦シムルモノアリト信ス。其所謂電氣ハ両耳ニ感スルコトアリ又ハ胸腔ニ感スルコトアリト云フ。之ニヨリテ舉動モ不安ニシテ又猥ニ人ヲ疑フカ如キ状アリ。

又嚙眉アリ、顔貌苦痛性ナリ。

明治三十八年八月十八日兵役免除ニヨリテ退院ス。³⁶

Diagnosis: Paranoid dementia [...]

Anamnesis: On July 30, 1905, the patient was transferred to the Tokyo Reserve Hospital.

Present symptoms: Physical and nutritional state are average. No anomalies in chest and abdomen. Pulse rate of 90 [beats per minute], body temperature normal, tongue furred, tremor of the hands, tendon reflexes increased. The patient complains about headache, nausea, precordial anxiety, and insomnia.

Memory is normal. He has hallucinations. Visual hallucinations encompass the seeing of people and snakes. Acoustic hallucinations consist of hearing voices that seem to scold the patient. These are female voices for the most part. The delusions are mainly delusions of persecution and delusions of electrical influence. He thought that someone would accuse him of a crime, that he was being tortured by electricity. He believed he sensed this so-called electricity in both ears and also in his chest. Because of this, his behavior became restless and he started accusing people without cause.

³⁵ Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 145.

³⁶ Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 86.

At times he knits his eyebrows and has a tormented expression.
On August 18, he was exempted from military service and discharged
from the hospital.

Apart from the symptoms noted by Araki, Kure observed that the patient grew suspicious of other people. Sutō had apparently expressed the fear that someone applied electricity to his ears and chest either experimentally (*shikenteki* 試験的) or out of mischief (*akugi no tame ni* 悪戯ノ為メニ). Kure identified this condition as “delusions of electrical influence” (*denki mōsō* 電気妄想).³⁷ Even though Araki did not observe delusions himself, his diagnosis of hallucinatory insanity would not have been affected by their presence. In the introductory part of his article, he remarked that, among patients with this diagnosis, many developed different kinds of delusions as a cause of hallucinations.³⁸ However, it seems likely that Araki’s and Kure’s understanding of what constituted a delusion was slightly different. As in the case of Hibara, whom Araki had considered sane when he left Hiroshima, Kure identified all worries and fears that Sutō uttered as direct evidence for delusions. All in all, his threshold for diagnosing this particular symptom seems to have been much lower than in Araki’s case. This difference merely had negative consequences for the prognosis of Sutō, whereas it meant the difference between sanity and insanity for Hibara.

However, as we have already seen, the presence of cognitive disorders alone was not a sufficient condition for the diagnosis of any one form of dementia praecox in Kure’s classification. He could simply have diagnosed Sutō with paranoia, which had been defined as a chronic form of insanity marked by a prominence of delusions but without leading to mental deficiency.³⁹ As with depressed forms of dementia praecox and manic-depressive

37 Kure Shūzō, 69. These details are mentioned in Kure’s general discussion of symptoms in *dementia praecox* patients. As there was only one patient with *paranoid dementia*, the whole section must necessarily refer to Sutō’s case. In the corresponding German section, the “delusions of electrical influence” are translated as “Wahnideen von elektrischer Verfolgung” (Kure Shūzō, “Über die im japanisch-russischen Krieg beobachteten Geistesstörungen,” 29).

As we have seen in most of the discussions so far, the idea that the body could be affected by invisible forces such as electricity was not restricted to Japan. European patients exhibited similar fears and in some textbooks, fear of electricity appeared as a subtype of “somatic delusions of transformation” next to fear of magnetism, hypnotism, X-rays or telepathy. See for example Kraepelin, *Klinische Psychiatrie*, 191; Diefendorf, *Clinical Psychiatry*, 40–41. Ishida follows Kraepelin’s categorization and lists “delusions of electrical influence” under *butsuriteki tsuisekimōsō* 物理的追跡妄想 (physikalischer Verfolgungswahn), see Ishida Noboru, *Shinsen seishinbyōgaku* 34–35. Weygandt regarded a categorization of delusions according to their content as unnecessary, as in his opinion the objects of fear were often arbitrary and a classification by type had no diagnostic value, see Weygandt, *Atlas und Grundriss der Psychiatrie*, 70.

38 Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 145.

39 Kure did not diagnose *paranoia* in the Russo-Japanese War, and in Ishida’s textbook it is described as a rather rare illness amounting to less than 1% of the hospital population (Ishida Noboru, *Shinsen seishinbyōgaku* 110). As has been noted earlier, all the statistic data in Ishida’s book actually refers to Kraepelin’s

insanity, the distinction between paranoid forms of dementia praecox and paranoia rested upon the presence of other symptoms than affective and cognitive disorders.

In the description of Sutō's condition, the knitting of eyebrows (*binbi* 顰眉) is one of the few indications that pointed to dementia praecox in Kure's interpretation of symptoms.⁴⁰ It was also mentioned by Araki in his version of the anamnesis, but had no diagnostic value for him.⁴¹ In Kure's discussion of symptoms, on the other hand, knitting of eyebrows was also often listed as indicative in catatonic patients.⁴² However, in most of these cases, this inconspicuous sign had been accompanied by some other catatonia-related symptoms that to Kure indicated a dysfunction of volition.

6.3 Volition: Sword Dances and Drill Movements

Two more of Kure's patients who showed the same symptom of eyebrow-knitting had been diagnosed with melancholia by Araki only to be re-diagnosed with catatonia a few days later. As in Satō's case, they had both tried to commit suicide before they were hospitalized and had thereby drawn the attention of psychiatrists. Ono 小野 was a young transport soldier with a weak constitution who was among the last to be mobilized for the war in Manchuria.⁴³ Two weeks after he had received his call, when his division was about to leave Hiroshima on August 1, 1905, he had fainted for no apparent reason. Since then, he had been reported to show abnormal behavior with suicidal propensity.⁴⁴ Miyako 宮古, an infantry soldier of the reserve army in his late thirties, had frightened his comrades-in-arms when he had surprisingly fired his rifle in the barracks in the middle of the night.⁴⁵

Heidelberg clinic. The exact same numbers for the occurrence of *paranoia* can therefore also be found in his textbook: Kraepelin, *Klinische Psychiatrie*, 443.

40 If one were to follow Kraepelin's textbook, several other aspects of Sutō's condition could have been considered in the differential diagnosis. By putting more emphasis on the fact that Sutō's illness seemed to have been the result of physical exhaustion, one might for example have argued for *amentia*, which was described as presenting similar symptoms. On the other hand, Sutō's unimpaired memory would then have seemed to support the *dementia praecox* interpretation (Kraepelin, 206–207). To rule out the diagnosis of *paranoia*, one might have argued that Kraepelin considered hallucinations to be more prominent in *dementia praecox* (Kraepelin, 211). If one had followed Ishida's textbook, where the section on differential diagnosis was based on Weygandt's *Atlas und Grundriss der Psychiatrie*, in which he stressed the importance of “characteristic signs of the disturbance of volition,” one would rather have diagnosed him with *dementia praecox* (Weygandt, *Atlas und Grundriss der Psychiatrie*, 433, 451).

41 Araki recorded that there were wrinkles between his eyebrows (*miken shūbeki wo shōji* 眉間皺襞ヲ生ジ), see Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 173.

42 Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 68.

43 Case 26 (auxiliary transport soldier Ono [peasant], born March 1884) in Kure Shūzō, 84–85. Kure mentioned at the beginning of the case history that Ono had been born with a weak constitution and he also noticed Ono's poor physical state when he examined him in Tokyo. For Araki's data on Ono, see case 39 (22-year-old transport soldier) in Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 160.

44 Araki Sōtarō, 160.

45 Case 17 (first-class soldier Miyako [fisher] of the infantry corps of the reserve army, born February 1868)

It seemed that he had attempted to shoot himself while lying in bed, and despite being continually watched thereafter, he had still repeatedly tried to kill himself. Only when he had started to eat grass and feces and tried to swallow his campaign medal (*jūgun kishō* 従軍徽章) was he eventually sent to the rear and admitted to the mental health section.

Both Ono and Miyako were first examined by Araki and diagnosed with melancholia. According to Araki's report, Ono had shown the symptom of depression (*chinutsu*) when he had been examined in Korea in August 1905, had avoided talking to other people, had given incorrect answers, and had been unable to sleep.⁴⁶ In Hiroshima, Araki first saw him on October 8. He noticed Ono's sad face (*ganyō taishū* 顔容帶愁) and inhibited movements (*undō yokusei* 運動抑制) and reported that he did not talk at all (*mugon* 無言). As Ono's division was garrisoned in the north of Japan, he was to be transferred to the Hirosaki Reserve Hospital and left Hiroshima on October 16.⁴⁷

Two days later, Ono passed through Tokyo, where he was examined by Kure before traveling further north. Kure did neither detect any signs of depression on Ono's face, nor did he comment on affectivity at all. Instead, he noted that his facial expression was indifferent (*ganbō fukansei* 顔貌不管性) and that his eyebrows were knitted (*hinbi*).⁴⁸ Ono was still uncommunicative and avoided other people's company, but his movements were no longer described as inhibited:

現在症 [...] 不潔ニシテ終日臥床ス。感情鈍麻シ、同一姿勢、奇
症アリテ舞踊ノ如キ真似ヲナシ、喇叭ノ譜ノ真似ヲナシ、
室外ニ突然駈ケ出シ、空笑シ、又拒絶症アリ。⁴⁹

Present symptoms: [...] The whole day he lies in bed dirty. His spirits are blunted. He shows stereotypy and mannerism, imitating a dance or the playing of a trumpet. Sometimes he suddenly storms out of the hospital room, laughs without motivation. Apart from this, there is also negativism.

in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 80. Apparently, the first shot had been a miss. This is mentioned in the German version of Araki's report: Fall 64 (38 jähriger Infanterist) in Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 656. The corresponding Japanese version is: Case 29 (38-year-old infantry soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 156–157. When people hurried to see what had happened, Miyako attempted firing a second shot, but was hindered and burned his left hand (Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 80).

46 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 160.

47 This hospital (*Hirosaki yōbi byōin* 弘前豫備病院) was receiving wounded soldiers of the 8th division of the Imperial Japanese Army (Nihon Sekijūjisha, *Meiji sanjūshichi-hachi nen seneki Nihon Sekijūjisha kyūgo hōkoku* 780).

48 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 85.

49 Kure Shūzō, 85.

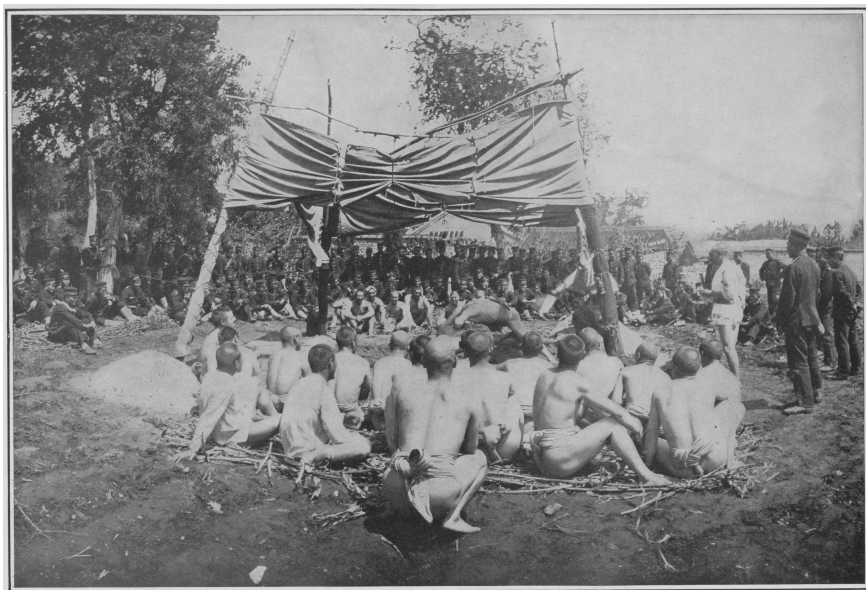


Figure 6.1: Sumo tournament, between battles

It seems that within only a few days, an exemplary melancholic patient who had shown both depression and motor retardation had been transformed into an exemplary catatonic patient with the characteristic “knitting of eyebrows,” “negativism” (probably referring to Ono’s refusal to speak), and two other signs related to volition and associated with catatonia, namely, “mannerism” (*genki shō* 衞奇症) and “stereotypy” (*dōitsu shisei* 同一姿勢).⁵⁰ These concepts had already become established terms in the psychiatrist’s vocabulary, and Kure rarely elaborated on the kind of movement his patients were exhibiting. For one, “mannerism” referred to ordinary movements (like greeting, eating, or walking) that were marked by an unnatural or exaggerated manner. “Stereotypy,” on the other hand, was defined as a series of repetitive movements not usually performed in everyday life. It could, for instance, be identified in the repetition of dance movements and trumpet-playing, as in Ono’s case, or in the imitation of battle or drill movements, or in the performance of sumo 角力 (i.e. Japanese wrestling) or sword-dance moves—a form of expression that we have already encountered in Mrs. Kurosawa’s story in chapter 3 (see section 3.2).

⁵⁰ Sometimes Kure also referred to “stereotypy” as *jōdō sei* 常同性 or *jōdō shisei* 常同姿勢. The former is the more general expression comprising both movement and speech, whereas the latter specifically refers to repetitive movement. In Ishida’s textbook, it is translated as *sassbutsushō* 刷出症 (Ishida Noboru, *Shinsen seishinbyōgaku* 44). In his textbook on the methods of clinical diagnosis, Kure uses *jōdō shō* 常同症 (Kure Shūzō, *Seishinbyō shinsatsuhō* 72).

However, this kind of behavior was not in all cases interpreted as catatonic. When facial expressions and body movements disagreed with each other, Kure usually diagnosed dementia praecox. In the case of infantry soldier Kobayashi 小林, his imitation of drill movements (*renpei no mane* 練兵ノ真似) was accompanied by an indifferent, blank face (*ganbō fukansei hyōjō ni tobashiku* 顔貌不管性表情ニ乏シク) and deemed indicative of catatonia.⁵¹ In the case of the transport soldiers Kawanabe 川鍋 and Uchida 内田, on the other hand, their artistic performances were seen as expressions of the manic state of manic-depressive insanity.⁵² As sumo was regularly seen by the soldiers in the Russo-Japanese War (see Figure 6.1), it is not surprising that Kawanabe was able to prove his familiarity with this sport when he displayed his skills in the Tokyo Reserve Hospital.⁵³ Apparently not an amateur of sumo, the sword-dancing Uchida was described as cheerful (*sōkai* 爽快), talkative (*tagen* 多言), singing marching songs, and yelling. Both Kawanabe and Uchida were described as having an astute look (*gankō ga surudoku* 眼光が鋭く), which meant that both their bodily expressions and their facial expressions were considered to be exalted. Since matching facial and bodily expressions were more likely to be seen as a sign of manic-depressive insanity, these two were categorized as manic by Kure.⁵⁴

Apart from the general uncertainty about the diagnostic value of the “symptoms” of mannerism and stereotypy, Ono’s diagnosis as a catatonic patient did not only rely on the presence of “stereotypy” and “flat affect” (a failure to express feelings). Other symptoms included unmotivated laughter, the refusal to talk or interact with other people, and the general impression that he seemed uninterested in his environment and current situation and spent most of his time in his hospital bed. A similar picture presented itself in the aforementioned case of Miyako, the soldier who had tried to shoot himself with his rifle. When Miyako was in Hiroshima on August 27, Araki found that he answered poorly (*ōtō fujūbun* 應答不充分), that his conduct lacked vigour (*taido fuyō* 態度不揚), and

51 Case 23 (second-class soldier Kobayashi [teacher] of the infantry corps of the conscript reserve, born May 1884) in Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 83.

52 For Kure’s data on Kawanabe see case 30 (transport soldier Kawanabe (peasant), born May 1882) in Kure Shūzō, 98.

For Araki’s data on Uchida see case 50 (22-year-old transport soldier) in Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 164. There is no German version. For Kure’s data on Uchida see case 32 (transport soldier Uchida [miner] of the transport unit, born May 1884) in Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 99.

53 Sumō was frequently practised in the evenings and “nearly every village in which troops were billeted possessed its wrestling ring” (Kuhn, “Report of Major Joseph E. Kuhn, Corps of Engineers,” 13). See also Macpherson, *The Russo-Japanese War*, 507. The image in Figure 6.1 showing the Sumō tournament can be found in Richard Harding Davis et al., eds., *The Russo-Japanese War: A Photographic and Descriptive Review of the Great Conflict in the Far East*, Gathered from the Reports, Records, Cable Despatches, Photographs, Etc., Etc., of Collier’s War Correspondents (New York: P. F. Collier & Son, 1905), 106.

54 Uchida had formerly been diagnosed with *mania* by Araki as well (Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 164).

that his movements were sluggish (*dōsa fukappatsu* 動作不活發).⁵⁵ He also noted that the suicidal propensity (*jisatsu kito* 自殺企圖) was still present and concluded that the patient was suffering from melancholia.⁵⁶

On September 1, Miyako left Hiroshima for Hirosaki and arrived in Tokyo on the 3rd.⁵⁷ Here, the patient's diagnosis was changed from melancholia to catatonia:

病名 緊張病 [...]

現在症 體格中等ニシテ心音不純心悸亢進アリ左ノ前膊ニ疼痛アリ、脊柱中部以下ニ壓痛アリ、兩下肢感覺鈍麻シ、膝蓋腱反射缺如ス。

顔貌不管性ニシテ顴眉アリ、常ニ小聲獨語ス、指南力記憶及ヒ判斷能力不良、觀念經過遲滯、感情鈍麻シ、常同性、強梗症、反響言語ノ痕跡等アリ。終日多クハ無為ニ就床スルモ時ニ裸體トナリテノ寢臺ノ下ニ臥スコトアリ。⁵⁸

Diagnosis: Catatonia [...]

Present symptoms: Physical and nutritional state average. Impure heart sounds and cardiac palpitation. He has pain in the left forearm and pressure pain below the middle section of the spine. Sensibility is suspended in the lower limbs, the tendon reflexes are missing.

His facial expression is indifferent and the eyebrows are knitted. All the time he talks to himself in a low voice. Orientation, memory, and judgment are impaired. The thought process is slowed, emotions blunted. He shows signs of stereotypy, catalepsy, and echolalia. The whole day, he lies in bed doing nothing [and] sometimes he lies under the bed with his clothes off.

Kure's description contains many of the typical catatonic symptoms. Apart from the ones already discussed earlier in this chapter, he also observed "catalepsy" and "echolalia."⁵⁹

⁵⁵ Araki usually translated *taido fuyō* 態度不揚 as "Bewegungshemmung" (inhibited movements) or "Körperbewegung träge" (sluggish movements) in his German version (Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 646, 656). A more literal translation would be "a general lack of vitality in a person's demeanour."

⁵⁶ Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 156.

⁵⁷ Araki Sōtarō, 157; Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 80.

⁵⁸ Kure Shūzō, 80.

⁵⁹ Although I do not intend to suggest a retrospective diagnosis of Miyako's case, I would like to point out that some of the symptoms in Kure's description could also have been regarded as indicative of *syphilis*: Almost 10 years before the described events, Miyako had developed an ulcer on his penis which healed after about ten days. In May 1905, he had an adenoma in the inguinal region and a rash on both thighs.

“Echolalia” (*hankyō gengo* 反響言語) referred to the patient’s “involuntary” imitation of someone else’s, e.g. the doctor’s, speech. Patients could and would actively be tested for this kind of symptom. In his textbook on diagnostic methods, Kure suggested that one should loudly enounce short words such as *ichi* 一 (one), *ni* 二 (two), *hi* 火 (fire), *mizu* 水 (water), *kaze* 風 (wind), *ame* 雨 (rain), *ten* 天 (sky), *tsuchi* 地 (earth) in front of the patient and observe if they would repeat them.⁶⁰ “Echopraxia,” a related symptom involving the imitation of movements, could be provoked by using a similar technique. Knitting eyebrows, sticking out one’s tongue, nodding or shaking one’s head, raising one’s arms, and like movements were to be performed in front of the patient in order to test them for echopraxia.⁶¹ These so-called “echo-symptoms” were considered typical of dementia praecox, and Kure invariably diagnosed patients who presented them either as catatonic or hebephrenic.

In early-twentieth-century medical literature, “catalepsy” could refer to anything from muscular tension to an extreme rigidity of the body.⁶² It could also refer to a phenomenon called *flexibilitas cerea* [waxy flexibility], where the limbs of the patient can easily be moved and remain in any position that they are placed in for a long time.⁶³ As Kure never gave any details regarding the particularities of this symptom, it is difficult to tell what he might actually have observed. In his case histories, “catalepsy” is mentioned in six cases, all of which were diagnosed with catatonia, so that it would seem that Kure regarded this symptom to be characteristic of catatonia.

Conversely, this was not the case in Araki’s diagnostic practice. In his report, he also gave examples of dementia praecox cases including catatonia, but his version of the illness was much more narrowly defined. As a result, he could merely identify eight such patients among his 211 cases. For Araki, dementia praecox was characterized by an advanced state of dementia (*shinkō seinshin suijaku* 進行精神衰弱), i.e. a profound mental enfeeblement,

Numbness in the lower extremities, lack of reflexes, impaired memory, and disorientation also point in the same direction. However, regardless of Miyako’s actual affliction, it is remarkable that both Araki and Kure selectively emphasized those and only those symptoms that supported their respective diagnosis.

60 Kure Shūzō, *Seishinbyō shinsatsuhō* 100.

61 Kure Shūzō, 99–100. In his lectures, Kraepelin furthermore recommended to raise or to clap one’s hands in front of the patient to see whether he would imitate the movement and thus show “echopraxia” (Kraepelin, *Einführung in die psychiatrische Klinik*, 26).

62 In the report, Kure uses both *kyōkō shō* 強梗症 and *kyōkō shō* 強硬症 as a translation for catalepsy (Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 68, 78). In other sources, the phonetic transliteration (*katarepushi* カタレプシー) is also common, see Kure Shūzō, *Seishinbyō shinsatsuhō* 91; Ishida Noboru, *Shinsen seishinbyōgaku* 42.

63 In Japanese, this term was literally translated as *rōkusshō* 蠟屈症 or *rōyō kukkyōku shō* 蠟様屈曲症. See Ishida Noboru, 42–43; Kure Shūzō, *Seishinbyō shinsatsuhō* 91; Araki Sōtarō, *Seishinbyōgaku sūki* 31.

whereas “catalepsy” played no decisive role.⁶⁴ In one case of catatonia, Araki described the symptom of *flexibilitas cerea* in sufficient detail to be recognizable:

上肢ヲ動スニ抵抗セズ、試ニ或位置ニ來シテ之ヲ放却スレバ、
暫ク其位ニ留リ、漸々舊位ニ復ス⁶⁵

When an arm is moved, there is no resistance. If one puts it in some position and leaves it as it is, it remains there for some time before it slowly returns back to its former position.

However, Araki’s diagnostic practice shows that he did not regard this symptom as an exclusive sign of dementia praecox. A case in point is that he also noted *flexibilitas cerea* (*rōkussbō* 蠟屈症) during the melancholic phase of a case of circular insanity (*kaikikyō* 回歸狂).⁶⁶ That unnamed patient had shown alternating phases of melancholia and mania, which lasted for several months in each case. For conceptual reasons, there could not have been any cases of circular insanity in Kure’s classification of mental disorders. A case like this might have been classified under manic-depressive insanity, but it seems that Kure generally gave more weight to catatonic symptoms when affective disorders were involved. This also becomes evident in the case of officer’s batman Nakatsuji 中辻, whom Araki had diagnosed as manic-melancholic, but whom Kure in turn re-diagnosed with dementia praecox.⁶⁷

Nakatsuji was said to have a nervous and cowardly disposition (*shisei shōshin ni shite* 資性小心ニシテ), but as the battalion commander’s batman, he still had to run back

64 Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 146. This does not mean that Araki recognized cases of mental deterioration with more certainty than Kure, but his criteria were much more strict. In the case of the transport soldier Kobayashi, Araki had made the tentative diagnosis of *dementia paralytica* (*mabikyō* 麻痺狂) with such typical symptoms as disturbance of speech, staggering gait, tremor of the hands, and severe impairment of memory and judgment. Apparently, the patient was not able to perform the simplest calculations (Araki Sōtarō, 214). In Araki’s diagnostic scheme, not being able to calculate indicated an impairment of judgment and therefore Kobayashi’s case fitted the criteria for *dementia* (for Araki’s definition of *dementia* see section 4.1). However, after Kobayashi had been transferred to Tokyo, most of his symptoms receded and left him with nothing but a slight headache (Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 137). Therefore, Kure speculated that Kobayashi had probably suffered from psychotic symptoms after an infectious disease (*netsubyōsei seishinbyō* 熱病性精神病).

65 Case 182 (21-year-old infantry soldier) in Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 210. Although no differentiation between different kinds of *dementia praecox* is made in the Japanese version, this case is specified as *catatonia* in the German text, see Fall 88 (21 jähriger Infanterist) in Araki Sōtarō 荒木蒼太郎, “Beobachtungen,” 667.

66 Case 75 (23-year-old infantry soldier) in Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 172. In the German version, the Latin expression is used, see Fall 74 (23 jähriger Infanterist) in Araki Sōtarō 荒木蒼太郎, “Beobachtungen,” 660.

67 For Araki’s data on Nakatsuji see case 74 (27-year-old officer’s batman) in Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 171–172, and Fall 9 (27 jähriger Pferdeknacht) in Araki Sōtarō 荒木蒼太郎, “Beobachtungen,” 631. For Kure’s data see case 12 (officer’s batman Nakatsuji [telegraph construction

and forth to his master under heavy gunfire (*dangan uchū* 彈丸雨注, literally “hail of bullets”).⁶⁸ He was terrified by this experience (*kyōgaku* 驚愕) and continuously suffered from anxiety attacks (*shintsū* 心痛).⁶⁹ During a melee, he once lost his master’s saddle and had been blaming himself ever since. At about that time, his colleague, who had been in charge of the battalion commander’s auxiliary horse, was substituted by a mere transport soldier for heavy loads. Nakatsuji felt inferior to this worker and thought that the others regarded him with contempt (*ta yori besshi seraruru* 他ヨリ蔑視セラレル).⁷⁰ He became depressed and had suicidal thoughts. On the night of May 9, he left the barracks and was completely covered in mud (*zenshin deido ni mamirete kaereri* 全身泥土ニ塗レテ歸レリ) upon his return.⁷¹ It was assumed that he had tried to drown himself in a puddle.⁷² Consequently, Nakatsuji was sent to the rear and admitted to the Hiroshima Reserve Hospital on May 22. Upon admission, he showed a depressed face (*ganmen chinutsu wo shimeshi* 顔面沈鬱ヲ示シ), gave unclear answers, and complained about headaches. He was generally depressed but would sometimes start to sing or perform a sword-dance.⁷³ When Araki examined him, he observed:

初診 五月二十八日、態度少シク尊大ニシテ、運動亢奮示シ、放歌、吟詩、劍舞ヲナス、多辯ナラス、時々沈思スルコトアリ、

診断 鬱躁狂

誘因 過勞

経過 五月三十日東京豫備病院ニ轉送セラル、⁷⁴

Status praesens: May 28. Somewhat haughty, exalted. He is singing, reciting, and sword-dancing. He is talkative, but sometimes he just sits in silent thought.

Diagnosis: Manic-melancholia

Exciting cause: Exhaustion.

worker], born 1879) in Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 76–77.

As a *basotsu* 馬卒 (German: Offizierspferdeknecht), Nakatsuji was in charge of the officer’s main horse, but was also acting as a “runner.” Nakatsuji was a civilian formerly employed as a telegraph construction worker.

68 Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 171–172.

69 Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 77.

70 Kure Shūzō, 77.

71 Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 172.

72 Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 77.

73 Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 172.

74 Araki Sōtarō, 172.

Further Development: Transferred to the Tokyo Reserve Hospital on May 30.

Although Araki identified Nakatsuji's condition as manic-depressive insanity (*Manisch-depressives Irresein*) in the German version of his article,⁷⁵ I would like to propose translating the German term as manic melancholia (*utsusōkyō* 鬱躁狂), since it becomes clear from his report that this illness was conceptually different from Kure's manic-depressive illness (*sōutsubyō* 躁鬱病). In his description of the illness in the general introduction of the Japanese text, he writes the following:

躁鬱狂 鬱躁狂 沈鬱狂ノ經過中ニ、數時間至數日ニ彌リテ、躁狂證候タル發揚、亢奮ヲ斜挿シ、又躁狂經過中ニ、數時間至數日ニ彌リテ、沈鬱狂證候タル沈鬱、昏迷ヲ斜挿シ、兩狂疾證候ノ相錯綜シテ經過スルアリ、之ヲ躁鬱狂若クハ鬱躁狂ト云フ —— 第七十二ヨリ第七十四ニ至ル三例⁷⁶

Manic melancholia—Melancholic mania When there are any symptoms of manic exaltation or agitation for [at least] several hours up to a maximum of a few days in the course of *melancholia*; or when there are any symptoms of melancholic depression or stupor for [at least] several hours up to a maximum of a few days in the course of *mania*; or when the symptoms of both conditions are interwoven in the course of the illness, this is referred to as *manic melancholia* and *melancholic mania*—3 cases, numbers 72–74.

This conception of the illness is consistent with the definition that Araki provided in his textbook, discussed in chapter 4. Judging from that description, it would certainly seem that the definition theoretically comprised the manic, depressed, and mixed states of Kure's manic-depressive illness, but this turns out to be misleading in practice. This is evidenced in Kure's assessment of Nakatsuji's case:

病名 破瓜病 [...]

現在症 體格榮養共ニ佳良、眼光鋭く、独語シ沈思默考シ、幻覺妄想アリ自殺念慮ヲ抱ク。⁷⁷

Diagnosis: Hebephrenia [...]

Present state: The patient is in a good physical and nutritional state. He has an astute look, talks to himself, and is lost in deep thought. He has hallucinations and delusions and harbors suicidal thoughts.

⁷⁵ Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 631.

⁷⁶ Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 144.

⁷⁷ Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 76–77.

This short assessment of Nakatsuji's condition makes it difficult to estimate how Kure came to his diagnosis of dementia praecox.⁷⁸ It could be that the hallucinations, whose presence and content are not further explained, led Kure to classify the patient as hebephrenic. But it could also be that the contradiction between his relatively cheerful state of mind on the one hand and his suicidal inclinations on the other were seen as the main indicator of dementia praecox. Be that as it may, the case clearly shows that the relationship between what constituted melancholia, manic-depressive insanity, and dementia praecox was a much more complicated matter in practice than it might appear superficially.

The comparison between Araki's and Kure's diagnostic methods has shown that the introduction of new diagnostic criteria destroyed the integrity of the earlier melancholia concept. It also became clear that the relationship between melancholia and dementia praecox can best be described by examining the signs that allegedly belonged to the mental sphere of volition. The newly introduced signs of negativism, echo-symptoms, catalepsy, knitted eyebrows, stereotypy, and mannerisms that presumably allowed the recognition of dementia at an early stage were conceptualized as revealing a dysfunction in the sphere of volition. Being a proponent of the associationist theory, Araki did not recognize the existence of a faculty of volition, nor did he pay much attention to this group of "symptoms." For him, most of these signs, which assumed the status of objectively observable symptoms in Kure's diagnostic practice, had no diagnostic relevance.

Another major difference between Kure's and Araki's diagnostic practice was that they disagreed in their assessment of well-established symptoms such as delusions and hallucinations. Kure's threshold for identifying delusions was much lower than Araki's, which affected not only their choice of diagnosis but also their perception of sanity. Apart from this, Araki's evaluation of delusions mainly comprised a distinction between self-centered ideas and outwardly-directed ideas, which was important for his differentiation of mania and melancholia. Kure's treatment of delusions, on the other hand, also involved a judgment on the patient's rationality, as he distinguished between rational and irrational, or silly, delusions. This short comparison also reveals in which areas the conceptual shift did not occur. It shows that symptoms perceived as belonging to the sphere of affect or cognition neither played a role in the disintegration of the melancholia concept, nor were they crucial in distinguishing between manic-depressive insanity and dementia praecox.

Generally speaking, Kure's definition of manic-depressive insanity rested upon the absence of those signs that indicated a dysfunction of volition. But as these signs were very common, he had a tendency to identify more cases of dementia praecox than manic-depressive insanity. This is not only expressed in his statistical results for the mental health patients in the Russo-Japanese War but also in his statistical reports for Sugamo Mental

⁷⁸ Hebephrenia was considered a sub-form of dementia praecox.

Hospital. During the Russo-Japanese War, he diagnosed 49% of his patients with dementia praecox and 16% with manic-depressive insanity. The difference was all the more telling because the patient population that he examined during the war was exceptionally homogeneous. As a matter of fact, all of his patients were male, most were between the ages of twenty and twenty-four, and many had been peasants in their civil lives.⁷⁹

Although Kure was an outspoken partisan of Kraepelin's "psychiatric revolution," it is pointless to evaluate his diagnostic methods against Kraepelin's original text. The disease descriptions presented in Kraepelin's textbook are in many ways ambiguous and have been interpreted in different ways by different people. Without guidelines for how to weigh the different symptoms, there was ample room for dissent even among psychiatrists who tried to follow Kraepelin's classification method. However, even though Kure's diagnostic practice was certainly not representative of all adherents of Kraepelin's new diagnostic scheme, it does show some tendencies that indicate changes in observation and in rationalizing symptoms in different ways. In Kure's approach there is a strong tendency to psychologize the patient's reaction to the medical environment. There is also an inclination to evaluate degrees of rationality and to distinguish between "silly" delusions in dementia praecox and "understandable" delusions in manic-depressive insanity.⁸⁰ But the most significant changes occurred in the formation and naturalization of symptoms that allegedly showed a dysfunction in the volitional sphere. It was the invention and elaboration of these new symptoms that laid the foundation for the disintegration of the concept of melancholia.

The experience of the Russo-Japanese War had further spurred debates on the etiology of mental disorders. With the healthiest and fittest men of the country suddenly experiencing mental states which medical textbooks defined as hereditary illness, debates on the relationship between war and mental illness were bound to emerge. Although Araki and Kure could not agree on one diagnosis in the case of Nakatsuji, they both believed that his condition had been triggered by mental and physical exhaustion (*karō* 過勞). The social and discursive context of these etiological debates will be the subject of the next chapter.

79 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 22, 26.

80 Many of these developments had a lasting effect on the diagnostic practice of later generations of psychiatrists. For example in the Diagnostic and Statistical Manual of Mental Disorders the differentiation between bizarre and non-bizarre delusions was only abandoned 2013 (American Psychiatric Association, ed., *Highlights of Changes from DSM-IV-TR to DSM-5*, leaflet, 2013, 3).

7 Etiological Debates & the Question of Responsibility

The relationship between war and mental illness has invariably fascinated the psychiatrists and military doctors who have participated in the great military conflicts of the nineteenth and twentieth centuries.¹ The Russo-Japanese War was no exception, and most authors who shared their experiences of mental illness in the army also expressed their views on the etiology of these conditions. As the discussions on etiology were often linked to the disease concepts themselves, it is necessary to examine them together as two complementary aspects. The etiological assumptions behind the concept of melancholia differed from those surrounding dementia praecox. A reclassification of patients (as examined in the previous chapters) therefore changed the framework within which the possible causes of their conditions could be discussed.

Although the etiologies of mental disorders were specified in medical textbooks, the experience of the war had given rise to reconsiderations and required a war-specific contextualization. It also spurred discussions on certain war-specific questions, such as: were soldiers more prone to mental illness than civilians? Were there more cases of mental illness during the war than in peacetime? Which forms of mental illness were the most common in the military? Did the war produce any war-specific forms of insanity? Would healthy people also become ill or only those with a weak constitution or defective heredity? These questions were not only addressed by civilian psychiatrists (Kure and Araki) but were also of vital importance to the military authorities because they were linked to the issue of disability pensions.

In this chapter, I will investigate how these etiology-related questions were answered by Japanese physicians engaged in the evaluation of mentally ill patients. In examining the different strategies of argumentation, I will also consider the frameworks within which etiological questions were addressed and discussed. This concerns the intertextual context as well as the contemporary distinction between *exciting causes* and *original causes*, sometimes also referred to as “proximate causes” and “distal causes” (or “ultimate causes”). Furthermore, I will examine the relationship between disease concepts and the discussions on etiology. Finally, I will show that the different positions concerning the impact of the war on mental illness were not only conditioned by the different institutional and

¹ Micale and Lerner, *Traumatic Pasts*; Blazer, *The Age of Melancholy*, 117–133.

academic backgrounds of the physicians involved, but also by their degree of affinity with the military authorities.

The principal source for my analysis is the Japanese Ministry of War's official report on neuropsychiatric casualties during the war with Russia.² This text consists of a general introduction followed by two individual articles. The introduction contextualizes the Japanese Army's experience with mental illness by comparing it with the statistics from the Franco-Prussian War (1870–1871), the Second Boer War (1899–1902), the Philippine–American War (1899–1902), and the Russian statistics.³ It then presents the main findings of three Japanese physicians who were engaged in diagnosing mentally ill soldiers in the Russo-Japanese War and shows the morbidity for various mental disorders identified by the civilian doctors Araki and Kure as well as by Surgeon Major Hanabusa Ken'ya 英健也 (dates unknown).⁴ Hanabusa was charged with the task of determining the disability pension of the mental health patients among the veterans of the Russo-Japanese War. His original study had been published elsewhere, but the articles of Araki and Kure (introduced in chapter 5 and chapter 6) were part of the Ministry's report.⁵

Although the report was published by the Ministry of War, the three main contributors—Araki, Kure, and Hanabusa—were neither equally involved with military administration, nor did they all share the same theoretical background. As a military doctor, Hanabusa was part of the military system. He had been educated at a military school and owed his position and salary to the Japanese Army. Although it seems that Hanabusa

2 Rikugunshō, *Meiji sanjūshichi-hachinen sen'eki rikugun eiseishi*.

3 Rikugunshō, 1–2. The numbers for the statistical comparison were most likely taken from the comparative study of Ewald Stier, see below (Ewald Stier, “Neuere psychiatrische Arbeiten und Tatsachen aus den außerdeutschen Heeren” [Recent Psychiatric Studies and Facts from Non-German Armies], *Deutsche militärärztliche Zeitschrift* 36, no. 13 [1907]: 556–557).

4 Rikugunshō, *Meiji sanjūshichi-hachinen sen'eki rikugun eiseishi* 6; Hanabusa Kenya, “Guntai ni okeru seishinbyō narabi ni sono onkyū shindan ni tsuite.” Although the source material on Hanabusa is poor, it is clear that he made an excellent career in the medical department of the Japanese Army. During the Russo-Japanese War, Hanabusa was stationed in the Imperial Headquarters as Surgeon Captain (*ittō gun'i* 一等軍醫), see Daihon'ei 大本營, ed., *Sen'ekikan ichiji (oyoso gokagetsu ijō) daibonei ni hōshoku seshi mono* 戦役間一時（凡そ5月以上）大本營に奉職せし者 [[List of] Persons Who Temporarily (More than ca. 5 Months) Served in the Imperial Headquarters at the Time of War] (1905), accessed November 6, 2016, JACAR: Co6041273400, <https://www.jacar.archives.go.jp>. When his article on pensions was published in 1911, he already was Surgeon Major (*santo gun'i sei* 三等軍醫正) and he was later promoted to Lieutenant Colonel (*nito gun'i sei* 二等軍醫正) when he was serving as director of the military hospital in Nagoya, see “Jonin oyobi jirei” 紋任及辭令 [Appointments and Dismissals], *Kanpo* (Tōkyō), April 10, 1918, no. 1703, 1216. In 1922, he held the rank of Surgeon Colonel (*ittō gun'i sei* 一等軍醫正). He was stationed in Taiwan, where he conducted studies in tropical diseases, see his preface in *Taiwangun gun'ibu* 臺灣軍軍醫部, ed., *Nettaieisei narabi ni nettaihyō teiyō* 熱帶衛生並に熱帯病提要 [Manual on Tropical Hygiene and Tropical Diseases] (s. l.: Taiwangun gun'ibu 臺灣軍軍醫部, 1922).

5 Hanabusa first presented his results at the third joined conference of Japanese Medical Societies in 1911, see Hanabusa Kenya, “Guntai ni okeru seishinbyō narabi ni sono onkyū shindan ni tsuite.”

did not specialize in psychiatry, he was obviously deemed sufficiently qualified to determine the disability pension of mentally ill soldiers.⁶ His preference for diagnosing manic-depressive insanity and dementia praecox, but not melancholia, indicate that he was using the Kraepelinian classification system of mental disorders. In this regard, he was on the same theoretical grounds as Kure, whom the military authorities also officially considered to be a follower of the Kraepelin school (*Kureperin gakuha* クレペリン學派).⁷

But just as Araki and Kure differed in their views on psychiatry, so too did they differ in their involvement with the military authorities. On the one hand, Kure's report on mental illness in the army had been compiled at the direct request of the Ministry of War. Since he was professor of psychiatry at the state-sponsored Tokyo University, the Ministry naturally regarded him as the official authority on psychiatry in Japan. Thus, Kure was compelled both to comply with the Ministry's demands and to uphold his reputation as a specialist in psychiatry in the academic world. Araki, on the other hand, was free from any direct obligation to the Japanese Army. In fact, his article had already been published in a local medical journal several years before it was reprinted in the Ministry's report.⁸

7.1 Araki Sōtarō: The Strains of War

Among the three physicians whose work was considered in the Ministry's report, Araki was the one who argued most explicitly for the role of the war in the etiology of mental disorders. He assumed that even in times of peace, soldiers were more likely to become mentally ill than civilians, implying that it was an occupational hazard of military service.⁹

6 In the introduction to the medical examination of a deserter in a military court case, Hanabusa justified his involvement with psychiatry as a non-specialist. He argued that with the rise of mental health casualties in the army the task to investigate such cases could no longer be left to the experts alone (Hanabusa Kenya 英健也, "Tōbōzai wo okaseru taihei no sōhatsu chikyō kanja kantei no ichi rei" 逃亡罪ヲ犯セル隊兵ノ早發癡狂患者鑑定ノ一例 [Medical Examination of a Deserter Diagnosed with Dementia Praecox], *Gun'i gakkai zasshi*, no. 175 [1909]: 1061).

7 Kure's affiliation with this school was explicitly stated in the introduction of the Ministry of War's report (Rikugunshō, *Meiji sanjūshichi-hachinen sen'eki rikugun eiseishi* 6).

8 In the introduction to the report, Araki's position as a "non-Kraepelianer" is acknowledged. However, the author of the introduction justified the inclusion of his article with the fact that it provided many detailed descriptions of cases of mental illness that had followed other diseases such as *kakke*, meningitis, and pneumonia (Rikugunshō, 6). It is very likely that Hanabusa was the actual author of the introduction to the Ministry of War's report on mental illness. Indeed, although no author is indicated, there are many similarities between the introduction and Hanabusa's article on disability pensions. Additionally, the report on mental illness appeared as a part of the volume on infectious diseases (*densenbyō* 傳染病) for which Hanabusa was a specialist. See his contributions on this subject in Hanabusa Kenya 英健也, comment following Kasawara Mitsuoki's talk on Pleurisy, *Nihon neike gakkai kaishi* 日本内科学会会誌 3 (1907): 20; Hanabusa Kenya 英健也, "Guntai ni okeru kyōmakuen no gen'in" 軍隊ニ於ケル胸膜炎ノ原因 [The Causes of Pleurisy in the Army], *Dai nikai Nihon rengō igakkai kaishi*, 1907, 489–497.

9 Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 624. This view is also reflected in Araki's textbook on

According to Araki, army life (*heiei seikatsu* 兵營生活) did not only trigger mental illness in individuals with a hereditary predisposition (*iden soin* 遺傳素因), but the harshness of military discipline could also be the primary cause of mental disorders.¹⁰ Araki even hypothesized that the war itself created a disposition for mental illness and suggested that even soldiers who did not experience any psychotic symptoms on the battlefield might still become ill many years after returning from the front.¹¹

These convictions were certainly the result of Araki's personal experience with mental health patients in the reserve hospitals of Hiroshima and Himeji. Among his 211 cases, he had found only twenty-seven patients with a hereditary predisposition to mental illness.¹² These findings must have reinforced his impression that the war caused healthy people to become ill. Thus, summarizing his experience in military hospitals in 1905, Araki stressed the great role of the war:

Selbst wenn man in einer Reihe von Fällen erkennen kann, daß die Störung schon früher ausgebrochen oder wenigstens durch starke Belastung, Infektionskrankheiten und andere Momente vorbereitet war, kann man die große *ätiologische* Bedeutung des Krieges auf den Ausbruch von Psychosen und Neurosen der verschiedensten Art nicht verkennen.¹³

Even if in a couple of cases it became clear that the actual illness broke out earlier or was facilitated through a strong hereditary disposition, infectious diseases, or other etiological factors, one cannot fail to recognize the great *etiological* significance of the war for the emergence of various kinds of psychoses and neuroses.

Araki's general conviction that the war was responsible for mental illness remained unchanged in all of his publications and public talks, but some variations in how he presented his views can be identified. He first articulated his ideas in a talk at the fourth conference of the Japanese Society for Neurology in April 1905 (see section 4.1). On this occasion, he stated that the war mainly caused disorders such as *clouded consciousness*, *hallucinatory insanity* (including *traumatic delirium*), severe *neurasthenia*, *hysteria*, and *stupor*. However, when he presented his findings again at the second joint conference of the Japanese Medical Societies in April 1906, he primarily stressed the etiological impact of the war for melancholia and *dementia paralytica*, noting that, on the other hand, the direct influence of the war was less important for *mania* and *paranoia*, where heredity played a

psychiatry where he discussed the influence of the war on mental illness in the section titled "Occupation and Lifestyle" (*shokugyō seikatsubō* 職業 生活法 [sic!]) of his etiology chapter, see Araki Sōtarō, *Seishin byōri hyōshaku* 106–108.

10 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 137.

11 Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 625.

12 Araki Sōtarō 荒木蒼太郎, 650.

13 Araki Sōtarō 荒木蒼太郎, 667–668. Araki's emphasis.

greater role.¹⁴ A few months later, his article on mental illness in the war was published in the *Okayama Medical Journal*. In the introduction, he now asserted that the illnesses caused by the war were *neurasthenia*, *melancholia*, *mania*, *hallucinatory insanity* (*traumatic delirium*), *dementia paralytica*, and *hysteria*, and these should be referred to as war psychoses (*gunjinkyō* 軍陣狂).¹⁵

Some of these variations can be explained when the war is seen as both a direct and an indirect cause. Unfortunately, Araki did not always explicitly differentiate these two aspects in his texts. In his earliest writings, the case histories and the talk in 1905, he mostly employed the term “exciting causes” (*yūin* 誘因) when referring to the risks that could lead to mental illness (physical and mental exhaustion, infectious diseases, alcohol, or injuries of the head). In his later publications, such as the 1906 article and the textbook, he replaced this expression with the term “(original) causes” (*gen'in* 原因). This change may indicate that Araki had come to believe that the war was not merely triggering but actually causing mental illness by 1906. However, his use of these terms was very inconsistent. Although the most common expression in the case histories was *yūin*, which is rendered as *Veranlassende Ursache* [exciting cause] in the German version, Araki also used the term *gen'in* [original cause] as an equivalent expression in some case histories.

Araki was most explicit about causation when he talked about the impact of the war at the conference in 1906. Here, he differentiated between two different kinds of mental disorder that were to be encountered in wartime. One group consisted of disorders that were directly caused by the war (*seneki o motte chokusetsu no gen'in* 戦役ヲ以テ直接ノ原因).¹⁶ The other group contained disorders that were only indirectly caused by the war because they mainly became manifest due to a hereditary predisposition. This distinction testifies to the fact that Araki did, indeed, make a difference between *direct* and *indirect causation* and believed that the war took effect both as a catalyzing moment and as an ultimate cause. The distinctive feature for this division was the presence of predisposition, which was not a basic property of all mental disorders, according to Araki.

Apart from his personal experience during the war, Araki also relied on existing literature on war psychoses that may have influenced his views on etiology. In the printed version of his 1905 talk that was published in the *Shinkeigaku zasshi*, some references to German-language literature had been appended.¹⁷ These texts were not mentioned in

14 Araki Sōtarō 荒木蒼太郎, “Seneki ni insuru seishinbyō ni tsukite” 戦役ニ因スル精神病ニ就キテ [On Psychoses Caused by the War], *Dai nikai Nihon rengō igakkai kaishi*, 1907, 208–210. Araki’s talk was presented in the section of psychiatry and neurology of the 2nd Japanese Congress of Medicine. This meeting coincided with the 5th conference of the *Japanese Society for Neurology* that usually took place at this time of the year.

15 Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 138. The introductory part of the article was also included in the section on etiology of his textbook on psychiatry (Araki Sōtarō, *Seishin byōri hyōshaku* 107–108).

16 Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 210.

17 Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite.”

Araki's Japanese article, but he referred to them again in his German article. Among these references was an article on war psychoses by Robert Sommer and the official report of the German Ministry of War for the war with France in 1870–71.¹⁸ The German Ministry's report contained a whole volume on neuropsychiatric casualties that documented the experience of German and French physicians with mental illness in the Franco-Prussian War. Apart from providing 100 case histories, this volume also featured discussions on etiology. Evidence for a direct appropriation of the ideas presented in the Ministry's report can be found in the German version of Araki's article that was published in 1907. However, it is safe to assume that Araki had already considered these etiological discussions when he addressed his Japanese audience in 1905–06. Indeed, the position he took on the subject of war-related mental illness in these years seems to have been considerably influenced by this German publication.

After arriving in Giessen in 1907, Araki completely restructured his article on mental illness in the Russo-Japanese War for his German-speaking audience.¹⁹ In the Japanese version, his article consisted of two parts. The first eleven pages can be described as the analytical part that consisted of a short introduction, an overview of the main etiological factors (mental and physical exhaustion, infectious diseases, alcohol intoxication, and head injuries), some statistical data, and short descriptions of the characteristics of the various forms of illness that Araki had encountered in the war. The remaining sixty-nine pages were filled with 200 case histories that were arranged according to disease forms.

In the German version, this bipartite structure was abandoned, and the case histories were integrated into the analytical discussion. With these structural changes, the focus of Araki's article shifted towards a discussion of etiology that supported his argument that the war had played an important part in the emergence of mental disorders. Of the eighty-nine case histories that Araki translated for his German article, fifty-six were included into the section on etiology and the remaining thirty-three were presented in the section on disease forms. Moreover, the section on etiology was expanded to include subsections on heredity, organic diseases, age, and combat divisions. Thus, this section now comprised two thirds of the whole article, with the majority of the case histories having been integrated into this part and arranged according to etiological criteria.

Another move to enforce and give credibility to his argument was to contextualize his experience within the German debate on war-related mental illness that had followed the

18 *Militär-Medizinal-Abtheilung des Königlich Preussischen Kriegsministeriums*, ed., *Traumatische, idiopathische und nach Infektionskrankheiten beobachtete Erkrankungen des Nervensystems bei den deutschen Heeren im Kriege gegen Frankreich 1870–71* [Traumatic, Idiopathic and Post-Infectious Diseases of the Nervous System Observed in the German Armies during the War Against France 1870–71] (Berlin: Ernst Siegfried Mittler und Sohn, 1886). On Araki's and Sommer's relationship, see the discussion on page 49.

19 The German version of the article also included footnotes and a list of references. Although these elements were not mandatory in German medical articles around 1900, those formal changes certainly had to do with differences in publication standards in Japan and Germany.

wars of German unification. Araki began his article by naming a dozen German authors who had published on mental illness in the wars of 1866 and 1870–71.²⁰ He mostly relied on the work of Carl Dietz (1859–1904), who had summarized the opinions and experiences of several French and German authors. Based on this meta-analysis, Dietz had come to the conclusion that the war of 1866 had caused a predisposition for mental disorders in 1870–71 in several cases.²¹ He had then expanded this argument to the general observation that war could create a disposition to mental illness and that it also affected healthy individuals with no hereditary predisposition—in short, that the war constituted a direct etiological agent.²² Araki obviously shared this view when he stated that the war was “not only the direct cause of mental and nervous disorders, but it also left behind a disposition.”²³

Even though the Franco-Prussian War and the Russo-Japanese War were separated by more than thirty years, the official report of the German Ministry of War offered the advantage of being based on a nationwide survey and, therefore, promised to provide reliable statistical data. The chapter on psychoses presented 100 cases of mental illness in which the government authorities had confirmed a causal relationship between the war and the mental disorder.²⁴ Araki made use of this data when he compared his statistics on the causes of mental illness with the German findings.

A comparison with the German statistics makes Araki’s insistence on the impact of the war appear hugely understated. In his overview on etiological factors, the most frequent causes are “typhoid fever” (twenty cases) and “exhaustion” (eighteen cases), whereas he was unable to identify any specific cause in ninety-seven cases (see Table 7.1).²⁵ According to the German statistics, most psychoses had been caused by the “strains of the war in general” (thirty cases), but there was also another category labeled “specific psychological influences” (fourteen cases) that overlapped with Araki’s understanding of “physical and mental exhaustion.”²⁶ Araki linked his eighteen cases of physical and mental “exhaustion”

20 All of these articles were also mentioned in the two sources that Araki had already used for his talk in 1905: Carl Dietz, “Geistesstörungen in der Armee im Frieden und Krieg” [Mental Disorders in the Army in Times of Peace and War], *Allgemeine Zeitschrift für Psychiatrie* 44 (1888): 209–257; Kriegsministerium, *Erkrankungen des Nervensystems bei den deutschen Heeren 1870–71*.

21 Dietz, “Geistesstörungen in der Armee im Frieden und Krieg,” 238–239.

22 Dietz, 240–241.

23 Araki Sōtarō 荒木蒼太郎, “Beobachtungen,” 625.

24 Kriegsministerium, *Erkrankungen des Nervensystems bei den deutschen Heeren 1870–71*, 417.

25 This table can be found in Araki Sōtarō 荒木蒼太郎, “Beobachtungen,” 626. No such table is included in any of Araki’s Japanese publications. In other parts of Araki’s text, *delusional insanity* (German: Wahnsinn) is referred to as *hallucinatory insanity*. The numbers in brackets are not included in the total number. They refer to a few cases which Araki considered to be cases of *alcohol intoxication*, *kakke*, and *congenital mental deficiency*, but where the patients exhibited a *melancholic*, *manic* or *neurasthenic* state.

26 As Araki mentioned in a footnote, he was quoting the German Ministry’s report from Dietz’s article. In the report, the category “specific psychological influence” was actually labeled “other specific physical or

Table 7.1: Causes and disease forms (Araki)

Causes	Disease forms											Total	
	Melancholia	Mania	Manic-depr. & circular insanity	Delusional insanity & delirium	Paranoia	Neurasthenia	Hysteria	Acute alcoholism	Beriberi psychoses	Dementia paralytica	Dementia praecox		Congenital mental deficiency
Exhaustion	7	5	1	—	—	5	—	—	—	—	—	—	18
Typhus abdomin.	7	4	—	4	—	5	—	—	—	—	—	—	20
Pneumonia	2	2	—	—	—	—	—	—	—	—	—	—	4
Influenza	3	—	—	1	—	4	—	—	—	—	—	—	8
Dysentery	1	1	—	1	—	1	1	—	—	—	—	—	5
Cerebrospinal meningitis	1	—	—	—	—	1	—	—	—	—	—	—	2
Malaria	—	1	—	—	—	—	—	—	—	—	—	—	1
Head injury	1	1	—	1	—	4	—	—	—	—	—	—	7
Body injury	—	—	—	—	—	2	1	—	—	—	—	—	3
Catarrh of the stomach and intestines (catarrh of the colon)	3	—	—	—	—	3	—	—	—	—	—	—	6
Syphilis	2	—	—	—	—	—	—	—	—	1	—	—	3
Other organic diseases	4	1	—	—	—	—	—	—	—	—	—	—	5
Acute alcoholism	(2)	(3)	—	—	—	—	—	5	—	—	—	—	5
Kakke (Beriberi)	(10)	(2)	—	—	—	—	—	—	12	—	—	—	12
Congenital brain dysfunction	(4)	(2)	—	—	—	(1)	—	—	—	—	—	15	15
Unknown causes	28	20	3	4	5	19	2	—	—	8	8	—	97
Total	59	35	4	11	5	44	4	5	12	9	8	15	211

with the thirty cases of “strains of the war” from the German statistics. He explained that the relatively low proportion of merely 8.5% in his own analysis was probably due to the short observation time and that a proper examination would have allowed him to identify more such cases.²⁷

Araki’s table, which shows the relationship between causes and disease forms, also reveals the influence of disease concepts on etiological discussions. While an external influence such as “exhaustion” could theoretically be considered as a possible cause in the cases of melancholia (12%), mania (15%), and neurasthenia (11%), this was less likely in the cases of paranoia and dementia praecox, where Araki only lists “unknown causes.” These latter two were conceptualized as diseases where a strong hereditary influence was seen as the main cause, and Araki’s experience in the war could not challenge this general assumption.²⁸

Yet Araki’s experience in the war might, in turn, also have influenced his view on certain forms of mental illness. His textbook was only published after the end of the war, and some passages, such as the section on war as a cause of mental illness, were taken directly from his Japanese articles on war psychoses.²⁹ Araki’s conviction that the war could create a disposition to mental illness is also reflected in his textbook’s section on physical trauma. Here, he explained that a head injury might directly cause an illness but that it might also leave the patient vulnerable to becoming mentally ill later. Such patients were prone to suffer from headaches, nausea, and irritability in later years; they experienced mental fatigue, lacked resilience at work, and were likely to become depressed or agitated.³⁰ Furthermore, Araki’s textbook discussion of dementia paralytica and melancholia also bears traits of his wartime experience. In fact, since he had identified only one case of syphilis among his dementia paralytica patients, Araki came to emphasize the role of exhaustion and other weakening influences as causative agents.³¹ In turn, it may have

psychological influence” (Kriegsministerium, *Erkrankungen des Nervensystems bei den deutschen Heeren 1870–71*, 474). However, Dietz’s renaming is not without justification. Among the 14 cases, 5 were associated with fright, 5 with the stressful experience of working at an outpost, and the remaining 4 with various forms of mental stress (Dietz, “Geistesstörungen in der Armee im Frieden und Krieg,” 241–242). Araki’s understanding of exhaustion also comprised elements of emotional stress, such as the “constant mental tension of being at the front line, serving at an outpost or having watch duty” (Araki Sōtarō 荒木蒼太郎, “Beobachtungen,” 627).

27 Araki Sōtarō 荒木蒼太郎, 628.

28 See the discussion of *paranoia* in contemporary German and Japanese textbooks published before the war: Krafft-Ebing, *Lehrbuch der Psychiatrie*, 400; Ziehen, *Psychiatrie für Ärzte und Studierende*, 1st ed., 216; Kure Shūzō, *Seishinbyōgaku shuyō* 163; Kadowaki Masae, *Seishinbyōgaku* 472. In the case of the relatively new concept of *dementia praecox*, Kraepelin had argued for a “autointoxication” theory, but the “hereditary predisposition” theory was still more widespread (Kraepelin, *Klinische Psychiatrie*, 203–204).

29 See also footnote 9 on page 194.

30 Araki Sōtarō, *Seishin byōri hyōshaku* 127.

31 Araki Sōtarō, 235–236; Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite,” 210.

been the role of exhaustion in his melancholia cases that convinced him that heredity was, in fact, of minor significance for this illness.³² However, it is also possible that a combination of Araki's personal experience and shared ideas was at play here. Indeed, the role of hereditary predisposition for melancholia was also de-emphasized in Ziehen's textbook (1894),³³ which had been the model for Araki's textbook (1906).³⁴ Like Araki, Ziehen stressed the influence of exhaustion as "one of the most important etiological factors," along with persistent grief and sorrow.³⁵

Araki's position in the discussion of war-related mental illness was characterized by his emphasis on external factors. Although he did acknowledge the influence of mental stress, he rarely differentiated between mental and physical exhaustion in his case histories.³⁶ As he was in no way obligated to the military authorities, he did not have to temper his critical attitude, and he explicitly voiced his opinions on the pathogenic effect of war at public conferences and openly expressed them in academic journals. His opinion was based on the conviction that for some forms of illness, such as melancholia and dementia paralytica, hereditary predisposition was of relatively minor importance. He also made the observation that an exceptionally high number of soldiers became ill directly on the battlefield, a fact which he interpreted as a sign of the war's direct influence. The German-language sources from the 1880s which he quoted to support his arguments nicely reflected his general view on the pathogenic effect of the war. Although Kure and Hanabusa took different positions, they employed similar argumentative strategies. As opposed to Araki's German sources, they considered some Russian sources on mental illness in the war.

7.2 Kure Shūzō: A Numbers Game

The style and content of Kure's article for the Ministry of War's official report was largely determined by the requirement to present a comprehensive study of all the forms of mental illness encountered during the Russo-Japanese War.³⁷ Although the discussion of eti-

32 Araki Sōtarō, *Seishin byōri hyōshaku* 108.

33 Ziehen, *Psychiatrie für Ärzte und Studierende*, 1st ed., 216.

34 See the discussion in section 4.1.

35 Ziehen, 307.

36 In most of his cases, this differentiation was impossible because his patients suffered both from physical exhaustion and had experienced some kind of emotional stress. There were only a few cases where Araki assumed a purely psychological cause such as "grief over the death of a younger brother" (*otōto no shi wo awaremu* 弟ノ死ヲ哀ム), cf. case 40 (30-year old infantry soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 160.

37 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite." According to the catalogue of the National Diet Library, all of the volumes of the Ministry's report have been published in 1924, but Okada Yasuo dates the text 1912, cf. Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 321. As the text must have been written before the publication of its German translation in 1913, this estimation

ology was naturally part of such a treatise, Kure did not try to build a strong argument about the pathogenic influence of war. A crucial aspect that seems to have shaped Kure's discussion of etiology was his involvement with the military authorities. In January 1905, he was ordered to make an inspection of the military reserve hospitals throughout Japan (Hiroshima, Kokura, Himeji, and others).³⁸ Kure neither condemned nor trivialized the war. When he presented his own observations, he always gave an overview of other positions, and even when he found that his own experience was at variance with that of other authors, he usually avoided making generalized statements on the basis of his own limited data. In this respect, his article represents a more intermediate position when compared to the texts of Araki and Hanabusa.

Generally speaking, Kure did not deny that the war had a huge influence on the minds and bodies of soldiers, but at the same time he did not feel entitled to investigate this causal relationship. In the introduction to the section on causes, he noted that feelings of fear and misery, personal worries, and especially the exhaustion of marches must naturally affect the body and soul. He assumed that, with the progress made in military science (*gunjigaku* 軍事學) and weapons technology (*gunki seizōhō* 軍器製造法), these influences were only going to become worse.³⁹ Although he believed that a thorough investigation of etiological factors would be very useful, he opined that “this was perfectly feasible for military doctors working in field hospitals, but not something we assistant employees could hope to undertake.”⁴⁰

Kure's reservations were based on two aspects that had a restricting effect on his work with mentally ill soldiers during the war, namely, his subordinate position as a civilian and his workplace in the reserve hospital. Kure's status as civilian entailed some limitations to his work, a fact he was painfully aware of. He noted that “in the reserve hospitals, military doctors were in charge of the care for the mentally ill” and that, due to his lower hierarchical position, he was not in a position to “freely choose his [research] material.”⁴¹ These circumstances naturally affected Kure's statistical results and his ability to draw general conclusions from his cases. But the location of his workplace in Tokyo was perhaps even more significant for the investigation of etiological factors. Indeed, the patients' condi-

seems plausible (Kure Shūzō 呉秀三 [Kure, Shuzo], “Über die im japanisch-russischen Krieg beobachteten Geistesstörungen” [On Mental Disorders Observed during the Russo-Japanese War], *Shinkeigaku zasshi* 12, no. 13 [1913]: 1–47).

38 Kashida Gorō, *Nihon ni okeru seishinbyōgaku no nichijō* 38. On the inspection of the hospital in Hiroshima, see also footnote 57 on page 157.

39 Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 35.

40 “野戦部隊附軍醫トシテハ能ク之ヲ為シ得ヘキモ余等ノ如キ幫助員ニ在リテハ望ムヘキコトニアラス” (Kure Shūzō, 35). In the German version of the article, Kure also mentioned that working in a reserve hospital further complicated the matter (Kure Shūzō, “Über die im japanisch-russischen Krieg beobachteten Geistesstörungen,” 14).

41 “[...] 病院ニハ軍醫ノ診治ノ任ニ當ラルルアリテ [...] 其材料ノ取捨選擇ヲ縦ニスルコト得ス” (Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 7).

tion and symptoms might completely change, or at least evolve, during the journey from the field hospitals to the Japanese capital, making an estimation of their original state well-nigh impossible.

However, even if Kure was affronted by his subordinate position, he showed restraint in expressing his contempt, as the report of the Ministry of War would certainly not have been the ideal medium to openly voice such criticism. On the Russian side, the power struggle between psychiatrists and military doctors was addressed more openly. While care for the mentally ill was firmly in the hands of the Russian military authorities at the beginning of the war, it was completely delegated to the Russian Red Cross Society, who ensured that the patients were treated by trained psychiatrists from December 15, 1904 onwards.⁴² In the process of this transition, the psychiatrists successfully portrayed the military authorities as ignorant, unorganized, and incompetent when it came to handling mentally ill soldiers.⁴³ To name but one example, the psychiatrist Efim Solomonovič Borišpol'skij (1869–1942), who had been sent to work in the hospitals of Manchuria, complained that the military authorities were unprepared to deal with neuropsychiatric casualties, were unfamiliar with the German literature on war psychoses, and were “unwilling to think about the situation until they were confronted with the bitter reality and even then their thoughts did not go very deep.”⁴⁴ When compared to the polemic of Russian psychiatrists, Kure's remark on the restrictions that psychiatrists encountered in military hospitals appears very moderate indeed.

42 Pëtr Michajlovič Avtokratov described the organization of the care for the mentally ill by the Red Cross (Pëtr Michajlovič Avtokratov, “Prizrenie, lečenie i evakuacija duševno-bol'nyh vo vremja Russo-Japonskoj vojny v 1904–1905 godach” [The Care, Treatment and Evacuation of the Mentally Ill during the Russo-Japanese War in the Years 1904–1905], *Obozrënie psichiatrii, neurologii i eksperimental'noj psichologii*, no. 10 [1906]: 665–688; Pëtr Michajlovič Avtokratov, “Prizrenie, lečenie i evakuacija duševno-bol'nyh vo vremja Russo-Japonskoj vojny v 1904–1905 godach,” *Okončanie* [The Care, Treatment and Evacuation of the Mentally Ill during the Russo-Japanese War in the Years 1904–1905 (Conclusion)], *Obozrënie psichiatrii, neurologii i eksperimental'noj psichologii*, no. 11 [1906]: 721–741). See also Friedlander, “Psychiatrists and Crisis in Russia, 1880–1917,” 205–249.

43 Some of the more telling examples of these polemic attacks can be found in Gerasim Egorovič Šumkov, “Ėvakuacija duševno-bol'nyh s Dal'nego Vostoka” [Evacuation of the Mentally Ill from the Far East], *Voenno-meditsinskij žurnal* 83, no. 213 (1905): 310–315, 534–548; Efim Solomonovič Borišpol'skij, “Postanovka dela prizrenija duševno-bol'nyh na teatre voennyh dejstvij vo vremja rusko-japonskoj vojny za 1-yj god eë” [The Situation Concerning the Care for the Mentally Ill on the Theatre of War in the First Year of the Russo-Japanese War], *Ruskij Vrač* 40 (1906): 1259–1252.

44 Borišpol'skij, 1249. Another anecdote that is often quoted in this context is Borišpol'skij's description of his first encounter with military authorities. When he first arrived in Manchuria and informed the military-medical inspector of the Priamur military district that he was a trained psychiatrist, the inspector smiled and told him that he would hardly find any work in his speciality, as there would hardly be any mental and nervous patients in the war. When Borišpol'skij remarked that the experience of the Franco-Prussian war had shown that the opposite was the case, the inspector replied: “Это тамъ, а у насъ этого не будетъ.” (Well, that was there [in France and Germany], but we will not have this [kind of problem] here.) (Borišpol'skij, 1249).

Nonetheless, these formal restrictions were more than matched by the spatial (and temporal) distance that complicated the investigation of etiological factors. In contrast to the civilian psychiatrists on the Japanese mainland, military doctors working in field hospitals had the distinct advantage of being able to observe mental disorders on-site shortly after they occurred. They were also in a privileged position when it came to making inquiries about the circumstances under which a patient had become ill, as they had direct access to their fellow soldiers. In the reserve hospitals, the situation was rather less favorable. Usually, it took more than a month for a patient to be transferred from the battlefields in Manchuria to the Tokyo Reserve Hospital. This meant that by the time the patient arrived there, some of his more acute symptoms might already have changed or receded altogether. In many cases, it was also impossible to obtain any etiologically relevant information on the patient. Moreover, some patients were merely passing through Tokyo to get to their home divisions, which made a thorough examination even more difficult.⁴⁵ However, not even these severe restrictions discouraged Kure from investigating and categorizing the various etiological factors that he had found in his cases.

The section under which Kure discussed etiology was titled “exciting causes,” which indicates that he treated these causes as catalyzing moments. This view is consistent with the general discussion of etiology in his textbook on psychiatry published in 1894 and 1895.⁴⁶ In this text, Kure also made a strict division between “predisposition” (*soin* 素因) and “exciting causes,” stating that the influence of the former was far more important than the latter.⁴⁷ His position on the matter apparently remained unchanged until 1904, when he compiled the Sugamo hospital’s annual report for the year 1902.⁴⁸ Although Kure never explicitly formulated how he understood the relationship between heredity and exciting causes in his report for the Ministry of War, it is safe to assume that he favored the view expressed earlier in his textbook and annual report.

45 Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 7.

46 The first part of the book was originally published in September 1894, the second in August 1895 (Okada Yasuo, *Kure Shūzō sono shōgai to gyōseki* 444).

47 He added that a predisposition was in many cases sufficient to give rise to mental illness (Kure Shūzō, *Seishinbyōgaku shuyō* 230). As has been noted by other authors, Kure’s textbook was for the most part based on the textbook of Krafft-Ebing, where the exact same explanation can be found (Krafft-Ebing, *Lehrbuch der Psychiatrie*, 144).

48 According to the statistics of this report, 67% of the 197 patients had a predisposition to mental illness while only 2% were found with no predisposition in 1902 (the predisposition was unknown in the remaining cases). In half of the cases, an exciting cause had also been identified. A table showing the relationship between heredity and exciting causes revealed that in 54% of the cases with a hereditary predisposition an exciting cause was present, whereas it was absent in 21% (Kure Shūzō 呉秀三, “Meiji sanjūgo nen Tōkyōfu Sugamo byōin nenpō” 明治三十五年東京府巢鴨病院年報 [Annual Report of the Sugamo Hospital in Tōkyō Prefecture for the Year 1902], *Shinkeigaku zasshi* 2, no. 6 [1904]: 702). This distribution confirms the idea that exciting causes were merely seen as accessory phenomena.

Table 7.2: Causes and disease forms (Kure)

Causes	D. P.	M. D.	G. P.	Ep.	Hy.	Inf.	Alc.	Imb.	Total
1. Mental									
Domestic troubles	2	—	—	—	—	—	—	—	2
Family conflicts, divorce	1	—	—	—	—	—	—	—	1
Blindness of wife, debauchery of brother	1	—	—	—	—	—	—	—	1
Being scolded by father for debauchery	1	—	—	—	—	—	—	—	1
Insult, suicide of wife	1	—	—	—	—	—	—	—	1
Distress over adenoma in the inguinal region	1	—	—	—	—	—	—	—	1
Fear of war	2	1	—	—	—	—	—	—	3
(Mental & physical)									
Mental and physical exhaustion	3	1	—	—	—	—	—	—	4
Exhaustion and injury	1	—	—	—	—	—	—	—	1
Domestic troubles, anger, gunshot wound in the left forearm	1	—	—	—	—	—	—	—	1
2. Physical									
Cerebral hemorrhage	1	—	—	—	—	—	—	—	1
Beriberi	2	1	—	—	—	—	—	—	3
Beriberi and typhoid fever	1	—	—	—	—	—	—	—	1
Typhoid fever	—	—	—	—	—	3	—	—	3
Malaria	—	—	—	—	—	1	—	—	1
Dysentery	—	—	—	—	—	1	—	—	1
Pneumonia	—	—	—	—	—	1	—	—	1
Influenza	2	—	—	—	—	1	—	—	3
Gunshot wound in the left thigh	1	—	—	—	—	—	—	—	1
Shell splinter injury in the left palm	1	—	—	—	—	—	—	—	1
Chest trauma caused by a shell	1	—	—	—	—	—	—	—	1
Trauma on parietal bone	1	—	—	—	—	—	—	—	1
Shell splinter injury in the left side of the neck	1	—	—	—	—	—	—	—	1
Alcohol consumption	—	—	—	—	—	7	2	—	9
Unknown	40	19	2	6	3	—	—	—	70
Total	65	22	2	6	3	14	2	—	114

When comparing Kure's statistical data on exciting causes (Table 7.2) to Araki's table (Table 7.1), a few notable differences can be observed.⁴⁹ Apart from the fact that the two physicians used different classification systems of mental disorders, they also had a different approach to discussing the causes. First, there is a subdivision into mental and physical causes in Kure's table.⁵⁰ Second, there is a more detailed differentiation of causes in Kure's account. Third, Kure mainly relied on the data of patients that he had diagnosed with dementia praecox, which essentially makes his table a study on the exciting causes found in this illness.⁵¹ Finally, despite the apparent wealth of detail, the data in this table does not seem to have had any influence on Kure's view on war psychoses or any psychosis in particular. Unlike Araki's table on causes, which reflects and supports his argument, Kure's seems to have been compiled solely for statistical purposes.

Even though Kure's own observations on the causes of war psychoses were not very informative by his own standards, it is interesting to examine what kind of data he considered to be relevant for this topic in the works of other authors and how he used it. For instance, among the texts that he quoted in his section on exciting causes were articles by three Russian physicians. One was by Aleksandr Vasil'evič Ljubarskij (1860–?), who worked in a local hospital of Nikol'sk-Ussurijsk in the Russian Far East; another by Ivan Dmitrievič Ermakov (1875–1942), who worked in a mental hospital in Harbin; and the last was by Martyn Osipovič Šajkevič (1869–?), who worked in a clinic in Moscow.⁵² All three authors had made very different observations and had diverging views on the causes of war psychoses. Ljubarskij had mainly observed cases of paranoia and melancholia and argued for the dominant influence of the war as a pathogenic factor, whereas Ermakov and Šajkevič stressed the prevalence of signs of degeneration (asymmetries of the skull, attached earlobes, irregular teeth, etc.).⁵³ Ermakov mostly saw cases of epilepsy and general

49 Kure's table can be found in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 38; Kure Shūzō, "Über die im japanisch-russischen Krieg beobachteten Geistesstörungen," 14–15. I have followed the German version. The tables are almost identical in content, except for a mistake in the "infection psychoses"-column that lists 7 alcohol-drinking-patients too many, which results in a false total in the Japanese table and too many *infection psychoses* patients in the German table (there were only 7 in total). Additionally, the total number of *imbecility* patients (3) is missing in the German version, which results in a different grand total (110 in the Japanese, 114 in the German version). *Kakke* is translated as "Beriberi" in the German version, otherwise I would not have translated the term. The abbreviations in the first row stand for: D. p. *Dementia praecox*, M. D. *Manic-depressive insanity*, G. p. *General paresis*, Ep. *Epileptic insanity*, Hy. *Hysterical insanity*, Inf. *Infection psychoses*, Alc. *Alcohol psychoses*, Imb. *Imbecility*.

50 This was also a feature of the tables in the 1902 report for the Sugamo hospital.

51 In fact, some of his remaining data borders on the tautological. For instance, it is hardly surprising that all of the patients with *infection psychoses* had suffered from an infection and that all of the *alcohol psychosis*-patients had become ill from drinking alcohol.

52 The city of Nikol'sk-Ussurijsk (present day Ussurijsk) was located in Primorskij kraj about 112km north of Vladivostok.

53 Aleksandr Vasil'evič Ljubarskij, "Psichiatricheskoe otdělenie pri Nikol'skom městnom lazarete v g. Nikol'sk-Ussurijskom vo vremja Russko-Japonskoj vojny" [The Psychiatric Ward at the Local Hospital

paresis in his patients, whereas Šajkevič claimed that he was able to identify a war-specific kind of psychosis that he himself had named *amentia depressivo stuporosa*. Among the exciting causes for this new disease, he especially stressed fear, mental and physical exhaustion, and mental shock caused by the nearby explosion of shells.⁵⁴

However, in quoting from these Russian works, Kure focused exclusively on those passages where the authors mentioned participation in battles. He noted that according to Ljubarskij, 78 of his 242 patients had participated in battles, while 123 had not participated in battles, and 24 patients were injured. He further quoted Ermakov saying that among his 257 patients, 146 had become ill at the front and 88 had become ill in connection with battles.⁵⁵ Lastly, he referred to Šajkevič, who stated that one part of the patients had become ill during a battle, whereas the other part had become ill several hours after a battle.⁵⁶ It would seem that Kure presumed that participation in a battle naturally and always constituted the most significant exciting cause, even though the Russian authors did not generally establish a causal relationship between battle experience and mental illness.

Kure's selective reception of Russian articles was partly due to the fact that he mostly relied on short abstracts and incomplete translations as his sources. Some Japanese psychiatrists had knowledge of French and English, but the majority was, of course, trained in German. The transmission of information from Russia to Japan therefore mainly relied on Russian language speakers who translated medical texts into German, as virtually no Japanese physicians received any training in Russian. Many of these translators originated from the Baltic countries, where ethnic Germans formed a large part of the population. Although the Baltic countries had become part of the Russian Empire at the beginning of the eighteenth century, German remained the language of instruction in many institutions well into the nineteenth century. The University of Dorpat (present day Tartu, Estonia), in particular, attracted many German academics, such as the psychiatrists Hermann Emminghaus (1845–1904) and Emil Kraepelin, who were the first two directors of Dorpat's psychiatric clinic.⁵⁷ It is only natural that medical students originating from

in the City of Nikol'sk-Ussurijsk at the Time of the Russo-Japanese War], *Obozrēnie psichiatrii, neurologii i eksperimental'noj psichologii* 12, no. 2 (1907): 84; Ivan Dmitrievič Ermakov, "Psichičeskie zaboľevanija v Russko-Japonskuju vojnu po ličnym nabljudenijam" [Mental Illness during the Russo-Japanese War According to Personal Observation], *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 7, nos. 2–3 (1907): 389; Martyn Osipovič Šajkevič, "K voprosu o duševnyh zabolēvanijach v vojskē v svjazi s japonskoj vojnoj: Predvaritel'noe soobščenie d-ra M. O. Šajkeviča" [On Mental Illness in the Army in Connection With the Japanese War: Preliminary Report by Dr. Šajkevič], *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 4, no. 6 (1904): 1103.

⁵⁴ Šajkevič, 1105.

⁵⁵ As will be shown below, this is a mistranslation of Ermakov, see page 208.

⁵⁶ Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 35.

⁵⁷ Erich Donnert, *Die Universität Dorpat-Jurev 1802–1918: Ein Beitrag zur Geschichte des Hochschulwesens in den Ostseeprovinzen des Russischen Reiches* [The Dorpat-Jurev University 1802–1918: A Contribution to the History of Higher Education in the Baltic Provinces of the Russian Empire] (Frankfurt am Main: Peter Lang, 2007), 196.

these regions constituted a group of agents that was predestined to become cultural brokers between Germany and Russia.

An examination of the reviews of Russian articles in the Japanese journal *Shinkeigaku zasshi* reveals that the large majority of the Japanese texts were based on German reviews. For instance, the review of Šajkevič's text had originally been written by Richard Jakob Salomon Weinberg.⁵⁸ Weinberg's short review of Šajkevič's text in turn became the source for the translation in the *Shinkeigaku zasshi*.⁵⁹ The only information given in this review was that Šajkevič had observed a few cases of mental illness in the Manchurian Army, and that he had noted that in some cases the psychoses appeared during a battle and sometimes a few hours or up to two months after a battle.⁶⁰ Exactly the same information is reproduced in the Japanese review, and the exact same wording is used by Kure in his report on mental illness. Although it is clear from his other quotations that Kure had also

58 Richard Jakob Weinberg, review of "Ueber Geistesstörungen beim Militär (im Zusammenhang mit dem russisch-japanischen Kriege)" [On Mental Disorders in the Military (in connection with the Russo-Japanese War)] by M. Schaikewicz [Martyn Osipovič Šajkevič], *Centralblatt für Nervenheilkunde und Psychiatrie* 28 (1905): 687.

Weinberg was an anatomist of Baltic origin who made his career in the medical institutions of the Russian empire. He began his studies at the University of Moscow (Arnold Hasselblatt, ed., *Album academicum der Kaiserlichen Universität Dorpat* [Album Academicum of the Imperial University of Dorpat] [Dorpat: C. Mattiesen, 1889], 869) and after submitting his dissertation on Estonian brains at the University of Dorpat, he became professor of Anatomy at the Medical Institute for Women in St. Petersburg in 1906 ("Bericht der Kaiserlichen Universität Dorpat zum 12. Dezember 1906" [Report of the Imperial University of Dorpat on December 12, 1906], *Düna-Zeitung* [Riga], December 12, 1906, no. 286, 1). On his anthropological research see Ken Kalling and Leiu Heapost, "Racial Identity and Physical Anthropology in Estonia 1800–1945," in *Baltic Eugenics: Bio-Politics, Race and Nation in Interwar Estonia, Latvia and Lithuania 1918–1940*, ed. Björn M. Felder and Paul J. Werindling (Amsterdam: Rodopi, 2013), 87–88. Apart from his translations for the *Centralblatt für Nervenheilkunde*, he also compiled extensive reviews of Russian medical literature in anatomy for the *Ergebnisse der allgemeinen Pathologie und pathologischen Anatomie des Menschen und der Tiere*, see e.g. Richard Weinberg, "Bericht über die russische allgemein-pathologische und pathologisch-anatomische Literatur für 1904/1905" [Report on General-Pathological and Pathological-Anatomical Russian Literature 1904–05], *Ergebnisse der allgemeinen Pathologie und pathologischen Anatomie des Menschen und der Tiere* 10 (1906): 1–104; Richard Weinberg, "Bericht über die russische allgemein-pathologische und pathologisch-anatomische Literatur für 1905/1906" [Report on General Pathological and Pathological-Anatomical Russian Literature 1905–06], *Ergebnisse der allgemeinen Pathologie und pathologischen Anatomie des Menschen und der Tiere* 11 (1907): 730–802.

59 Kageyama Yūzō 影山勇藏, review of "Nichiro sensō ni kanshi guntai ni okeru seishin shōgai ni tsuite" 日露戦争ニ關シ軍隊ニ於ケル精神障礙ニ就テ [On Mental Disorders in the Army in Connection with the Russo-Japanese War] by Shaikowitchi シャイコウイッチ [Martyn Osipovič Šajkevič], *Shinkeigaku zasshi* 5, no. 3 (1906): 143. In this case the source of the review is indicated as *Centralblatt für Nervenheilkunde und Psychiatrie* 1905. In many other cases the actual source is not indicated.

60 R. J. Weinberg, review of "Ueber Geistesstörungen beim Militär (im Zusammenhang mit dem russisch-japanischen Kriege)" [On Mental Disorders in the Military (in connection with the Russo-Japanese War)] by M. Schaikewicz [Martyn Osipovič Šajkevič].

consulted other sources on Šajkevič, it would definitely seem that he preferred copying ready-made passages from the *Shinkeigaku zasshi*.⁶¹

This mechanism is even more evident in the case of Ermakov's article, which also seems to have been available to Kure only in the form of a translated review.⁶² In all of the quotations that refer to Ermakov, Kure limited himself to the text of the Japanese review and even reproduced the translation errors found in this text.⁶³ In the original Russian version, Ermakov actually stated that among his 257 patients, eighty-eight had already become ill at home before they even made it to Manchuria, but in the Japanese version, this information was for some reason misinterpreted as "eighty-eight patients became ill in connection with the war."⁶⁴ Not only was the argument that some Russian soldiers had become mentally ill because of the war not based on Ermakov's observation, but its inclusion in Kure's report was the result of an unspotted translation error that only existed in the Japanese versions of Ermakov's text.

A similar translation problem can also be identified in Kure's quotation of Ljubarskij. In this case, no German intermediary was involved, as the translation was made directly from Russian into Japanese by Kurosawa Genshichi 黒澤源七 (1867-?).⁶⁵ Kurosawa's

61 In his discussion of the most common forms of mental illness encountered during the war, Kure quoted a lengthy passage from Šajkevič's article to describe the latter's conception of *amentia depressivo stuporosa*. Compare the passage in question in Martyn Osipovič Šajkevič [Schaikewicz, M.], "Über Geisteskrankheiten im russischen Heer während des russisch-japanischen Krieges" [On Mental Illness in the Russian Army during the Russo-Japanese War], trans. from the Russian by s. n., *Centralblatt für Nervenheilkunde und Psychiatrie* 29 (1906): 873–874 with Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 11.

62 Originally, Ermakov had presented his research on April 26, 1907, at the 10th Pirogov Conference of Russian physicians (Ivan Dmitrievič Ermakov, "x Pirogovskij s'ezd v Moskvě (25 aprělja—2 maja 1907 g.)" [x. Conference of the Pirogov Society in Moscow, April 25 to May 2, 1907], *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 7, nos. 2–3 [1907]: 545). Although the source of the Japanese review is indicated as the *Russian Journal for Skin and Venereal Diseases*, there are no articles by Ermakov published in this journal (Ujiie Makoto 世家信, review of "Nichiro seneki ni okeru seishinbyō" 日露戦役ニ於ケル精神病 [Mental Illness in the Russo-Japanese War] by Erumakofu エルマコフ [Ivan Dmitrievič Ermakov], *Shinkeigaku zasshi* 7, no. 7 [1908]: 319–320). Instead, the Japanese text seems to be based on a German review, see Miron Lubowski, review of "Psychische Erkrankungen im Russisch-Japanischen Kriege" [Mental Illness during the Russo-Japanese War] by J. D. Jermakow [Ivan Dmitrievič Ermakov], *Ärztliche Sachverständigen-Zeitung* 13, no. 20 (1907): 430.

63 See the quotations in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 21, 23, 35, 106, 128.

64 Ermakov, "Psichičeskie zabolevanija v Russko-Japonskuju vojnu po ličnym nabljudenijam," 390[319]ermakov1908. The German review gives a correct translation: "[...] während 88 schon krank in den Krieg gezogen sind" (while 88 went to war being already ill) in Lubowski, review of Jermakow, "Psychische Erkrankungen im Russisch-Japanischen Kriege," 430.

65 Ljubarskij, "Psichiatričeskoe otdelenie"; Aleksandr Vasil'evič Ljubarskij [A. We. Ryubärusukii ア、ウエ、リュバルスキイ], "Nichiro sensō no toki Roryū Nikorisuku-Ussuri-ken no Nikorisuku chihō byōin ni okeru seishinbyōsha no jōkyō" 日露戦争ノ時露領ニコリスकुウツスリイ縣ノニコリスकु地方病院ニ於ケル精神病者ノ狀況 [The Situation of the Mentally Ill at the Local Nikol'sk

translation of Ljubarskij's text appeared in the *Shinkeigaku zasshi*, together with a full translation of Pëtr Michajlovič Avtokratov's (1857–1915) report on the work of the Russian Red Cross Society that organized care for the mentally ill in the Russo-Japanese War.⁶⁶ Taken together, these two texts constituted the most detailed descriptions of the Russian mental health services in the war that were available in Japanese. This may explain why Ljubarskij's article, which was almost completely absent from French and German medical literature, appears as one of the most frequently quoted works in Kure's report.⁶⁷

Kurosawa had obviously tried to make a close translation of Ljubarskij's text, but the result was a sometimes rather free rendition of the original text. A very prominent change in meaning was unfortunately introduced by the translator into a passage that was to be quoted by Kure later on. In the original, it reads:

Hospital in the Russian-Governed Prefecture of Nikol'sk-Ussurijsk at the Time of the Russo-Japanese War], trans. from the Russian by Kurosawa Genshichi 黒澤源七, *Shinkeigaku zasshi* 6, no. 10 (1908): 588–594. Another text that had also been translated by Kurosawa and quoted in Kure's report is the article by Stanislav Dominikovič Vladyčko (1878–1936), who had described the siege of Port Arthur and its impact on the minds of the besieged (Stanislav Dominikovič Vladyčko, “Duševnye zabojevanija v Port-Arture vo vremja osady” [Mental Disorders in Port Arthur during the Siege], *Voenno-meditsinskij žurnal* 85, no. 218 [1907]: 108–118, 318–326; Kurosawa Genshichi 黒澤源七, review of “Rōjō no sai Ryojunkō ni okeru seishinbyō” 籠城ノ際旅順港ニ於ケル精神病 [Mental Illness in the Port of Ryujun during the Siege] by Uraduichiko ウラデウイチコ [Stanislav Dominikovič Vladyčko], *Shinkeigaku zasshi* 6, no. 10 [1908]: 601–602).

At the time of the Russo-Japanese War, there were only a few institutions where Japanese could learn Russian. There was the government-established Tokyo School of Foreign Languages and the Nikolai Orthodox Seminary (Shomu Nobori and Katsumaro Akamatsu, *The Russian Impact on Japan: Literature and Social Thought*, Two Essays, ed. Peter Berton, Far Eastern and Russian Research Series 5 [Los Angeles: University of Southern California Press, 1981], 92). Since 1890, some of the Japanese graduates of Russia's theological schools had also been teaching Russian at Japanese military schools. During the Russo-Japanese War, some graduates of the Tokyo Orthodox Seminary were employed as Russian-language specialists (Ilya Nikolayevich Kharin, “Self-Realization of the Japanese Orthodox Church, 1912–1956” [PhD diss., Princeton University, 2011], 178). Kurosawa had also attended the theological seminary of the Japanese Orthodox Church (ニコライ神学校) in his youth, but later decided to become a doctor (“Kurosawa Genshichi kun: Nanajū nana sai no daichōrō” 黒澤源七君：七十七歳の大長老 [Mr Kurosawa Genshichi: A 77-Year-Old Senior Citizen], *Nihon iji shinpō*, 1943, no. 1067). His medical career and the previous involvement with the Orthodox Seminary explains how he came to be able to translate Russian medical texts.

66 Pëtr Michajlovič Avtokratov [Autokratou アウトクラトウ], “Nichiro seneki chū Rokoku guntai no daseru seishinbyōsha ni tsukite” 日露戦役中露國軍隊ノ出セル精神病者ニ就キテ [On the Appearance of Mentally Ill Patients in the Russian Army during the Russo-Japanese War], trans. from the Russian by s. n., *Shinkeigaku zasshi* 6, no. 10 (1908): 571–588. This Japanese translation was based on a German version, cf. Pëtr Michajlovič Avtokratov [Awtokratow, P. M.], “Die Geisteskranken im russischen Heere während des japanischen Krieges” [On the Mentally Ill in the Russian Army during the Russo-Japanese War], trans. from the Russian by s. n., *Allgemeine Zeitschrift für Psychiatrie und psychisch-gerichtliche Medizin* 64, nos. 2–3 (1907): 286–319. On the Russian version see footnote 42 on page 202.

67 Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite,” 10, 21, 23, 24, 26, 31, 33, 35, 107, 126.

Интересно было бы выяснить, какое отношеніе между душевно-больными, участвовавшими въ сраженіяхъ и не участвовавшими; у меня получились слѣдующія данныя: [...] ⁶⁸

It would be interesting to investigate the proportion of mental patients that have participated in battles in relation to those that have not. I have obtained the following data: [...]

In Kurosawa's translation, this was rendered as:

戦争ニ参加シタルニ因テ發シタル精神病者ト参加セザル者トノ
間ニ如何ナル關係アルカヲ説明スルコトヲ得バ興味必ズ多カラ
ン、予ハ左ノ事實ヲ示サン⁶⁹

It would certainly be very interesting if one could explain what kind of relationship exists between those mental patients that became ill because they participated in battles as compared to those that have not participated [in the battles]. I would like to present the following facts: [...]

Although it might at first glance seem that Kurosawa got the gist of the text exactly right, this was not so. Either inadvertently or for lack of better knowledge, he had on the one hand introduced the little word “because” (*ni yotte* ニ因テ), and on the other hand he had transformed Ljubarskij's “data” into “facts.” So, whereas the object of inquiry in Ljubarskij's text had been the ratio between two groups of mental patients (combatants vs. non-combatants) without the postulation of any causal relationship between combat and mental illness, exactly this kind of causal relationship was established in Kurosawa's translation. Although Ljubarskij had been content to voice the opinion that different patient populations could be gainfully compared, Kurosawa presented him as someone who had jumped ahead of his own research and postulated that participation in battles was a direct cause of illness. This is all the more surprising as Ljubarskij commented on his own data that “no conclusion can be drawn based on these numbers, because they are too small and pure coincidence might have played its part.”⁷⁰

Ljubarskij then went on to speculate about the possible causes of mental illness in wartime. Among other things, he mentioned the constant strain on the nervous system; the permanent fear of being attacked, killed, or injured; and the worries about family

⁶⁸ Ljubarskij, “*Psichiatričeskoe otdelenie*,” 82.

⁶⁹ Ljubarskij, “*Nichiro sensō*,” 591.

⁷⁰ Ljubarskij, “*Psichiatričeskoe otdelenie*,” 82. Ljubarskij then added that the same was also true for all the following tables that he provided in his article, and that they would only gain any significance when all the data from the Russo-Japanese War was gathered together. In line with his former misrepresentation, this passage also gained a new meaning Kurosawa's version: “Here I must say simple and random things about the tables that follow. Perhaps in the event of a future war, the collection of material will eventually be of value” (Ljubarskij, “*Nichiro sensō*,” 591–592).

members who had been left behind and whose futures were at stake should the father of the family be killed or crippled. He furthermore suspected that the soldiers' sheer distance from their homes was depressing, causing them to fear that they would never be able to return. Lastly, he mentioned the circumstance that they could not understand what they were dying for and that they took the fact that they were losing every battle to be heavenly proof that they were fighting for an unjust cause; that God had therefore abandoned them to let the non-believers prevail.⁷¹

It is remarkable that none of these predominantly psychological causes listed by Ljubarskij were included in Kure's foreign-literature review on exciting causes. However, as he obviously did not intend to give a full rendition of the Russian discussion, he must have felt compelled to select information that was both coherent and concise. In this respect, his quotations of Ljubarskij, Ermakov, and Šajkevič seem to be a perfect match. In Kure's version, the numeric expressions borrowed from these authors convey the impression of a simple and direct causal relation between combat and illness that does not require further explanation.

Generally speaking, Kure's discussion of etiological questions was characterized by an impersonal attitude. While providing a lot of detailed information and drawing on a multitude of different sources, Kure's own opinion remained invisible. His understanding of the relationship between heredity and external causes was never explicitly articulated. Even though he noted in his section on heredity that there had been more cases without a hereditary disposition among the patients he had examined in the Tokyo Reserve Hospital, he did not use this observation to develop it into an argument.⁷²

Furthermore, some of Kure's attitudes seem to have stemmed from his concern about the "modernity" of Japanese psychiatry. For instance, he seems to have found that the German Ministry of War's report from 1885 was outdated. Unlike Araki, he did not consider the views expressed on etiology in this reference at all, but otherwise quoted from it extensively. When it came to disease forms, Kure found the German report lacking, as most cases had simply been denoted as "mental illness."⁷³ In these "old texts" (*furuki bunseki* 舊キ文籍), there also was no mentioning of "recently" (*kinji* 近時) introduced disease names, such as Kure's favored dementia praecox. But he also deplored that "there were hardly any traces of well-informed descriptions of this disease-form" on the Russian side, either.⁷⁴

71 Ljubarskij, "Psihiatriceskoe otdelenie," 83. Kurosawa's translation of the passage about God's wrath is flawless. It would seem that the time spent at the Orthodox Seminary eventually paid off.

72 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 27.

73 Kure Shūzō, 10; Kriegsministerium, *Erkrankungen des Nervensystems bei den deutschen Heeren 1870–71*, 415.

74 "是等ノ病症ヲ能ク理解シヨク觀察シタル蹤跡ハ希ナリ" (Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 69). However, Kure did make an exception for Suchanov in this matter. Indeed, Suchanov shared Kure's vision of "psychiatric modernity," which he

Kure had been commissioned to write an account of mental illness for the Ministry of War's official sanitary report. Although he might have been dissatisfied with his position as a civil assistant, he was certainly bound by his duties as a government official. In fact, it would almost certainly have been considered a provocation to openly demonize the war as the cause of mental illness in the eyes of the military authorities.

7.3 Hanabusa Ken'ya: Compensation

An even higher degree of personal involvement characterized the approach of Hanabusa, who was charged with determining the disability pension of mental health patients. Within this context, the discussion of the etiological role of the war had even more practical significance. Six years after the end of the Russo-Japanese War, Hanabusa presented his study on war-inflicted mental health casualties. His survey revealed that, out of the 5,215 veterans who were to receive compensation, 125 mental health patients were deemed to be entitled to a pension. 71 of these 125 had been diagnosed with *traumatic psychosis* (*gaishōsei seishinbyō* 外傷性精神病).⁷⁵ The term traumatic psychosis referred to an illness that was caused by a physical trauma, such as ballistic trauma, falling into the trenches, blows on the head, or falling from a horse.⁷⁶ Even among his nineteen cases of manic-depressive illness, there were five patients who had developed the illness after a head injury. The preponderance of this diagnosis in his report clearly reflects Hanabusa's preference for physical over psychological influences. This view was also expressed by several Russian physicians whom Hanabusa quoted to support his argument.

In general, Hanabusa assumed that "there were no great differences between mental disorders found in the Japanese and the Russian armies."⁷⁷ He based this statement on the reports of the various Japanese reserve hospitals (explicitly mentioning Araki's study), his own observations, and the works of the Russian authors "Pribytkow, Yermakow, Sankhnoff [sic!]" and "Suchanow."⁷⁸ Although he did not provide any bibliographical information on these Russian texts, they can be identified by examining the reviews of Russian articles on war-related mental illness in the *Shinkeigaku zasshi*, the only Japanese journal on psychiatry available in 1911.

All three Russian psychiatrists (Suchanow and "Sankhnoff" actually refer to one and the same person) had delivered talks on mental illness in the army at the Tenth

emphatically identified with the Kraepelin school and his classification of mental disorders, see Suchanov, "O sovremennoj klassifikacii duševnykh bolëznej."

75 Hanabusa Kenya, "Guntai ni okeru seishinbyō narabi ni sono onkyū shindan ni tsuite," 1982. This means that the large majority of Russo-Japanese War veterans (5,090 out of 5,215) were to receive a disability pension due to physical disabilities (Hanabusa Kenya, 1985).

76 Hanabusa Kenya, 1985.

77 "日露兩國軍隊ノ精神病ハ種別ハ著シキ差ナク" (Hanabusa Kenya, 1982).

78 Hanabusa Kenya, 1981–1982.

Pirogov Conference of Russian physicians held in Moscow from April 25 to May 2, 1907. Pribytkov described fifty-six cases of gunshot wounds with injuries of the skull and brain.⁷⁹ Ermakov reported on 257 cases of various forms of mental illness that included descriptions of *traumatic psychoneuroses*, *amentia*, *general paresis*, *epilepsy*, *alcoholic psychoses*, and *dementia praecox*.⁸⁰ Suchanov (usually transliterated as “Soukhanoff” in French publications) had also observed various forms of mental illness, such as *manic-depressive insanity*, *dementia praecox*, *alcoholic psychoses*, and *traumatic psychoneuroses* in Russian soldiers in a private hospital in Moscow.⁸¹ Apart from his talk at the Moscow conference, Suchanov published another article on war-related mental illness that was reviewed in the *Shinkeigaku zasshi*. This time he focused on cases of *acute mental confusion* that were also known as *amentia*.⁸²

79 Ujiie Makoto 世家信, review of “Nichiro sensō ni okeru zugaikotsu sonshō” 日露戦争ニ於ケル頭蓋骨損傷 [Injuries of the Cranial Bone in the Russo-Japanese War] by Puribitokofu プリビートコフ [Georgij Ivanovič Pribytkov], *Shinkeigaku zasshi* 7, no. 6 (1908): 262. The German entry was indicated as: “Pribytkhw, Verletzungen der Schädelknochen im Russisch-Japanischen Kriege. Pirogowsches Kongress, Moskau 1907”. See the report of Georgij Ivanovič Pribytkov (1857–1909) presented on April 28, 1907 (Ivan Dmitrievič Ermakov, review of “Nabljudenija nad ognestrēl'nymi povreždenijami čerepa i mozga v rusko-japonskuju vojnu” [Observations on the Injuries of the Cranial Bone and Brain Caused by Gunshot Fire in the Russo-Japanese War] by Georgij Ivanovič Pribytkov, *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 7, nos. 2–3 [1907]: 557). As the Japanese reviewer did not have a Russian-language background, his review was most likely based on a German review, see for example Miron Lubowski, review of “Beobachtungen über Verletzungen der Schädelknochen im Russisch-Japanischen Kriege” [Observations on Injuries of the Cranial Bones in the Russo-Japanese War] by G. J. Pribytkow [Georgij Ivanovič Pribytkov], *Ärztliche Sachverständigen-Zeitung* 14, no. 1 (1908): 12.

80 Ujiie Makoto, review of Erumakofu, “Nichiro seneki”, 319–320. See also footnote 62 on page 208.

81 Ujiie Makoto 世家信, review of “Nichiro sensō ni kansuru seishin shōge” 日露戦争ニ関スル精神障礙 [Mental Disorders in Connection with the Russo-Japanese War] by Zuhhyanofu ズツヒヤノフ [Sergej Alekseevič Suchanov], *Shinkeigaku zasshi* 7, no. 10 (1908): 598. Compare the talk by Sergej Alekseevič Suchanov delivered on the same day as Ermakov's (Ivan Dmitrievič Ermakov, review of “Po voprosu o psichičeskych razstrojstvach v svjazi s rusko-japonskoj vojnoj” [On the Issue of Mental Disorders in Connection with the Russo-Japanese War] by Sergej Alekseevič Suchanov, *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 7, nos. 2–3 [1907]: 544–545).

82 Hashi Kenkō 橋健行, review of “Rokoku guntai chū ni shōzeshi kyūsei seishin sakuran oyobi sono tokusei” 露國軍隊中ニ生ゼシ急性精神錯亂及ビ其特性 [Acute Mental Confusion among Russian Soldiers and Its Peculiarities] by Saukanoffu サウカノッフ [Sergej Alekseevič Suchanov], *Shinkeigaku zasshi* 8, no. 8 (1909): 363–364. The Russian text was originally published as one of Suchanov's lectures delivered at the military hospital for mentally ill soldiers in Moscow, see Sergej Alekseevič Suchanov, “Vnešnie projavlenija ostroj sputannosti u soldat, dostavlennych s Dal'nego Vostoka” [External Appearance of Acute Mental Confusion in Soldiers Brought Back from the Far East], in *Pervičnoe slaboumie vzroslych. Ob ostroj sputannosti: Iz kliničeskich lekcij, čitannyh pri lečebnice dlja duševnol'ných vojnov v Moskve* (Moskva: Tipografija Russkij Trud, 1906), 94–104. In the *Shinkeigaku zasshi*, the source of the article was indicated as “Soukhanoff, Acute mental confusion and its peculiarities among Russian soldiers. Journal de neurologie. Vol. XI. 1906. No. 22.” The English title suggests that the reviewed article originally appeared in an English journal and indeed, there is an English review of the French translation of Suchanov's lecture: C. L. Allen, review of “Acute Mental Confusion and Its Peculiarities among Russian Soldiers” by Soukhanoff, S., *The Journal of Nervous and Mental Disease* 35, no. 11 (1908): 716.

Judging by the forms of mental illness observed by these Russian authors, Hanabusa concluded that in both armies 1) *manic-depressive insanity* was the most common form. This was followed by 2) *post-traumatic psychoses*, 3) *postinfectious psychoses*, 4) *dementia praecox*, 5) *amentia* (which was more common in the Russian army than in the Japanese), 6) *general paresis*, 7) *epileptic insanity*, 8) *neurasthenia* (which was equally common in the Russian and Japanese armies), 9) *alcoholic insanity* (which was common in the Russian army but rare in the Japanese), 10) *hysteria* (which was as common in wartime as in peacetime), and finally 11) mental illness following *kakke* (which only occurred in the Japanese army and was non-existent in the Russian army).⁸³

The relative frequency of certain forms of mental illness during war as compared to peacetime was important for Hanabusa's evaluation of the role of war in the etiology of these disorders. He identified three different groups of mental disorders. In the first group were those disorders which, according to Hanabusa, occurred equally often both in war and peace (*manic-depressive insanity*, *dementia praecox*, *epileptic insanity*, *hysteria*, *general paresis*, and *imbecility*). The second group comprised disorders which appeared frequently during wartime (*traumatic psychoses* and *infectious psychoses*). The third group was made up of disorders which tended to occur increasingly during wartime (*fright neurosis*, *acquired neurasthenia*, and *congenital neurasthenia*).⁸⁴

The advantage of this division was the implied argument that only disorders which occurred more frequently in wartime could have been caused by the war. Based on this division, Hanabusa argued that, while fright neurosis (*kyōfusei shinkeishō* 恐怖性神経症), which he identified with traumatic neurosis (*gaishōsei noirōze* 外傷性ノイローゼ), was more common during the war, hysteria (*hisuteri kyō* ヒステリー狂) was not, and therefore one could not say that psychoneuroses (*seishinsei shinkeishō* 精神性神経症, i.e. a superordinate category for both disorders) appeared more frequently during the war.⁸⁵ This is a curious line of argument, because theoretically it could just as well be used the other way round: hysteria was not more common in wartime, but fright neurosis was; therefore, one cannot say that the psychoneuroses as a group were less common in wartime. It would thus seem that Hanabusa's intention was not to provide a solid

The actual source used for the review in the *Shinkeigaku zasshi* is unknown, but it was most likely a German review of the American review of the French translation of the Russian article. This long chain of transmission explains why it took three years for Suchanov's article to be reviewed in a Japanese journal.

83 Hanabusa Kenya, "Guntai ni okeru seishinbyō narabi ni sono onkyū shindan ni tsuite," 1982.

84 Hanabusa Kenya, 1983. Hanabusa remarked on *congenital neurasthenia* that it was difficult to obtain reliable statistical results and that therefore some doubts remained concerning this form of mental illness during the war.

85 Hanabusa Kenya, 1984. *Traumatic neurosis* and *hysteria* were not always considered as belonging into the same category. The Berlin neurologist Hermann Oppenheim (1857–1919), who had developed the concept of *traumatic neurosis*, insisted on keeping them separate (Paul Lerner, "From Traumatic Neurosis to Male Hysteria: The Decline and Fall of Hermann Oppenheim, 1889–1919," in Micalé and Lerner, *Traumatic Pasts*, 145).

academically founded argumentation but to exclude the etiological role of the war for as many disorders as possible.⁸⁶

In the problematic case of the psychoneuroses, he ultimately resorted to another line of argumentation. Stating that this kind of disorder was caused by a general disposition (*heiso no soshitsu ni motozuku* 平素ノ素質ニ基ツク) on the part of the patient, he shifted the discussion towards an argument based on a definition of the disorder.⁸⁷ As for other etiological factors, such as “exhaustion” or “lack of sleep,” he maintained that these could merely have an impact on the initial phase of *acquired neurasthenia*. In the end, Hanabusa’s argumentation left “physical trauma” and “infectious diseases” as the only noteworthy etiological factors in war-related mental illness. He finished his discussion on etiology with a quote from Suchanov:

S n c h a n o w 曰ク、日露戦争ニ於ケル不幸ハ決シテ新ラシ
キ精神病ヲ發セザルノミナラズ、亦ソノ發生ヲ極メテ容易ナラ
シムルモノニモアラザルナリト⁸⁸

[Suchanov] says: “Not only did the disaster of the Russo-Japanese War not produce any new psychoses, but it also had merely caused them to become manifest much more easily.”

Hanabusa added that he agreed with this view and, once again evoking the statistical argument, he observed that *manic-depressive insanity* and *catatonia* were also common in peacetime and that, therefore, there was no cogent connection with the war.⁸⁹ Indeed, Suchanov’s testimony seems to support Hanabusa’s view that the war’s impact on mental illness was negligible. It suggests that only ill people were affected and that the war

86 Hanabusa’s discussion of *hysteria* seems even more problematic when it is considered that the illness did virtually not exist as a male affliction outside the context of the military. In non-military institutions it appeared as an almost exclusively female malady. Although the reasons for this strange distribution (also observed in Europe) remain in the dark, there is a parallel between female hysteria and military male hysteria: Both were perceived as an expression of unwarranted selfishness or even egoism. While women were usually expected to suppress their individuality in all situations of ordinary life, this was not expected from men. However, in the military context the male soldier had to subordinate his individuality to the sovereignty of the military. If he failed to do so he was violating the expected social norms and thereby became “eligible” for a *hysteria* diagnosis.

87 Originally, the term *traumatic neurosis* emerged in the context of train and work accidents in Imperial Germany. Oppenheim had defined it as a nervous disorder provoked by a traumatic event that caused minute lesions in the brain and also left the patient psychologically damaged (Lerner, 144–145). However, after *traumatic neurosis* was recognized as a compensable condition by the Imperial Insurance Office in the wake of Bismarck’s accident insurance legislation (1884), it met with serious opposition from all those who feared for Germany’s public health and economic strength (Lerner, 149–150). As a consequence, since the 1890s a new definition was favored that characterized *traumatic neurosis* as a condition that only emerged in constitutionally pre-morbid individuals (Lerner, 152).

88 Hanabusa Kenya, “Guntai ni okeru seishinbyō narabi ni sono onkyū shindan ni tsuite,” 1984.

89 “予モ亦コノ觀察ニ同意スルモノニシテ” (Hanabusa Kenya, 1984).

itself did not cause healthy people to become mentally ill. However, Suchanov's statement had a slightly different meaning in its original context. When he delivered his talk in Moscow, he was contributing to a discussion that had been started by his colleague Martyn Osipovič Šajkevič in 1904. Šajkevič, who—like Suchanov—was treating mentally ill soldiers in a Moscow hospital, had announced that he had been able to identify a special kind of war psychosis.⁹⁰ He had named this newly discovered form of mental illness *amentia depressivo-stuporosa* and had thereby sparked a debate on whether war-specific forms of mental illness actually existed. In this context, Suchanov had repeatedly argued against Šajkevič's view that the war produced distinct kinds of war psychoses.⁹¹ The original Russian version of Hanabusa's quote reads as follows:

Въ общемъ надо сказать, что если нельзя доказать, что *русско-японская война* создала особые психозы, то несомнѣнно, что *она заставила скорѣе обнаружиться психозы у тѣхъ больныхъ, у которыхъ онѣ развились бы рано или поздно, какъ напр., dementia praecox и прогрессивный параличъ.*⁹²

Generally speaking, one must say that whereas it can not be proven that the Russo-Japanese War has created any special psychoses, it is certain that it has caused psychoses to present themselves earlier in those patients who would have developed them sooner or later, such as for example in *dementia praecox* and *general paresis*.

Two aspects had been modified in Hanabusa's version of the quote. In the first sentence, the main difference was between the expressions “new psychoses” and “special psychoses.” Whereas the latter is explicitly referring to the discussion of war-specific psychoses, the former is more ambiguous and may also have conveyed the idea that the war was not able to generate psychoses by itself. The second modification had to do with the

90 Šajkevič, “K voprosu o duševnykh zabolëvaniïch v vojskë v svyazi s japonskoj vojnoj,” 1104.

91 Suchanov had already made this point in an earlier article:

Что касается термина “депрессивно-ступорозный психоз” (“psychosis depressivo-stuporosa”), то съ моей точки зрѣнія онѣ представляеть неудобства. [...] На основаніи своихъ наблюденій я пришелъ къ заключенію, что можно говорить о томъ, что среди психически больныхъ солдатъ встрѣчается весьма много депрессивныхъ формъ; но нельзя сказать, что существуетъ какая-нибудь особая форма душевнаго разстройства (As for the term *psychosis depressivo-stuporosa*, from my point of view it presents certain inconveniences. [...] Based on my observations, I came to the conclusion that it can be said that there are many depressive forms among mentally ill soldiers; but one cannot say that there exists any one particular form of mental illness) (Sergej Alekseevič Suchanov, “O depressivnykh formach duševnago razstrojstva soldat” [On Depressive Forms of Mental Illness in Soldiers], *Ruskij Vrač*, no. 46 [1905]: 1442).

92 Sergej Alekseevič Suchanov, “O duševnykh razstrojstvach v svyazi s russko-japonskoj vojnoj” [On Mental Disorders in Connection with the Russo-Japanese War], *Vračebnaja gazeta*, no. 35 (1907): 970.

scope of the argument expressed in the second sentence. In Suchanov's version, the impact of the war as an accelerating force had been restricted to a limited group of psychoses (those leading to serious mental deterioration). Hanabusa, on the other hand, extended the argument to include other forms of mental illness, such as manic-depressive insanity.

This deviation in meaning can be explained by an examination of the Russian text's transmission process. Hanabusa's quote from Suchanov was copied from a Japanese review published in the *Shinkeigaku zasshi*.⁹³ As we have already seen above, most reviews in this journal were actually translations of German reviews found in journals such as the *Neurologisches Centralblatt* or the *Centralblatt für Psychiatrie und Nervenheilkunde*. Of course, none of the Japanese reviewers had a Russian-language background, but in extension of the questionable translation practice from Russian, their names also appeared with French, German, Italian, English, or Hungarian reviews.

It is safe to assume that the Suchanov "review" had also originally been based on a short German text and was in fact a translation. In the *Shinkeigaku zasshi*, the Japanese entry is supplemented by a German entry which reads: "Suchanow, Psychische Störungen in Verbindungen mit dem russisch-japanischen Kriege. Russisches [sic] Journal für Haut und venerische Krankheiten. April 1907." This entry at first seems to indicate a Russian source, but in fact, no article by Suchanov was ever published or even reviewed in the *Russian Journal for Skin and Venereal Diseases*. Instead, the German translation of the title and the German transliteration of Suchanov's name point to a German source. One review of Suchanov's talk had appeared in the *St. Petersburger medizinische Wochenschrift*; another in the *Ärztliche Sachverständigen Zeitung*.⁹⁴ The text of the latter has a close structural resemblance to the Japanese review.⁹⁵ In that German version, the passage quoted by Hanabusa already contained the modified expression that says that "the war created no *new* psychoses" and also omits the specification of psychoses which, in Suchanov's view, had been affected by the war.⁹⁶ In this case, it makes sense to assume

93 Ujiie Makoto, review of "Nichiro sensō ni kansuru seishin shōge" 日露戦争ニ関關スル精神障礙 [Mental Disorders in Connection with the Russo-Japanese War] by Zuhhyanofu ズツヒヤノフ [Sergej Alekseevič Suchanov], 598.

94 W. Schiele, review of "Ueber psychische Störungen im Zusammenhang mit dem russisch-japanischen Kriege" [On Mental Disorders in Connection with the Russo-Japanese War] by S. Suchanow [Sergej Alekseevič Suchanov], the literature-review section's pages are numbered separately, *St. Petersburger medizinische Wochenschrift* 33 (1908): 12; Miron Lubowski, review of "Zur Frage der psychischen Störungen in Verbindung mit dem russisch-japanischen Kriege" [On the Issue of Mental Disorders in Connection with the Russo-Japanese War] by S. A. Suchanow [Sergej Alekseevič Suchanov], *Ärztliche Sachverständigen-Zeitung* 13, no. 20 (1907): 430.

95 This does not mean that the Japanese reviewers actually consulted the *Ärztliche Sachverständigen Zeitung*. Reviews were often copied and the same text could have been reprinted in some other medical journal available in Tokyo.

96 The whole passage reads: "Suchanow ist der Meinung, daß das Kriegsunglück keine neuen Psychosen geschaffen, sondern deren Manifestwerden bedeutend erleichtert habe [...]" ([Suchanov] believes that the disaster of the war did not produce any new psychoses, but has significantly facilitated their emergence

that the changes in meaning had not been introduced by the Japanese translator but were already present in the German version of the review.

Hanabusa made use of Suchanov's altered and de-contextualized statement to support his own arguments, which seem to have ultimately been guided by the intention to de-emphasize the military's responsibility. His discussion of the etiological role of the war went in the opposite direction to that of Akari, who stressed the role of physical and mental exhaustion. Hanabusa, on the other hand, argued that exhaustion was overrated. He complained that the investigation of other factors, such as "heredity, syphilis, alcohol consumption, and degeneration" was being neglected and that "discussing the granting of pensions solely relying on mental and physical exhaustion was careless" and should be avoided in the future.⁹⁷

Hanabusa's preference for attributing the soldiers' condition to hereditary factors also became clear in another discussion. At the conference where he first presented his statistical research on pensions, the subsequent talk was on the subject of preventing suicide in the army. The speaker reported that the suicide rate in the war year 1905 had been exceptionally high. Whereas the numbers varied between sixty and ninety cases per annum in other years, the army registered 8,089 cases in the second year of the Russo-Japanese War.⁹⁸ As a "preventive measure" (*yobō-hō* 豫防法), the speaker argued for a more careful examination of recruits in order to exclude soldiers with mental debility from the army. Hanabusa made a comment on this talk in which he added that, apart from mental debility, suicides also occurred in cases of manic-depressive insanity and dementia praecox. According to him, 75% to 80% of these cases were hereditary in nature, and if army doctors would carefully investigate the hereditary predisposition in the recruits' families, the majority of the suicides could be "prevented."⁹⁹

Although it is impossible to say with absolute certainty, his ulterior motives might have been influenced by financial concerns. This interpretation is supported by the undeniable fact that his line of argumentation was well suited to reducing military expenses. Additionally, the tendency to favor certain diagnoses and disease concepts for economical reasons was neither a specificity of Japan nor of the handling of the post-Russo-Japanese

[...], see Lubowski, review of "Zur Frage der psychischen Störungen in Verbindung mit dem russisch-japanischen Kriege" [On the Issue of Mental Disorders in Connection with the Russo-Japanese War] by S. A. Suchanow [Sergej Alekseevič Suchanov], 430.

97 「戦時ノ精神病審査上遺傳、黴毒、酒精飲用、變質性格等ノ調査ヲ疎末ニシテ、単ニ戦役ノ心身過勞等ノ故ヲ以テ、恩給ヲ審議スルガ如キハ慎重ナラズ、狀來コレガ調査ノ様式ヲ一定シ置クラ要ス」(Hanabusa Kenya, "Guntai ni okeru seishinbyō narabi ni sono onkyū shindan ni tsuite," 1987).

98 Suganuma Tōichirō, "Guntai ni okeru jisatsu oyobi sono yobō," 1989.

99 Hanabusa Kenya 英健也, comment following Suganuma Tōichirō's talk on Suicide in the Army, *Dai sankai Nihon igakkai shi*, 1911, 1996–1997.

War period. For example, this was also evident in how German doctors approached “traumatized” soldiers at the beginning of World War I.¹⁰⁰

But Hanabusa's insistence on investigating the influence of heredity and degeneration may also indicate the Japanese military's concern to rid the army of supposedly “pernicious” individuals. Before the outbreak of World War I, preventive measures had also been at the core of the German military's discussions of mental illness.¹⁰¹ Indeed, identifying cases of “mental debility” or “psychopathic constitution” was a major concern in German military psychiatry. The incorporation of an intelligence test developed by the psychiatrist Theodor Ziehen into the recruiting system was an important instrument to satisfy the military's needs for quantitative assessments.¹⁰² In Japan, the military doctor Kawashima Keiji 川島慶治 (1869–1951) advocated the introduction of Ziehen's intelligence test into the Japanese recruiting system at around the same time as Hanabusa presented his study on pensions.¹⁰³

Araki and Kure also resorted to existing literature on war psychosis to contextualize their own experience with war-related mental illness within an academic framework. In discussing questions of etiology, one important reference for both Araki and Kure was the official report of the German Ministry of War for the war with France in 1870–71.¹⁰⁴ On the Russian side, the German statistics played an even greater role, as the organization of the mental health services during the Russo-Japanese War was based on Prussian statis-

100 Lerner, “From Traumatic Neurosis to Male Hysteria,” 155. Some doctors did not hesitate to make an explicit connection between a specific diagnosis and its economic consequences. In 1915, one German neurologist referred to “the terrible experiences” caused by the *traumatic neurosis* diagnosis: “Auch in Hinblick auf den enormen wirtschaftlichen Schaden für den Staat ist diese Auffassung nicht nur vom wissenschaftlichen, sondern auch vom praktischen Standpunkt aus abzuweisen” (Considering the enormous economic damage to the state, this conception should be rejected not only for economic, but also for practical reasons) in Alfred Säger, “Über die durch den Krieg bedingten Folgezustände am Nervensystem” [On War-Related Effects on the Nervous System], *Münchener medizinische Wochenschrift*, no. 16 (1915): 567. For a discussion on how economic needs affected pension distribution in Japan during the Asia-Pacific War (1931–1945) see Nakamura Eri 中村江里, “Sensō to seishin shikkan no ‘kōmu kiin’ o meguru seiji: Nihon rikugun ni okeru sensō shinkeishō to shōbyō onkyū ni kansuru kōsatsu o chūshin ni” 戦争と精神疾患の「公務起因」をめぐる政治：日本陸軍における戦争神経症と傷病恩給に関する考察を中心に [The Politics of War and Mental Illness: War Neurosis and Pension in Japan, 1931–1945], *Seishin igakushi kenkyū* 20, no. 1 (2016): 37–41; Eri Nakamura, “Psychiatrists as Gatekeepers of War Expenditure: Diagnosis and Distribution of Military Pensions in Japan during the Asia-Pacific War,” *East Asian Science, Technology and Society* 13, no. 1 (2019): 57–75.

101 Lengwiler, *Zwischen Klinik und Kaserne*, 189.

102 Lengwiler, 205–217. While Ziehen was professor of psychiatry at the Friedrich Wilhelms University in Berlin and director of the Charité (1904–1912), he was simultaneously teaching at the Kaiser Wilhelm Academy for Military Medical Education where he was also member of the Academic Senate (Lengwiler, 199). In 1906–07, Ziehen was dean of the Kaiser Wilhelm Academy (Hermann Schmidt, ed., *Die Kaiser Wilhelms-Akademie für das militärärztliche Bildungswesen von 1895 bis 1910* [The Kaiser-Wilhelm-Academy for Military Medical Education, 1895–1910] [Berlin: E. S. Mittler & Sohn, 1910], 138).

103 Kawashima Keiji, “Shinhei seishin jōtai kensa no yōgi,” 1046.

104 Kriegsministerium, *Erkrankungen des Nervensystems bei den deutschen Heeren 1870–71*.

tics.¹⁰⁵ It was estimated that the percentage of mentally ill soldiers during the war would be 1.5 to 2 times higher than in peacetime.¹⁰⁶ The Russian Red Cross Society, which was charged with the care of the mentally ill, therefore assumed that they would have to make provisions for about 1,500–2,000 mentally ill patients returning from the battlefields in Manchuria.¹⁰⁷

The experience of Russian and Japanese psychiatrists was, in turn, harnessed by French and German military doctors. The psychiatrist Ewald Stier (1874–1962), who advised the German Army in sanitary matters during World War I,¹⁰⁸ stressed the importance of using the knowledge and experience of other nations. In his detailed study on recent psychiatric literature from non-German armies compiled four years before the outbreak of World War I, he argued that the German army should be prepared to deal with neuropsychiatric casualties in wartime. He concluded that, with regard to the usefulness of the works he surveyed,

Unter diesen Erfahrungen der anderen Völker stehen an erster Stelle diejenigen, die die Engländer im Burenkriege, die Amerikaner im spanischen und vor allem diejenigen, die *Rußland* im letzten großen *japanischen* Krieg gemacht hat. Denn wir können wohl annehmen, daß in einem Zukunftskrieg, der uns vielleicht einmal bevorsteht und der naturgemäß auch ein Massenkrieg sein wird, ähnliche Bedingungen für das Auftreten geistiger Krankheiten wie jetzt im Kriege Rußlands, so dann auch für unser Heer bestehen werden.¹⁰⁹

Among the experiences of other countries, those of the British in the Boer War, of the Americans in the Spanish–American War, and especially those of *Russia* in the last great war against *Japan* rank first. For we can assume that in a future war which may lie ahead and which naturally will also be a large-scale war, similar conditions for the emergence of mental illness as those present in Russia's current war will also be prevalent in *our* army.¹¹⁰

105 L. F. Jakubovič, “Psihiatričeskaja pomošč’ na Dal’nem Vostokě v Russko-Japonskiju vojnu (1904–1905 g.)” [Psychiatric Care in the Far East in the Russo-Japanese War (1904–1905)], *Žurnal nevropatologii i psichiatrii imeni S. S. Korsakova* 7, no. 4 (1907): 609–610. Jakubovič further concluded that although the actual numbers obtained during the Russo-Japanese War slightly exceeded those expected, they approximately corresponded with the Prussian statistics.

106 Jakubovič, 597.

107 Avtokratov, “Prizrenie, lečenie i evakuacija duševno-bol’nyh,” 667.

108 Stephanie Neuner, *Politik und Psychiatrie: Die staatliche Versorgung psychisch Kriegsbeschädigter in Deutschland 1920–1939* [Politics and Psychiatry: Government Care for Mentally Ill Victims of the War in Germany 1920–1939], *Kritische Studien zur Geschichtswissenschaft* (Göttingen: Vandenhoeck & Ruprecht, 2011), 209.

109 Stier, “Neuere psychiatrische Arbeiten (Schluß),” 177–178. Stier’s emphasis.

110 This article focused on France, the Balkans, and Russia. As Stier did not know Russian, he could only

Based on the Russian experience, Stier then argued for a series of preventive measures within the German army's organization and made recommendations for the training of medical personnel.¹¹¹ Stier's suggestions and general conclusions regarding the care of the mentally ill in the army were largely echoed by the French physician Charles Vialette (1887–1973), who published a thesis on the topic in 1911.¹¹² A student of the Military Medical School in Lyon (École du service de santé militaire de Lyon) aiming for a medical career in the military, Vialette was naturally concerned with mental hygiene in the French colonies.¹¹³

Apart from a great amount of literature by German, French, and Russian authors, Vialette also consulted Araki's study on mental illness in the Russo-Japanese War, which was available to him in German. He was especially interested in Araki's description of psychotic symptoms following *kakke* (脚氣), which he identified with beriberi, an affliction that Vialette said to be "raging in our colonies in the Far East."¹¹⁴ Another instance in which Araki's text was used as supporting evidence was in Vialette's discussion of the role of exhaustion and overwork in the etiology of psychoses. Vialette argued that, in a time of war, *melancholic states* constituted a major part of the so-called "exhaustion psychoses" (psychoses d'épuisement), and he presented one of Araki's most detailed cases as an example of this condition.¹¹⁵

rely on articles and reviews published in German or French and on verbal communication with some Russian colleagues (Stier, 167; fn. 1). Stier had reviewed the medical literature of many other countries in two earlier articles: For Austria-Hungary, Great Britain, America, Scandinavia, and Holland see Stier, "Neuere psychiatrische Arbeiten." For Spain, Portugal, Italy, and Belgium see Ewald Stier, "Neuere psychiatrische Arbeiten und Tatsachen aus den außerdeutschen Heeren," Fortsetzung [Recent Psychiatric Studies and Facts from Non-German Armies (Continuation)], *Deutsche militärärztliche Zeitschrift* 36, no. 22 (1907): 985–996.

111 For example, he suggested that it was necessary for every military doctor to know the physical signs of degeneration (Stier, "Neuere psychiatrische Arbeiten (Schluß)," 181).

112 Charles Vialette, "Les maladies mentales dans les armées en campagne" (Faculté de médecine et de pharmacie de Lyon, 1911).

113 Stier was also interested in colonial medicine and considered the French literature on the subject to be the most comprehensive (Stier, "Neuere psychiatrische Arbeiten (Schluß)," 179).

114 Vialette, "Les maladies mentales dans les armées en campagne," 49. Araki himself remarked that he was not sure whether *kakke* and beriberi were the same illness (Araki Sōtarō 荒木蒼太郎, "Beobachtung," 643). As to the dispute on the etiology of beriberi, Vialette stated that it was a kind of polyneuritis that according to some was caused by an intoxication through food (spoiled rice), whereas others believed it to be an intoxication through infection. Vialette himself assumed that the affliction was related to Korsakoff's disease (Vialette, "Les maladies mentales dans les armées en campagne," 49). Since the development of nutritional sciences, both beriberi and Korsakoff's syndrome came to be regarded as disorders caused by vitamin deficiency. However, their equation with premodern disease concepts remains problematic, cf. footnote 4 on page 142.

115 Vialette only translated the anamnesis-part of the case history (Vialette, 55–56). It was the case of a young soldier who had become famous for his engagement in a forlorn hope unit (*kesshitai* 決死隊), but later suffered from physical and mental exhaustion and was diagnosed with *melancholia*. See case 36 (23-year-old military engineer) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 159. The German version

Araki's article was easily accessible to European physicians, as it was written in German and appeared in a medical journal that was published in Halle. Moreover, a year after its publication, reviews of the article became available in several widely read European journals, such as the German *Allgemeine Zeitschrift für Psychiatrie*, the *Centralblatt für Nervenheilkunde und Psychiatrie*, and the Russian *Žurnal nevropatologii i psichiatrii*.¹¹⁶ These circumstances ensured that Araki's article would be noticed well beyond Japan at a time when European psychiatrists were looking to other parts of the world to quench their thirst for literature on the topic of war-related mental illness.¹¹⁷

directly relevant for Vialette's translation has some omissions, but it also contains some additional explanations for German readers, see Fall 3 (23 jähriger Pionier) in Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 629–630.

- ¹¹⁶ A short review of Araki's text appeared in the bibliographical section (Literaturheft, "Psychiatrie und Militär," 69*) of the *Allgemeine Zeitschrift für Psychiatrie* for the year 1907 (the pages in the "Literaturheft" are marked with an asterisk setting them apart from those in the journal proper). It was part of a larger review of related works that all dealt with the subject of psychiatry in the military. In the *Zentralblatt für Nervenheilkunde und Psychiatrie*, Araki's article was summarized in a review of the whole volume in which it had appeared, see the "Bibliographie"-section in vol. 31 [October 1908]: 736. There, the reviewer also emphasized Araki's description of psychotic states following *kakke*.

In the *Žurnal nevropatologii i psichiatrii*, Araki's text was reviewed as: Araky, "Iz nabljudenij nad duševnymi i nervnymi zabojevanijami v japonsko-russkuju vojnu 1904–5 gg" in vol. 8 (1908): 350.

- ¹¹⁷ The official sanitary reports of both Russia and Japan (including Kure's contribution) were published many years after the war and therefore received limited attention in Europe that was by then engulfed in World War I. According to a German military doctor, the Russian report "had been awaited for years in vain" (Blau, "Forschungsergebnisse aus dem russischen Militär-Sanitätswesen im kriegsbesetzten Gebiet" [Research Results Concerning Russian Medical Services in the Occupied Territory], *Deutsche militärärztliche Zeitschrift*, 1916, 96). Blau had found the document in the ruins of the captured Russian fortress at Novogeorgievsk (in present day Poland) after the successful German siege in August 1915 and had subsequently published excerpts of it in the *Deutsche militärärztliche Zeitschrift*.

Conclusion

By tracing the gradual displacement of melancholia from psychiatric thought and practice at the turn of the twentieth century, this study has shown that the forces that enabled the disintegration of this concept were the result of an ongoing renegotiation of mental states, the introduction of new forms of observation, and the entanglement of the psychiatric discipline with institutional structures and practical demands.

Examining Japanese psychiatry in the global context has revealed that it was truly global psychiatry, deeply rooted in worldwide psychiatric trends, producing academic discourse comparable to that of Western countries, and reinforcing center–periphery dynamics through its active appropriation and validation of foreign medical theories. However, Japan’s unique institutional framework, with the unquestioned primacy of Tokyo Imperial University and Kure Shūzō’s long-standing influence as the main proponent of Kraepelin’s classification system, created conditions where the disappearance of melancholia became virtually inevitable. The institutional dimension proved crucial for understanding conceptual changes in both countries. In Germany, the emergence of the “great dichotomy” between dementia praecox and manic-depressive insanity resulted from institutional changes and professional struggles within psychiatry. In Japan, the introduction of these conceptual innovations was driven by the Meiji government’s comprehensive modernization project and Professor Kure’s intention to distinguish his teaching from his predecessors.

On a conceptual level, this study has reconstructed Kraepelin’s intellectual debts to contemporary thinkers and highlighted the metaphors that guided concept formation. The dementia praecox concept emerged from combining ideas about adolescence and motor anomalies with theories from experimental psychology, creating an ambiguous framework open to varied interpretations. The empirical methods that accompanied these new concepts both lent prestige to Kraepelin’s classification and, paradoxically, created opportunities to challenge it. Psychometric experiments gave psychiatry the appearance of scientific rigor, producing numbers that appeared to be hard empirical facts despite often being based on very small samples, preconceived ideas, and a crude oversimplification of mental phenomena. This fixation on metrics raises fundamental questions about whether what was measured was truly significant for understanding mental illness. As this study has shown, the psychological experiment introduced a new reductionism into psychiatric evaluation that significantly contributed to the disintegration of older disease concepts such as melancholia.

Through examination of the theories proposed by Araki Sōtarō, Kadowaki Masae, and Matsubara Saburō, this study has demonstrated how associationist theory provided the conceptual foundation that enabled the renegotiation of mental states. While Araki and Kadowaki offered modest critiques of Kraepelin's system, Matsubara developed a more radical approach after studying under Adolf Meyer in the United States. His distinction between pure depression and alternating types is more in line with later psychiatric distinctions between unipolar depression and bipolar disorder, challenging Kraepelin's risk-management-oriented system that prioritized separating curable from incurable conditions. The multilingual approach employed in this study has illuminated the complex interplay between translation, adoption, and appropriation of foreign concepts. The ambiguous indigenous concept of *utsu/fusagu* (鬱) played a crucial role in accommodating various melancholia concepts within Japanese language and thought while making the conceptual shift less visible in Japan than in Europe. As the term could encompass both the emotional dimension of melancholia and the physiological dimension of "depression," the conceptual change from melancholia to manic-depressive insanity did not require a morphological change of vocabulary in Japanese contexts.

In the second part of this book, the examination of diagnostic practices during the Russo-Japanese War revealed how changes in observing and documenting mental phenomena fundamentally altered doctors' perceptions. Close analysis of case records documented by Araki and Kure demonstrated how diagnoses of melancholia were systematically deconstructed and replaced with alternative categories by reinterpreting patient behaviors and symptoms. These transformations were not merely terminological—they involved profound shifts in what was considered medically significant, achieved through structural and stylistic modifications in case documentation that emphasized certain phenomena while marginalizing others. Contrary to expectations that conceptual changes resulted primarily from new understandings of mood or affect, this study has demonstrated that the most significant changes occurred in what contemporaries identified as the "sphere of volition." The introduction and naturalization of new signs related to movement, posture, and response to the clinical environment (conceptualized as revealing dysfunctions in volition) fundamentally altered the landscape of psychiatric diagnosis. The comparison between Araki's and Kure's diagnostic approaches revealed how these signs, insignificant under associationist frameworks (favored by Araki), assumed the status of objectively observable symptoms in the emerging Kraepelinian paradigm, contributing decisively to the disintegration of melancholia as a viable diagnostic category.

Another major difference in their diagnostic approaches concerned the assessment of established symptoms like delusions and hallucinations. Kure's threshold for identifying delusions was much lower than Araki's, affecting not only diagnosis choices but also perceptions of sanity. While Araki distinguished between self-centered and outwardly-directed ideas to differentiate mania and melancholia, Kure's approach in-

volved judgments about rationality, distinguishing between “rational” and “irrational” or “silly” delusions. Significantly, symptoms in the spheres of affect or cognition played minimal roles in both the disintegration of melancholia and the distinction between manic-depressive insanity and dementia praecox. In practical terms, Kure’s definition of manic-depressive insanity rested upon the absence of signs indicating volitional dysfunction. As these signs were common, he identified substantially more cases of dementia praecox (49%) than manic-depressive insanity (16%) among war patients—a striking difference given the relatively homogeneous patient population of military men.

The war context further illuminated how institutional demands shaped diagnostic practices, particularly in relation to pension eligibility. Military doctor Hanabusa’s preference for attributing soldiers’ mental conditions to hereditary factors rather than war experiences served to minimize financial compensation. His statistical research and arguments about preventing suicides through identifying hereditary predispositions aligned with economic incentives to reduce military expenses. This tendency to favor certain diagnoses for economic reasons was not unique to Japan—similar patterns emerged in German approaches to traumatized soldiers at the beginning of World War I. The experience of Russian and Japanese psychiatrists during the Russo-Japanese War had far-reaching impacts, informing subsequent military psychiatric preparations in Europe. German psychiatrist Ewald Stier explicitly acknowledged the value of Russian experiences in this conflict when advising the German Army before World War I, while French physician Charles Vialette incorporated Araki’s findings into his work on mental hygiene in French colonies. Araki’s research on war-related mental illness, published in German and reviewed in multiple European journals, circulated internationally at a time when European psychiatrists were increasingly concerned with psychiatric casualties in warfare.

This study has significant implications for how we understand the evolution of psychiatric knowledge and practice. It challenges the often-teleological narratives of psychiatric progress by revealing the complex interplay of institutional, social, and theoretical factors that shaped diagnostic categories. Rather than representing straightforward scientific advancement, the displacement of melancholia emerged from multifaceted negotiations between competing frameworks and practical demands. This research demonstrates the value of approaching psychiatric history through a global lens while remaining attentive to local specificities. The Japanese case reveals how psychiatric knowledge was not simply “transferred” from West to East but was actively reinterpreted and transformed within specific institutional contexts. This perspective helps dismantle simplistic center-periphery models of knowledge dissemination and highlights the agency of Japanese psychiatrists as active participants in global scientific discourse.

By focusing on a concept that disappeared rather than one that emerged, this study illuminates processes of knowledge transformation that often remain invisible in conventional histories of psychiatry. The disintegration of melancholia shows how established ways of understanding mental suffering can become unintelligible when the conceptual

frameworks that supported them are reconfigured. This process reveals the historical contingency of psychiatric categories that we might otherwise take for granted. The examination of diagnostic practices during wartime reveals the profound entanglement between psychiatric knowledge and broader social, economic, and military concerns. The reclassification of war-related mental distress as congenital rather than acquired had immediate consequences for patients' lives, affecting their access to compensation and treatment. This finding underscores the material and ethical stakes of psychiatric categorization beyond purely theoretical concerns.

The focus on what contemporaries identified as the "sphere of volition" as the site of major conceptual transformation challenges conventional narratives about the development of modern psychiatric categories. Rather than emphasizing changes in the understanding of affect or cognition, this research highlights how shifts in the conceptualization of observable bodily phenomena—slowed speech and movements, levels of cooperation, resistance to examination, and physical responses to the clinical environment—fundamentally altered the landscape of psychiatric diagnosis. These aspects of patient behavior, which were reinterpreted and given new diagnostic significance under Kraepelin's system, played a crucial role in displacing earlier disease concepts like melancholia. This insight invites reconsideration of how we narrate the emergence of twentieth-century psychiatric frameworks.

Additionally, this study contributes to a more nuanced understanding of Kraepelin's role in psychiatric history. By contextualizing his work within broader institutional and theoretical currents and examining contemporary responses to his classification system, this research moves beyond retrospective interpretations that either elevate or diminish Kraepelin's significance based on present-day psychiatric concerns. Instead, it situates Kraepelin within the intellectual and institutional landscape of his own time, examining how his ideas resonated with contemporaries, how they were challenged by rivals, and how they functioned within the scientific standards and professional realities of nineteenth-century psychiatry. This approach reveals Kraepelin as one important node in a complex network of psychiatric theory and practice whose influence took shape through specific historical conditions, institutional frameworks, and local adaptations.

Beyond its contributions to psychiatric history specifically, this research speaks to broader questions in the history of medicine, science, and knowledge. It exemplifies how concepts that once structured understanding and practice can vanish not through direct refutation but through shifts in the underlying conditions that made them intelligible. This process of conceptual disappearance differs from the familiar pattern of scientific revolution in which new theories explicitly challenge and replace older ones. The case of melancholia's displacement also highlights the importance of institutional structures in shaping scientific knowledge. Universities, hospitals, military organizations, and pension systems all played crucial roles in determining which psychiatric concepts would thrive and which would fade. This institutional dimension reminds us that scientific knowledge

emerges not from disembodied rational processes but from specific social arrangements with their own internal logics and pressures.

This study demonstrates the value of approaching the history of medicine from multiple linguistic and cultural perspectives. By working with source materials in German, English, French, Russian, and Japanese, this research has recovered connections and influences that would remain invisible in monolingual accounts. This multilingual approach reveals how psychiatric concepts circulated globally while being transformed through processes of translation and local adaptation. The examination of the Russo-Japanese War's impact on psychiatric practice also contributes to our understanding of how warfare shapes medical knowledge. As one of the first major conflicts in which modern psychiatric perspectives were systematically applied to combatants, this war represented a crucial moment in the development of military psychiatry. The lessons drawn from this experience would inform approaches to psychological casualties in subsequent conflicts, demonstrating how wartime demands drive innovation in medical theory and practice.

This research speaks to enduring questions about the relationship between psychiatric categories and human experience. As melancholia disappeared and was replaced by new diagnostic frameworks, the ways in which suffering could be articulated and recognized were fundamentally altered. This transformation reminds us that psychiatric categories are not simply neutral descriptions of natural phenomena but powerful frameworks that shape how distress is understood, communicated, and addressed.

The displacement of melancholia and the conceptual transformations examined in this study connect to numerous topics that merit further investigation. Readers interested in extending their understanding of these issues might explore several related areas. The heredity-based understandings of mental disorders that gained prominence in this period were closely linked to the rise of eugenics movements globally. Further research might examine how psychiatric concepts of heredity and degeneration informed eugenic policies in Japan and elsewhere, particularly as these ideas gained institutional support in the early twentieth century. The connections between Kraepelinian psychiatry and eugenic thought deserve special attention, as they helped legitimize interventions ranging from marriage restrictions to sterilization programs.¹ This trajectory reached its horrific culmination in the euthanasia of mentally ill patients in Nazi institutions, where those diagnosed with "incurable" conditions were systematically murdered under the guise of

1 Volker Roelcke, "Programm und Praxis der psychiatrischen Genetik an der Deutschen Forschungsanstalt für Psychiatrie unter Ernst Rüdin: Zum Verhältnis von Wissenschaft, Politik und Rasse-Begriff vor und nach 1933" [Program and Practice of Psychiatric Genetics at the German Research Institute for Psychiatry under Ernst Rüdin: On the Relationship between Science, Politics and the Concept of Race before and after 1933], *Medizinhistorisches Journal* 37, no. 1 (2002): 21–55; Sumiko Otsubo and James R. Bartholomew, "Eugenics in Japan: Some Ironies of Modernity, 1883–1945," *Science in Context* 11, nos. 3–4 (1998): 545–565; Yoko Matsubara, "The Reception of Mendelism in Japan: 1900–1920," *Historia Scientiarum* 13, no. 3 (2004): 232–240.

medical judgment.² Particularly significant is the role played by Ernst Rüdin (1874–1952), Kraepelin’s colleague at the German Research Institute for Psychiatry, whose work represents a direct link between psychiatric theories of hereditary mental illness and later Nazi racial hygiene policies.³ The abject human trials conducted by both German and Japanese medical researchers in the decades following the period examined in this study represent another dark legacy of psychiatric categorization. The classification of certain individuals as inherently defective or inferior created conditions where their mistreatment could be justified in the name of scientific advancement.⁴ Understanding the conceptual foundations of these practices helps illuminate how medical knowledge can be weaponized when divorced from ethical considerations.

The evolution of diagnostic tools and experimental methods represents a critical area for further investigation. This study has touched on how changing approaches to observation and documentation transformed the diagnosis of mental illness, but a more comprehensive examination of diagnostic technologies would significantly enhance our understanding of psychiatric practice. From early rating scales and questionnaires to projective tests, brain imaging technologies, and contemporary digital assessment tools, the instruments of psychiatric diagnosis have continuously shaped what can be observed, measured, and categorized.⁵ Research might explore how psychological experimentation continued to influence psychiatric categorization throughout the twentieth century, particularly as new technologies for measuring brain function became available.⁶ The relationship between these diagnostic technologies and the conceptual frameworks they both serve and modify deserves deeper exploration, as representational practices involved in visualizing the brain and mind have transformed not only scientific understanding but also

2 Michael Burleigh, *Death and Deliverance: “Euthanasia” in Germany c.1900–1945* (Cambridge: Cambridge University Press, 1994); Hans-Walter Schmuhl, *Rassenhygiene, Nationalsozialismus, Euthanasie: Von der Verhütung zur Vernichtung “lebensunwerten Lebens”, 1890–1945* [Racial Hygiene, National Socialism, Euthanasia: From Prevention to Destruction of “Life Unworthy of Life”, 1890–1945] (Göttingen: Vandenhoeck & Ruprecht, 1987); Maike Rotzoll et al., eds., *Die nationalsozialistische “Euthanasie”. Aktion “T 4” und ihre Opfer: Geschichte und ethische Konsequenzen für die Gegenwart* [The National Socialist “Euthanasia” campaign Aktion “T4” and its Victims: History and Ethical Consequences for the Present] (Paderborn: Ferdinand Schöningh, 2010).

3 Volker Roelcke, “Ernst Rüdin: Renommierter Wissenschaftler, radikaler Rassenhygieniker” [Ernst Rüdin: Renowned Scientist, Radical Racial Hygienist], *Der Nervenarzt* 83, no. 3 (2012): 303–310.

4 George J. Annas and Michael A. Grodin, *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation* (New York: Oxford University Press, 1992); Takashi Tsuchiya, “The Imperial Japanese Experiments in China,” in *The Oxford Textbook of Clinical Research Ethics*, ed. Ezekiel J. Emanuel et al. (Oxford: Oxford University Press, 2008), 31–45.

5 Joseph Dumit, *Picturing Personhood: Brain Scans and Biomedical Identity* (Princeton: Princeton University Press, 2004); Kelly A. Joyce, *Magnetic Appeal: MRI and the Myth of Transparency* (Ithaca: Cornell University Press, 2008).

6 Schmidgen, *Hirn und Zeit*; Cateelijne Coopmans et al., eds., *Representation in scientific practice revisited* (2014).

cultural conceptions of selfhood and mental illness.⁷ Particularly relevant would be research examining how diagnostic tools mediate between theoretical constructs and clinical observations, potentially reinforcing certain diagnostic categories while making others less visible. The historical development of diagnostic manuals—from early classification attempts to the standardized systems of today—also warrants investigation, these manuals being both products and producers of changing psychiatric knowledge. The shift toward computational psychiatry and digital phenotyping represents the latest chapter in psychiatry’s ongoing engagement with experimental methods and measurement.⁸ These developments echo the earlier transformations documented in this study, as new technologies continue to shape which aspects of mental experience become visible to clinical observation and which recede from clinical attention.

While this study has focused on the Russo-Japanese War, comparative research across different conflicts would illuminate how understandings of war-related mental distress have evolved over time. The conceptualization of mental-health consequences of warfare shows interesting parallels across different historical periods, from the responses observed during the Russo-Japanese War to conditions later described as “shell shock” in World War I, “combat fatigue” in World War II, and more recent formulations such as “post-traumatic stress disorder.”⁹ Each war and historical period has brought its own distinct characteristics to psychiatric thought, reflecting contemporaneous understandings of mental health, stress, and trauma. The question of compensation and treatment for veterans with mental health conditions remains a critical issue deserving further historical investigation. The tension between providing support for those suffering mental distress and managing financial liabilities continues to influence psychiatric practice and policy today.¹⁰

The transformation of psychiatric concepts examined in this study had significant implications for forensic practice and legal determinations of responsibility. Further research might examine how the decline of melancholia and the rise of new diagnostic cate-

7 Anne Beaulieu, “Images Are Not the (Only) Truth: Brain Mapping, Visual Knowledge, and Iconoclasm,” *Science, Technology, and Human Values* 27, no. 1 (2002): 53–86; Simon Cohn, “Making Objective Facts from Intimate Relations: The Case of Neuroscience and Its Entanglements with Volunteers,” *History of the Human Sciences* 21, no. 4 (2008): 86–103.

8 Kit Huckvale, Svetha Venkatesh, and Helen Christensen, “Toward Clinical Digital Phenotyping: A Timely Opportunity to Consider Purpose, Quality, and Safety,” *Nature Partner Journals Digital Medicine* 2 (2019): 1–11.

9 Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Hove: Psychology Press, 2005); Paul Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890–1930* (Ithaca: Cornell University Press, 2003).

10 Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (New York: Palgrave, 2002); Beth Linker, *War’s Waste: Rehabilitation in World War I America* (Chicago: University of Chicago Press, 2011); David A. Gerber, ed., *Disabled Veterans in History*, Revised and enlarged edition (Ann Arbor: University of Michigan Press, 2012).

gories altered assessments of criminal responsibility and competency.¹¹ The Kraepelinian approach of lowering the threshold for psychiatric intervention—admitting patients at earlier stages of illness to observe the full disease course—finds a parallel in later developments of preventive detention practices. Just as psychiatrists expanded their domain to include milder or early-stage mental conditions, legal systems increasingly incorporated psychiatric expertise to identify and detain individuals showing early signs of potentially dangerous psychopathology.¹² This expansion of psychiatric authority across both clinical and legal domains warrants deeper examination, particularly in the Japanese context, where these changes intersected with rapidly evolving legal and institutional frameworks.¹³

The complex processes of translation, adaptation, and transformation evident in the Japanese engagement with European psychiatric concepts invite further comparative research. Studies examining similar processes in other non-Western contexts would enhance our understanding of how psychiatric knowledge circulates globally while being transformed through local practice. Such research would help us move beyond simplistic models of diffusion toward more nuanced accounts of transcultural exchange. Finally, further research on Asian contributions to psychiatric knowledge would help correct persistent Eurocentric biases in the history of medicine. The active engagement of Japanese psychiatrists with global scientific discourse demonstrated in this study suggests the value of investigating other Asian contexts where psychiatric knowledge was not merely imported but actively transformed and developed. Such research would contribute to a more balanced understanding of psychiatry as a truly global enterprise shaped by diverse cultural traditions.¹⁴

This study has demonstrated that the history of psychiatric concepts cannot be adequately captured through teleological narratives of inevitable progress. The disappearance of melancholia was not simply a matter of scientific advancement but emerged from complex interactions between institutional structures, theoretical developments, and practical demands. By recovering these multilayered processes and diverse voices, we gain a more nuanced understanding of how psychiatric knowledge evolves and the profound consequences these conceptual shifts have for those diagnosed and treated within changing frameworks of understanding.

11 Katherine D. Watson, *Forensic Medicine in Western Society: A History* (London: Routledge, 2011); Richard F. Wetzell, *Inventing the Criminal: A History of German Criminology, 1880–1945* (Chapel Hill: University of North Carolina Press, 2000).

12 Richard F. Wetzell, “Psychiatry and Criminal Justice in Modern Germany, 1880–1933,” *Journal of European Studies* 39, no. 3 (2009): 270–289.

13 Yoji Nakatani, “Psychiatry and the Law in Japan: History and Current Topics,” *International Journal of Law and Psychiatry* 23, nos. 5–6 (2000): 589–604.

14 Harry Yi-Jui Wu, *Mad by the Millions: Mental Disorders and the Early Years of the World Health Organization* (Cambridge: MIT Press, 2021).

Appendix

Concordance of Patient Case Histories

The following table is an inventory of the case histories that are mentioned in the text. The case histories are ordered by patient's name if they are known; otherwise, they follow the sequence of case histories in the Japanese version of Araki's article.¹⁵

¹⁵ In the table header, “Araki JAP” refers to Japanese version of Araki's article (Araki Sōtarō, “Seneki ni insuru seishinbyō ni tsukite”), “Araki GER” to the German version of his article (Araki Sōtarō 荒木蒼太郎, “Beobachtungen”), and “Kure” refers to Kure Shūzō, “Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite.”

Concordance of patients' files

Patient Name	Araki JAP	Araki GER	Kure
Akiyuki 秋元	Case 19 (23-year-old transport soldier) 第十九例二十三歳輸卒 p. 153		Case 36 (transport soldier Akiyuki of the transport unit [peasant], born February 1883) 第三十六例輜重輸卒 (農) 秋元某明治十六年二月生 pp. 101–102
Chiba 千葉			Case 16 (first-class soldier Chiba of the infantry corps of the reserve army, born July 1874) 第十六例後備歩兵一等卒千葉某明治七年七月生 pp. 79–80
Hamada 濱田			Case 48 (superior soldier Hamada of the corps of engineers, born 1883) 第四十八例工兵上等兵濱田某明治十六年生 pp. 120–121
Hibara 檜原	Case 27 (25-year-old transport soldier) 第二十七例二十五歳輸卒 p. 156		Case 38 (transport soldier Hibara [peasant], born May 1881) 第三十八例輸卒 (農) 檜原某明治十四年五月生 pp. 102–103
Kawanabe 川鍋			Case 30 (transport soldier Kawanabe [peasant], born May 1882) 第三十例輸卒 (農) 川鍋某明治十五年四月生 p. 98

Concordance of patients' files (continued)

Patient Name	Araki JAP	Araki GER	Kure
Kibashi 木橋			Case 41 (corporal Kibashi [train conductor] of the corps of engineers, born January 1880) 第四十一例工兵伍長（鐵道車掌）木橋某明治十二年一月生 p. 104
Kobayashi 小林	Case 194 (25-year-old transport soldier) 第百九十四例二十五歳輸卒 p. 214	Case 86 (25-year-old transport soldier) Fall 86 (25 jähriger Trainknecht) p. 666	Case 55 (transport soldier Kobayashi [peasant] of the transport unit, born January 1882) 第五十五例輜重輸卒（農）小林某明治十五年一月生 p. 137
Kobayashi 小林			Case 23 (second-class soldier Kobayashi [teacher] of the infantry corps of the conscript reserve, born May 1884) 第二十三例補充歩兵二等卒（教員）小林某明治十七年五月生 p. 83
Miyako 宮古	Case 29 (38-year-old infantry soldier) 第二十九例三十八歳歩兵 pp. 156–157	Case 64 (38-year-old infantry soldier) Fall 64 (38 jähriger Infanterist) p. 656	Case 17 (first-class soldier Miyako [fisher] of the infantry corps of the reserve army, born February 1868) 第十七例後備歩兵一等卒（漁業）宮古某明治元年二月生 p. 80

Concordance of patients' files (continued)

Patient Name	Araki JAP	Araki GER	Kure
Nakatsuji 中辻	Case 74 (27-year-old officer's batman) 第七十四例二十七歳馬卒 pp. 171-172	Case 9 (27-year-old officer's batman) Fall 9 (27 jähriger Pferdeknecht) p. 631	Case 12 (officer's batman Nakatsuji [telegraph construction worker], born 1879) 第十二例馬卒 (電信工夫) 中辻某明治十二年生 pp. 76-77
Ono 小野	Case 39 (22-year-old transport soldier) 第三十九例二十二歳輸卒 p. 160		Case 26 (auxiliary transport soldier Ono [peasant], born March 1884) 第二十六例補助輸卒 (農業) 小野某明治十七年三月生 pp. 84-85
Satō 佐藤	Case 31 (31-year-old military engineer) 第三十一例三十一歳工兵 p. 157	Case 65 (31-year-old military engineer) Fall 65 (31 jähriger Pionier) pp. 656-657	Case 28 (first-class soldier Satō of the corps of engineers of the reserve army, born July 1876) 第二十八例後備工兵一等卒佐藤某明治九年七月生 pp. 85-86
Sutō 須藤	Case 79 (32-year-old non-commissioned officer of the artillery) 第七十九例三十三歳砲兵下士 pp. 173-174		Case 29 (sergeant-major Sutō [government official] of the artillery corps, born January 1873) 第二十九例砲兵曹長 (官吏) 須藤某明治六年一月生 p. 86
Uchida 内田	Case 50 (22-year-old transport soldier) 第五十例二十二歳輸卒 p. 164		Case 32 (transport soldier Uchida [miner] of the transport unit, born May 1884) 第三十二例輜重輸卒 (坑夫) 内田某明治十七年五月生 p. 99

Concordance of patients' files (continued)

Patient Name	Araki JAP	Araki GER	Kure
	Case 36 (23-year-old military engineer) 第三十六例二十三歳工兵 p. 159	Case 3 (23-year-old military engineer) Fall 3 (23 jähriger Pionier) pp. 629–630	
	Case 40 (30-year old infantry soldier) 第四十例三十歳歩兵 p. 160		
	Case 41 (26-year-old transport soldier) 第四十一例二十六歳輸卒 p. 161	Case 4 (26-year-old transport soldier) Fall 4 (26 jähriger Trainknecht) p. 630	
	Case 42 (28-year-old infantry soldier) 第四十二例二十八歳歩兵 p. 161		
	Case 56 (22-year-old infantry soldier) 第五十六例二十二歳歩兵 pp. 165–166		
	Case 75 (23-year-old infantry soldier) 第七十五例二十三歳歩兵 p. 172	Case 74 (23-year-old infantry soldier) Fall 74 (23 jähriger Infanterist) p. 660	

Concordance of patients' files (continued)

Patient Name	Araki JAP	Araki GER	Kure
	Case 132 (28-year-old infantry soldier) 第百三十二例二十八歳歩兵 p. 191	Case 20 (28-year-old infantry soldier) Fall 20 (28 jähriger Infaterist) pp. 635–636	
	Case 182 (21-year-old infantry soldier) 第百八十二例二十一歳歩兵 p. 210	Case 88 (21-year-old infantry soldier) Fall 88 (21 jähriger Infanterist) p. 667	

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Figure 1.1 *Neue Zeitschrift für Metapsychiatrie* [New Journal for Metapsychiatry], 1896, p. 8. Max-Planck-Institut für Psychiatrie MPIP HA K 31/12.

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Figure 1.3 Diagram adapted from Okada Yasuo 岡田靖雄, *Nihon seishinka iryōshi* 日本精神科医療史 [The History of Psychiatry in Japan] (Tōkyō: Igaku shoin, 2002), 169.

Figure 3.1 Emil Kraepelin, *Klinische Psychiatrie* [Clinical Psychiatry], vol. 2 of *Psychiatrie: Ein Lehrbuch für Studierende und Aerzte*, 6th ed. (Leipzig: Verlag von Johann Ambrosius Barth, 1899), 373.

Figure 3.2 Adolf Gross, “Untersuchungen über die Schrift Gesunder und Geisteskranker” [Examination of the Writing of the Healthy and the Insane], in Kraepelin, *Psychologische Arbeiten*, 2:453.

Figure 3.3 Adolf Gross, “Untersuchungen über die Schrift Gesunder und Geisteskranker” [Examination of the Writing of the Healthy and the Insane], in Kraepelin, *Psychologische Arbeiten*, vol. 2, Plate IV.

Figure 3.4 Adolf Gross, “Untersuchungen über die Schrift Gesunder und Geisteskranker” [Examination of the Writing of the Healthy and the Insane], in Kraepelin, *Psychologische Arbeiten*, vol. 2, Plate VI.

Figure 3.5 Diagram adapted from Kure Shūzō 呉秀三, “Utsuyū jōtai” 鬱憂状態 [Depressed States], *Iji shinbun* 620 (1902): between pages 1249 and 1250.

Figure 4.1 Araki Sōtarō 荒木蒼太郎, “Kyōshitsu no ruibetsu” 狂疾ノ類別 [Classification of Mental Disorders], *Igaku chūō zasshi*, no. 34 (1905): 1078. National Diet Library Digital Collections.

Figure 4.2 Kadowaki Masae 門脇眞枝, “Tōron” 討論 [Discussion], *Igaku chūō zasshi*, no. 34 (1905): 1078. National Diet Library Digital Collections.

Figure 5.1 Map created with QGIS software using *Natural Earth* vector map data and *OpenStreetMap* data. It is based on the Liaodong Peninsula section depicted in “Sketch Map of the Theatre of War,” 1904 published in General Staff, War Office, ed., *The Russo-Japanese War: Medical and Sanitary Reports from Officers Attached to the Japanese and Russian Forces in the Field* (London: Printed for His Majesty’s Stationery Office, by Eyre / Spottiswoode, 1908).

Figure 5.2 Detail of “Sketch Map of the Theatre of War,” 1904 published in General Staff, War Office, ed., *The Russo-Japanese War: Medical and Sanitary Reports from Officers Attached to the Japanese and Russian Forces in the Field* (London: Printed for His Majesty’s Stationery Office, by Eyre / Spottiswoode, 1908). Public Domain. Wellcome Collection.

Figure 6.1 Richard Harding Davis et al., eds., *The Russo-Japanese War: A Photographic and Descriptive Review of the Great Conflict in the Far East*, Gathered from the Reports, Records, Cable Despatches, Photographs, Etc., Etc., of Collier’s War Correspondents (New York: P. F. Collier & Son, 1905), 106. Library of Congress, Meeting of Frontiers.

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Negotiating States of Mind examines melancholia's demise as a scientific concept, tracing the conceptual changes that transformed psychiatric thinking in the late nineteenth century. Focusing on Meiji Japan's adaptation of European psychiatric concepts and diagnostic practices, this global intellectual history highlights how social hierarchies, institutional pressures, and quantitative methods shaped our understanding of mental illness. Through detailed case studies of mentally impaired soldiers from the Russo-Japanese War (1904–05), it investigates the impact of diagnostic changes on disability pension decisions, revealing real-world effects of conceptual change.

