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.

Jaskov, Helena: Negotiating States of Mind: The Transformation of Psychiatric Knowledge in Imperial Germany and Meiji Japan, Heidelberg: Heidelberg University Publishing, 2025. https://doi.org/10.17885/heiup.1244

(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.

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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 XXe 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-Zaitsu, *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 樫田五郎 and Kure Shūzō 呉秀三, *Seishinbyōsha shitaku kanchi no jikkyō oyobi sono tōkei-teki kansatsu* 精神病者私宅監置ノ実況及ビ其統計的觀察 [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 psichiatrii v Japonii" [On Psychiatry in Japan], *Obozrěnïe psichiatrii, nevrologii i ėksperimental'noj psichologii* 11 (April 1906): 260–268. The German version was soon after translated into Japanese: Wilhelm Stieda, "Nihon no seishinbyōgaku" 日本ノ精神病學, trans. s. n., *Shinkeigaku zasshi* 5, no. 7 (1906): 31–44.

23 Stieda, "O psichiatrii 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 Brennsohn, *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 Brennsohn, 381). In his article on Japan he referred to the St. Petersburg hospital as one representative of "our European public hospitals" (Stieda, "O psichiatrii 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 psichiatrii 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 ryōhō* 寝臺療法) 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 slaboumïi (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 (*Auffasungsfähigkeit*), 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 Studirende 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 Studirende 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* 新撰精神病學), 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* 精神病學集要), 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* 精神病學), 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 Studirende,* 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 (*sōhatsu chikyō* 早發痴狂) 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 seishinbyūgaku* no daiichiban kara daikuban made—sono naiyō no hensen" 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* 内科秘錄) 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 Studirende 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]

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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 Hebephrenie: Ein Beitrag zur klinischen Psychiatrie" [Hepephrenia: 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 Hebephrenie," 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 (*unmotivierte Redewiederholung, unmotiviertes Lachen*).[64] It also contained contrasting de-

derts [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 Gemüthserkrankung" [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 Gruppirung 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ちず、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ろ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" 發揚状態 [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 (*Zerreißung*) 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.