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.

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

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 [Chīhen チーヘン], *Seiriteki shinrigaku* 生理的心理学 [Physiological Psychology], trans. from the German by Matsumoto Kōjirō 松本孝次郎 (Tōkyō: Seibidō, 1901); Theodor Ziehen [Zigen, Teodor], *Fiziologičeskaja psichologija v 15 lekzijach* [Physiological Psychology in 15 Lessons], trans. from the German by Vladimir Dinze (St. Peterburg: Izdanïe 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 Instanity], *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 Studirende* [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]

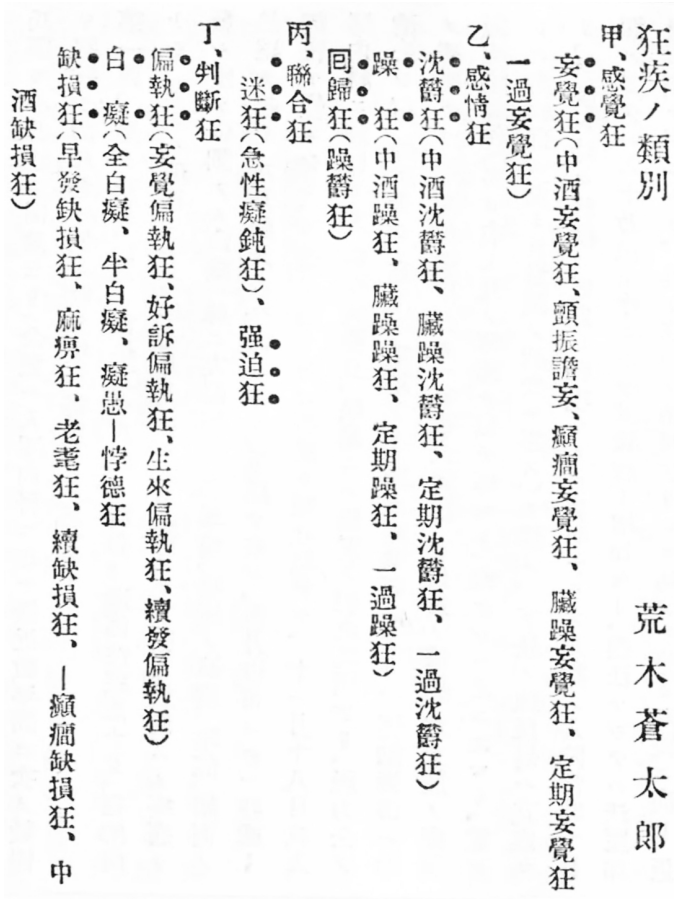
The original outline of Araki's classification in Figure 4.1 shows a basic division into four main categories, marked as A (*kō* 甲), B (*otsu* 乙), C (*hei* 丙), and D (*tei* 丁). Without knowledge of the associationist theory, the meaning of these four categories does not become readily apparent, but the 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* 感覺)—usually caused by an external stimulus (*gairai shigeki* 外来刺戟)—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* 觀念), which can reproduce an idea that is similar to the original idea in content (*sōji kannen* 相似觀念) or an idea with which it has already appeared simultaneously (*dōji ni kannen shōjitaru kannen* 同時ニ生シタル觀念). 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" 戰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


狂疾ノ類別

荒木蒼太郎

甲、感覺狂

妄覺狂（中酒妄覺狂、顚振譫妄、癲癇妄覺狂、臟躁妄覺狂、定期妄覺狂

一過妄覺狂）

乙、感情狂

沈欝狂（中酒沈欝狂、臟躁沈欝狂、定期沈欝狂、一過沈欝狂）

躁　狂（中酒躁狂、臟躁躁狂、定期躁狂、一過躁狂）

回歸狂（躁欝狂）

丙、聯合狂

迷狂（急性癡鈍狂）、强迫狂

丁、判斷狂

偏執狂（妄覺偏執狂、好訴偏執狂、生來偏執狂、續發偏執狂）

白　癡（全白癡、半白癡、癡愚—悖德狂

缺損狂（早發缺損狂、麻痺狂、老耄狂、續缺損狂、—癲癇缺損狂、中酒缺損狂）

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 judgement	Paranoia	Hallucinatory paranoia Querulent paranoia Congenital paranoia Secundary paranoia
	Idiotism	Idiocy Imbecility Debility (moral insanity)
	Dementia	Dementia praecox Dementia paralytica Senile dementia Secondary dementia (epileptic dementia, alcoholic dementia)
Insanity of association	Stuporous insanity	Acute stupidity
	Compulsive insanity	
Insanity of intellectual feeling	Melancholia	Alcoholic melancholia Hysteric melacholia Periodic melancholia Transitory melancholia
	Mania	Alcoholic mania Hysteric mania Periodic mania Transitory mania
	Circular insanity	Manic-melancholic insanity
Insanity of sensation	Hallucinatory insanity	Alcoholic hallucinatory insanity Delirium tremens Epileptic hallucinatory insanity Hysteric hallucinatory insanity Periodic hallucinatory insanity Transitory hallucinatory 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 (*handankyō* 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 misguiding] 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* 實地ニ當ッテ善イ) 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* 夢寐状態) 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, disscussion following Araki Sōtarō's talk on Classification, 34–35.

28 Kadowaki Masae, 35.

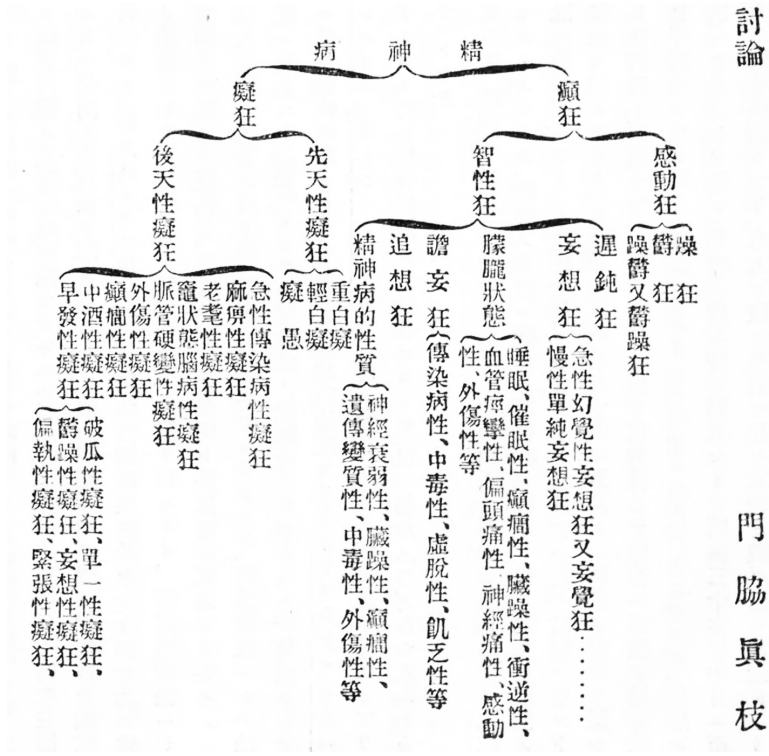


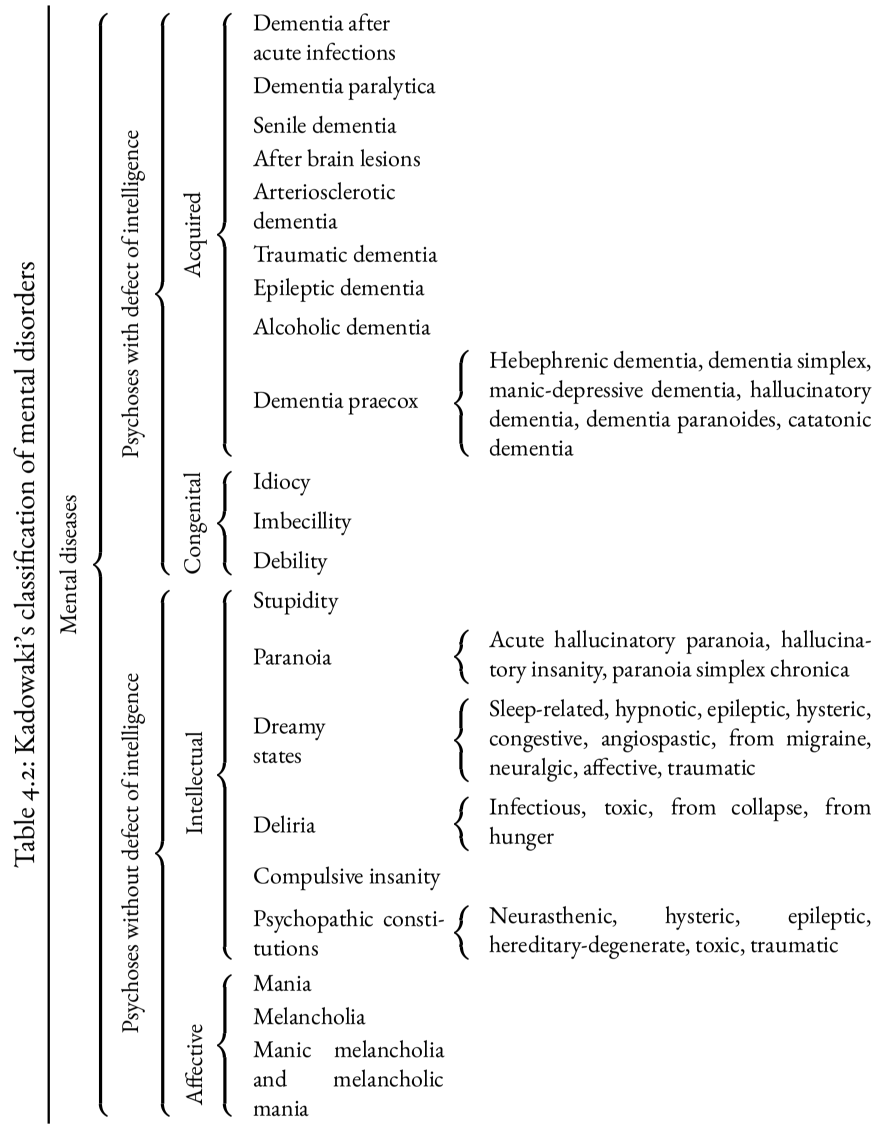
Figure 4.2: Kadowaki's classification of mental disorders in 1905

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



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 deemphasized. 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" (*rinshō-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 texbook (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, disscussion 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, "Ėksperimental'no-psichologičeskie issledovanija v maniakal'no–melancholičeskom psichoze: sostojanie sosredotočenija resp. vnimanija, umstvennaja rabotosposobnost' i associacii" [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 suppervision [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 1," 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ー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 1," 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 deferential 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斷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的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 involutional 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 involutional 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 psychoses 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 shiryōshitsu* 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* 他覺的ニ) 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 devided 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: 1. Beitrag. Experimentelle Untersuchungen über Assoziationen Gesunder* [Diagnostic Association Studies: 1. 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'sr 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).