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

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

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

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

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

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

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

Psychiatrists were not provided for under the medical service regulations of the Japanese Army, and military doctors received no training in psychiatry at medical military schools at the time of the Russo-Japanese War. Although Eguchi Noboru 江口襄 (1854–?) had started teaching psychiatry at the Medical Military Academy (*rikugun gun'i gakkō* 陸軍軍醫學校) in Tokyo in 1891, the subject was soon dropped from the curriculum, only to be introduced again after the end of the war in September 1906.[5]

Additionally, there were no military asylums in Japan. In both cases, the situation was most likely due to the fact that Japanese military institutions were modeled after the German system.[6] In contrast to other European countries such as Russia, England, and Austria, the German Army neither had its own military asylums, nor was military psychiatry fully institutionalized within the German military administration before 1914.[7] In the

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 5.1: The Chinese Eastern Railway in Manchuria in 1904

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

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

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

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

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

14 On the relation between the Japanese Army and the Red Cross Society see Aya Takahashi, *The Development of the Japanese Nursing Profession: Adopting and Adapting Western Influences* (London: RoutledgeCurzon, 2004), 84, 97, 111.

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

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

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

5.1 Manchuria: Confused Satō

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Satō's monthly wage as a first class soldier was 1.20 *yen*,[23] and 10 *sen* was no more than a twelfth of his monthly allowance. It does not seem that the note that he found could have had much financial importance for Satō. The value of the note becomes more tangible when some prices from the wartime period are compared. On July 12, 1905, the prices for the Japanese army at Fakumen (a settlement northwest of Tieling; see Figure 5.1) were fixed at the following amounts: coolies, salary per day: 60 *sen*; pork, per 1⅓ pounds: 20 *sen*; chickens, according to size: 60–90 *sen*; eggs, each: 2 *sen*.[24] These examples are telling insofar as Satō's salary would certainly have guaranteed his basic survival but not made him a rich man. Indeed, even a coolie could earn half his monthly allowance for a full day's work, i.e. six times the value of the 10-*sen* note. In any case, it seems likely that it was not the value of the money itself that caused Satō's unrest. Rather, it may have been caused by the potentially uneasy social interactions that were to be expected when mutual trust was threatened by the suspicion of theft in places as crowded as army barracks.

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

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

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

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

24 McClerand, 94.

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

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

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

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

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

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

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

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

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

5.2 Hiroshima: Melancholic Satō

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

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

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

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

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

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

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

36 Araki Sōtarō 荒木蒼太郎, 625.

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

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

> [...] 三十八年八月初旬昌圖ニ於テ發狂シ、沈鬱、自咎、過失アリトナシ、自殺ヲ企テ、夜間逃走シ、語ル所前後符合セズ、八月七日慶雲堡舎營病院ニ入リシ以來常ニ死ヲ欲シ、夜間逃走セントシ、不眠、頭重、眩暈、顔面蟻走感覺、眼火、耳鳴アリ、食欲、便通ハ常ノ如シ、八月二十一日廣島豫備病院ニ收容セラル [...][39]
>
> He got mentally ill in the first week of August 1905, while in Changtu. He was depressed, made self-accusations and acted as if he had made a terrible mistake. He tried to commit suicide and to escape at night. His speech was incoherent. On August 7, he was admitted to the cantonment hospital at Qingyunpu. Since then, he constantly wished to die and to escape at night. He suffered from lack of sleep, headaches, heaviness in the head, nausea, a tingling sensation on his face, blurred vision, and buzzing in the ears. Appetite and bowel movement were normal. He was sent to the rear and admitted to the Hiroshima reserve hospital on August 21.

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

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

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

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

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

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

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

In Araki's classification system, "depressed mood" was a fundamental symptom of melancholia. This view is consistent with the discussion of melancholia in his textbook, which was published in the same year (1906) as his article on mental illness in the Russo-Japanese War.[42] In the German version of his article, the term *chin-utsu kyō* 沈鬱狂 was always rendered as *Melancholie,* and in Satō's case, this diagnosis was followed by the additional note "*Selbstmordversuche*" [suicide attempts]. This addition, missing in the Japanese original, seemed to represent the main justification of the diagnosis.[43] Apart from this note, the German version did not provide any new information about Satō's condition.

41 Nihon Sekijūjisha 日本赤十字社, ed., *Meiji sanjūshichi-hachi nen seneki Nihon Sekijūjisha kyūgo hōkoku* 明治三十七八年戦役日本赤十字社救護報告 [Report on the Sanitary Assistance Provided by the Japanese Red Cross Society during the War in 1904–05] (Tōkyō: Nihon Sekijūjisha, 1908), 646. This relief squad of the Red Cross Society came from Wakayama and arrived in Hiroshima on June 25, 1904. They took care of more than 130 mental health patients from November 1904 to September 1905 (Nihon Sekijūjisha, 644–645). For some visual impressions of the working conditions of the Japanese Red Cross during the war, see (Hashimoto Kyūjirō 橋本忠次郎, ed., *Nichiro sensō Nihon sekijūjisha kyūgo shashinchō* 日露戦争日本赤十字社救護写真帖 [Photographs Showing the Work of the Red Cross Society of Japan during the Russo-Japanese War], vol. 2 [Tōkyō: Nihon sekijūji hakkōjo, 1906], not numbered).

42 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite"; Araki Sōtarō, *Seishin byōri hyōshaku*.

43 There are mainly two different kinds of melancholia-cases in Araki's report. First, those specified as suicidal and second, those characterized as suffering from delusions of self-accusation (Versündigungswahn). In other cases, when the patient was suffering from various diseases (colitis, tuberculosis, or syphilis), these were given in brackets after the main diagnosis and indicate a possible cause of illness (cases 16, 17, and 43).

Whereas the first part of Satō's case history contained at least a few narrative elements, Araki's own observations were simply presented in the form of a list of symptoms:

初診 八月二十七日、沈鬱、聯合抑制、音聲小、應答甚ダ不充分ニシテ片々斷裂シ、連續スル談話ヲナサズ、語ル所極メテ單簡ナリ、食欲振ハズ、睡眠十分ナラズ、自殺ヲ欲ス、

診斷 沈鬱狂 [...]

經過 九月一日東京豫備病院ニ轉送セラル、[44]

Status praesens:[45] August, 27: Depression, inhibition of associations, low voice. His response to questions is very poor. He speaks in a clipped manner. His speech is incoherent and his answers extremely simple. Absence of appetite, bad sleep, he wishes to kill himself.

Diagnosis: Melancholia.

Further developments: Transferred to the Tokyo Reserve Hospital on September 1.

There are two relevant aspects for Araki's framing of Satō's case as melancholic that can be observed from this short description. The first has to do with the similarity of the words (for the main symptom and disease name), and the second with the sequence of symptoms. Araki began his own enumeration of symptoms with depression (*chin-utsu* 沈鬱), thereby consciously echoing the structure of Satō's anamnesis. He constructed a case history that convincingly led to a diagnosis of melancholia, as it relied on about the same words for the description of symptoms (*chin-utsu*) as for the diagnosis (*chin-utsu kyō*). The importance of the order of symptoms becomes obvious when it is compared to the description of cases of neurasthenia (forty-four cases), which was Araki's second most common diagnosis after melancholia (fifty-nine cases). Although "depressed mood" was also considered to be a characteristic symptom of neurasthenia,[46] Araki never started the description of a neurasthenic's observation with this symptom. Usually, he began these cases with "headache," "forehead pain," or "vertex pain." This manner of arranging symptoms suggests that in Araki's structure, symptoms at the top of the list were weighted more heavily and were closer related to the diagnosis.

The brevity of Araki's report leaves it open how he actually observed Satō's depressed mood, but from his other melancholia cases it is evident that he usually paid careful attention to a patient's facial expression. The phrase most commonly used in the text was

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

45 "Status praesens" is the term used by Araki in the German version. It was also common in contemporary English texts and referred to the description of the patient's condition at initial observation.

46 See the general symptomatology of *neurasthenia* in Araki's article Araki Sōtarō, 146. The subject of *neurasthenia* will be discussed in another part in more detail.

ganyō taishū 顔容帯愁 [face marked by sadness] and variations of this expression. Sometimes, Araki used verbs which indicate visibility and, by implication, the act of observing. These were mainly *shimesu* 示ス [show, indicate] and *hyōji su* 表示ス [show, express], as in *ganbō hiai o shimeshi* 顔貌悲哀ヲ示シ [his face showed sadness].[47] In a few rare cases, depression itself (not just sadness) was visible on the face: *ganyō chinutsu o hyōji shi* 顔容沈鬱ヲ表示シ [his face showed depression].[48]

Occasionally, he recorded when a patient was sighing, crying, or brooding over some real or imagined worry, but in Satō's case, there is no such detailed description of direct expressions of mood. It could, however, be argued that Satō's suicide attempts were interpreted as an indirect sign and a result of his mood, a causal relation also suggested in Araki's textbook.[49] Even if Satō showed any visible signs, Araki chose to subsume most of them under the category of "depression" in his report. The only observable expression of depressed mood directly recorded by Araki was Satō's low voice. It may be assumed that Araki's technique of note-taking and case-writing was guided by certain patterns of perception, where facial expressions and other directly observable markers of disturbed mood were already translated into technical terms at an early stage of the diagnostic process.

On the whole, there was a strong emphasis on the patient's manner of speaking.[50] The "inhibition of associations" (*rengō yokusei* 聯合抑制) is a symptom that describes a specific disturbance of the train of thought.[51] In theory, it meant that the patient's mental ability to perceive external impressions, to link one idea to another, and to physically react to the impression was markedly retarded. Of course, none of these mental processes was directly observable. In practice, "inhibition of associations" referred to a patient's slowness in speaking and answering the doctor's questions. Other observations, such as "incoherent speech" and "simple answers," served to reinforce the idea that Satō's thought process was disturbed. Disturbed speech then became a direct manifestation of disturbed thought. At this point, Satō's case already contained two of the necessary symptoms for a melancholia diagnosis: depression and inhibition of associations.

At the end of his observation, Araki mentioned a few symptoms that he generally treated as "physical," namely, appetite and sleep. These were routinely mentioned because they affected a patient's physical condition and sometimes required medical intervention (such as forced feeding). In any case, Araki did not necessarily make a direct connection between Satō's appetite and his diagnosis, an aspect that gained significantly in

47 See case 41 in Araki Sōtarō, 161.

48 See case 42 in Araki Sōtarō, 161. For a short discussion of physiognomy as a means of diagnosis in psychiatry see also Arnold I. Davidson, *The Emergence of Sexuality: Historical Epistemology and the Formation of Concepts* (Cambridge and London: Harvard University Press, 2004), 47–52.

49 Araki Sōtarō, *Seishin byōri hyōshaku* 147.

50 On the role of "disturbed speech" as a marker of insanity see especially Wübben, *Verrückte Sprache*, 9, 33–40.

51 *Rengō yokusei* is referred to as "Assoziationshemmung" in the German version.

importance in Kure's report. Araki's rather short description and some of the discrepancies with Kure's report might, in part, have been caused by the circumstance that he did not get the chance to observe Satō's condition for a long period, as he only saw him once before the latter was transferred to Tokyo.[52] On that day, August 27, 1905, Araki examined at least seven other patients in the insanity ward of Hiroshima.[53] His attention was, therefore, not restricted to Satō's case, and he was unable to observe the course and outcome of the condition. In general, he noted that most patients seemed to recover from melancholia after a few months.[54] However, Araki's view was not the final verdict on Satō's condition. When Satō was admitted to the Tokyo Reserve Hospital a few days later, his case history was substantially rewritten, and his prognosis worsened dramatically.

5.3 Tokyo: Deranged Satō

The journey from Hiroshima to Tokyo usually took about two days and one night, and was made in stages. The first night was spent in Ōsaka, about twelve hours' journey from Hiroshima by train. The patients travelled in hospital clothing and were housed for the night by being billeted in inns and houses in the neighborhood of the railway station. On arrival in Tokyo, stretcher parties, ambulance rickshaws, and ordinary rickshaws carried the patients to the hospitals.[55]

When Satō was admitted to Tokyo on September 1, he came under Kure's care. Kure's collection of case histories had a character much different from Araki's, as the Ministry of War had ordered him to compile the official report on mental illness in the army.[56] Before starting his work in the reserve hospitals of Tokyo in January 1905, he was sent to Hiroshima to inspect the insane wards there and to ensure that they met modern standards.[57] Kure's report can therefore be considered to represent the authoritative view on mental illness in the Russo-Japanese War.

52 From the dates given as the date of first examination (*shoshin* 初診) in the 200 cases of the Japanese version, one can conclude that he worked in Himeji on Wednesdays and in Hiroshima on Sundays. As Satō was transferred to Tokyo on the next Friday after his examination, Araki could not have seen him more than once.

53 According to his records, two among these seven were diagnosed with *melancholia*, one with *mania*, and four with *neurasthenia*.

54 See Araki's general symptomatology of melancholia, Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 142–143.

55 Macpherson, *The Russo-Japanese War*, 354.

56 Rikugunshō, *Meiji sanjūshichi-hachinen sen'eki rikugun eiseishi* 6. In the preface of the chapter on mental illness, it is explicitly stated that Kure composed his article for the army's sanitary report.

57 Tabata Yukie 田端幸枝, "Kure Shūzō ga hōmon shita Nichiro sensō no rikugun Hiroshima yobibyōin no seishinka iryō kono 1: Rikugun Hiroshima yobibyōin no gaiyō" 呉秀三が訪問した日露戦争時の陸軍廣島豫備病院の精神科医療その１：陸軍廣島豫備病院の概要 [Psychiatric Care in the Military Reserve Hospital of Hiroshima Visited by Kure Shūzō (Part 1): Overview of the Military Reserve Hospital of Hiroshima], *Seishin igakushi kenkyū* 13, no. 1 (2009): 70. The oldest military hospitals

His report also served a didactic purpose. Unlike Araki, who gave the diagnosis at the end of a case history as the result of the anamnesis and his own medical evaluation, Kure always put it at the beginning of a case. In this writing mode, the individual case was turned into the illustration of an illness with general characteristics. In this context, Satō's case was merely one example of the manifold manifestations of *catatonia*. The didactic function of the text also explains the confidence with which Kure presented his diagnostic judgment. While Araki sometimes expressed doubts about his classification and openly stated that his results were of a preliminary nature, there was no trace of uncertainty in Kure's report.[58] His evaluation was presented as definite and unambiguous:

> 病名　緊張病
>
> 既往症　生来壯健ナリ、飲酒喫煙ヲ好ム、沈著快恬ニシテ業務ニ熱心ナリ明治三十八年九月 [sic!] 淸國昌圖ニテ軍用手票十錢ヲ拾ヒ最初自分ノ遺失セルモノトテ懐中セシモ後チ自分ノモノニアラヲ [ザ] ルヲ知リ、之ヲ戰友ニ問フモ遺失者無ク戰友ハ自分窃取ヲ疑フト思ヒ自殺ノ企圖セントシ又夜間戸外ニ逃走セルコトアリ談話ハ要領ヲ得ス
> 開原、奉天、大連等兵站病院ヲ経テ後送セラレ九月一日戸山分院ニ入ル。[59]
>
> **Diagnosis:** Catatonia
>
> **Anamnesis:** The patient had a healthy constitution, but was fond of alcohol and smoking. He was of a calm and peaceful disposition and fulfilled his duties eagerly. In [August] 1905,[60] while in Changtu, China, he found a 10-*sen* war-note. At first, he thought that it was money he

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in Hiroshima had already been constructed during the First Sino-Japanese War (1894–1895). The insane wards were ordinary ward buildings, not different from other sections in the hospital. During the Russo-Japanese War, these wards were turned into specialized wards for the insane (Tabata Yukie, "Kure Shūzō ga hōmon shita Hiroshima yobibyōin 2," 71).

58 It should be noted that Araki discussed the subject of uncertainty only in his German version (Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 625, 668).

59 Case 28 (first-class soldier Satō of the corps of engineers of the reserve army, born July 1876) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 85–86. Both Araki and Kure use East Asian age reckoning (also in their German texts), according to which a person is one or two years older than in Western age reckoning.

As with Araki's quotes, I have reproduced the Japanese text in its original form without converting characters into their modern equivalents (*zu* 圖 instead of *zu* 図). I have also left the kana unmodified. In this edition, no *dakuten* (a diacritic sign used to indicate voiced consonants in kana) are used. Context and syntax provide sufficient clarity to identify these places (for example, *yōryō wo esu* 要領ヲ得ス should be read as *yōryō wo ezu* 要領ヲ得ズ).

60 Although it is stated in the Japanese text that the events took place in September, it must be a mistake because Satō was admitted to Tokyo on September 1 (see end of quote). I follow Araki's description, who states that it was the first week of August (see Araki's report on page 152).

> himself had lost, so he put it in his pocket. Later, he realized that it was not his own. Although he asked his comrades about it, the real owner could not be found. He thought that his comrades suspected him of stealing. He attempted suicide and sometimes tried to run away at night. His speech was incomprehensible.
> After passing the line of communication hospitals of Kaiyuan, Mukden, and Dalny,[61] he was sent to the rear and admitted to the Toyama branch hospital on September 1, 1905.

Kure gave a more detailed account of the circumstances of Satō's experiences in Manchuria. He might either have obtained this information from the patient file or by questioning his patient. More important, however, is the fact that he chose to include this story in his version of the patient's medical past, which seems to be related to his diagnosis, rather than an obsession with details. Indeed, while Araki summarized the 10-*sen* episode using abstract expressions such as "self-accusations" and "terrible mistake," Kure actively linked the manner of Satō's behavior to catatonia. To understand how exactly he achieved this, one must turn to the theories associated with this diagnosis. Catatonia was considered to be an incurable form of mental illness that invariably led to mental enfeeblement. However, the "true art of diagnosis" as it had been propagated by Kraepelin (see page 47) was to recognize catatonia and other forms of dementia praecox *before* mental deterioration was yet observable. These early signs, which allowed a skilled psychiatrist to make prognostic assessments by differentiating forms of melancholia that would lead to recovery from those that would lead to mental deficiency, were called "catatonic signs."

Apparently, Kure considered himself to be equipped with this diagnostic skill when he remarked in the introduction to his report that more than half of the melancholias witnessed by other psychiatrists in wartime actually belonged to the categories of hebephrenia and catatonia (both being forms of dementia praecox).[62] He did not exclusively refer to Araki's report when he criticized the melancholia interpretation but listed him among other physicians who noticed a prevalence of this illness in soldiers.[63] Nor did he mention Araki in his case histories, eliding the latter's diagnosis even in cases where he quoted from his report literally. Satō's re-evaluation as a catatonic patient is therefore hushed up in Kure's account, and his medical past is notably re-scripted to reveal "catatonic signs."

Indeed, if one follows contemporary textbook descriptions of dementia praecox, Kure's detailed portrayal of the 10-*sen* episode is very much part of his catatonia interpretation. In fact, among those symptoms which were recognizable at an early stage, the patient's "defective judgment" and the resulting "irrationality" (*fugōri* 不合理)

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61 For further information on the place names, see footnote 9 on page 143.

62 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 11.

63 Kure Shūzō, 10. Kure's general critique of German and Russian authors will be discussed in more detail in section 7.2.

and "queerness" (*kii* 奇異) of his delusions were considered typical.[64] In this train of thought, not only was the presence of delusions seen as pathological, but their content was evaluated in relation to some implied, but never explicitly articulated, standard of "rationality" as well.

Because the objective value of the note that Satō had found was not very high, it is safe to assume that Kure's "common sense" approach made Satō's suicidal behavior seem highly irrational. His otherwise calm and peaceful disposition, which was noted by Kure at the beginning of the case history, also made his actions appear more extreme. Even the statements about Satō's previous health and well-being had diagnostic value for Kure. They allowed for a differentiation between dementia praecox, which is a form of dementia that occurs in youth, and its congenital forms. The incoherence of speech also nicely fitted Kure's catatonia interpretation, but many other symptoms listed in Araki's version of the anamnesis were deleted from his account.

For instance, any reference to Satō's mood is conspicuously absent, illustrating the fact that Kure's narrative construction and all narrative constructions of case histories involve the process of selection.[65] By omitting the symptom of depression, Kure deliberately shifted the focus from the "affectivity" of Satō's behavior to its "irrationality." Although depressed mood was also a common symptom in the early stages of catatonia, it was not essential to its diagnosis. Consequently, other aspects of Satō's behavior were more prominently stressed. These aspects were then further elaborated in Kure's personal observation of Satō, reinforcing their significance and supporting the catatonia interpretation:

> 現在症　指南力不良、記憶正カラス、観念ノ経過遅滞シ幻聴アリ、佐藤〇太郎（自分姓名）ハ放火セリ、親ノ死亡時金五圓ヲ誤魔化セリ等ノコト聴エ、又居村ニ山林ノ事件アリトカ、父カ病氣ナリトカ思ハレ、犯罪ノ覺ナキニ處罰セラルルカ如クニ信ジ、自殺念慮アリ井戸ニ投身セントセルコトアリ、感情沈鬱性ナリシガ後昏迷状態トナリ。問フモ目ヲ閉キテ答ヘス食事ハ人ノ目前ニテナサス人居ラヲ [ザ] レハ食ス。胸腹部ニ異常ナク瞳孔反應存シ、膝反射減弱ス。[66]

> **Present symptoms:** Orientation not good, memory impaired. The train of thought is slowed and he has acoustic hallucinations. He is

64 See the general symptomatology of dementia praecox as it was taught by Kure at Tokyo Imperial University in Ishida Noboru 石田昇, *Shinsen seishinbyōgaku* 新撰精神病學 [New Psychiatry] (Tōkyō: Nankōdō, 1906), 74. The point is further reinforced in the corresponding sections of Kraepelin's sixth edition of his *Psychiatrie* (Kraepelin, *Klinische Psychiatrie*, 141) and in the American translation of this textbook (Diefendorf, *Clinical Psychiatry*, 157).

65 Guenter B. Risse and John Harley Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine* 5, no. 2 (1992): 190.

66 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 86.

> hearing that Satō [...] tarō (his first and family name) has set a house on fire, the time of death of his parents, that he has embezzled 5 *yen*. He thinks that there has been an accident in the woods of his native village, that his father became ill. He believes that he will receive a punishment, even though he is not aware of having committed any crime. He has suicidal thoughts and has tried to throw himself into a well. In the emotional attitude there was at first depression, while later he was in a stuporous condition [a state of mental and physical inertness]. When questioned, he closes his eyes and does not answer. He does not eat when other people are watching. When no people are there, he eats. No anomalies in chest and abdomen, pupillary reaction is present, loss of tendon reflexes.

Kure began his observation with statements on the field of what was generally referred to as "intellectual capacity." To evaluate whether orientation and memory were affected, the patient had to answer a series of questions. The catalogue of questions designed to test someone's orientation usually included inquiries about a patient's name, occupation, and place of residence as well as questions about their surroundings and their conception of the time of week, month, and year.[67] Similarly, the questions designed to test a patient's memory ranged from asking about family history to queries regarding geography, history, and religion.[68] Answering a certain number of these questions incorrectly was interpreted as an impairment of mental elaboration.

Another early symptom of catatonia was "slowness of the train of thought." Like deficiency in mental capacity, it was only observable through interrogation, but instead of evaluating the accuracy of answers, it referred to the response time a patient required to answer the doctor's questions. According to textbook descriptions of catatonia, neither the impairment of intellectual capacity nor retardation of the train of thought were essential to the diagnosis, but the presence of acoustic hallucinations, closely linked to the symptom of delusions, could be indicative of catatonia.[69]

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67 Kure Shūzō 呉秀三, *Seishinbyō shinsatsuhō* 精神病診察法 [Methods of Diagnosing Mental Illness] (Tōkyō: Chiryō gakusha 治療学社, 1908), 9. According to the preface, this book is mainly based on Sommer's *Textbook on Examination Methods in Psychopathology* (on Sommer, see footnote 93). This textbook provides the physician with many practical instructions and lists of questions.

68 Kure Shūzō, 16–25.

69 In the textbook description, acoustic hallucinations are stressed as the most prominent form of hallucinations, followed by hallucinations of sight, touch, smell etc. (Ishida Noboru, *Shinsen seishinbyōgaku* 72). This view is consistent with Kraepelin's textbook (Kraepelin, *Klinische Psychiatrie*, 155). Contrary to a seemingly widespread presumption, Kraepelin, the founding father of *dementia praecox*, did not emphasize hallucinations as a key symptom, nor did Eugen Bleuler (1857–1939), who is commonly believed to have further developed Kraepelin's disease concept into *schizophrenia*. According to Hacking, it was only after Kurt Schneider (1887–1967), in an attempt to operationalize the concept, put auditory hallucinations at the top of "first-rank-symptoms," that they almost became "a sine qua non of schizophrenia"

By picking up the subject of Satō's delusions already highlighted in the anamnesis ("He thinks that there has been [...]"), Kure once again put the focus on their content and so not only re-enforced his interpretation but additionally pointed to the lack of coherence among the various delusions. By simply listing the different subjects of Satō's fears (illness of father, fire in the woods, unjust punishment), he created an impression of inconsistency and randomness. In his general discussion of the main symptoms of catatonia observed in Tokyo's reserve hospitals, Kure referred to this kind of delusion as "unsystematized" (*keitōteki narazaru mōsō* 系統的ナラサル妄想),[70] an attribute that was also echoed in textbook descriptions of catatonia.[71]

Directly subsequent to the enumeration of Satō's diverse delusions, Kure mentioned the presence of suicidal thoughts. This structure suggests an affinity between delusions and suicidal propensity, an aspect entirely absent from Araki's report. Araki's account, quite in contrast, suggests a connection between despondent mood and suicide.[72] Kure's active recontextualization of the suicidal propensity as a result of "irrational delusions" completely alters the interpretation of Satō's mental state. It once again shifts the focus from an illness characterized by "affectivity" and "self-centeredness" to an illness defined by the patient's "irrationality." Although not explicitly pointed out within Satō's case history, the causal relationship between delusions and suicide is more clearly articulated in another part of Kure's report. There are a few references to Satō's case in Kure's general discussion on catatonia, which provide additional information on how Kure categorized and evaluated some of Satō's symptoms. Kure noted that, within a group of eight catatonic patients who did not exhibit symptoms of agitation but had undetermined and unsystematized delusions, there were three patients with delusions of self-accusation (*zaigō mōsō* 罪業妄想), of which two had suicidal thoughts resulting from these delusions (*sono kekka jisatsu no nenryo ari* 其結果自殺ノ念慮アリ). He then further explained that one of these two patients had tried to throw himself into a well (*ichinin wa ido ni tōshin sen to seri* 一人ハ井戸ニ投身セントセリ), which is a direct reference to Satō's case.[73]

(Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* [Princeton: Princeton University Press, 1998], 114). I do not agree with Hacking that Kraepelin emphasized "flat affect." At least during this period, Kraepelin de-emphasized all forms of affect in *dementia praecox* in favor of his "significant signs" (see the discussion in chapter 2). However, I find Hacking's portrayal of the rise and fall of hallucinations as a key symptom of schizophrenia convincing in general.

70 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 68.

71 Ishida Noboru, *Shinsen seishinbyōgaku* 74–75. See also Kraepelin, *Klinische Psychiatrie*, 141.

72 On the relation between melancholia and suicide in Victorian England, see Åsa Jansson, "From Statistics to Diagnostics: Medical Certificates, Melancholia, and 'Suicidal Propensities' in Victorian Psychiatry," *Journal of Social History* 46, no. 3 (2013): 716–731. For a discussion of medicalization of suicide in Japan, see Di Marco, *Suicide in Twentieth Century Japan*. An innovative, poetic, and literary approach focusing on the various forms suicide notes can take and serve can be found in Kirsten Cather, *Scripting Suicide in Japan* (Berkeley: University of California Press, 2024).

73 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 68. Even without the indication of a name or case number, one can easily match the passages from the general discussion

Based on the statements in the general discussion, it thus follows that Kure definitely saw a causal relationship between Satō's delusions and his suicide attempts, and that he furthermore categorized these delusions as "delusions of self-accusation."

Only towards the end of his report did Kure eventually concede that Satō had, indeed, been depressed at an early stage of the illness, but he instantly undermined the significance of affectivity by pointing to its transient nature. This newly introduced temporal dimension is completely absent from Araki's account. Whereas Araki reported that the depressed mood was observed simultaneously with the absence of appetite and bad verbal response, Kure attributed these symptoms to two different stages of Satō's illness. He thereby suggested that there was a change in the emotional attitude of the patient, who was depressed at first but later became inert and unapproachable.[74] Although such a progression of symptoms is contradicted by Araki's account, who observed them all on the same day, Kure's choice in favor of the catatonia interpretation committed him to reporting a certain development in Satō's condition, because the element of progress was crucial to the diagnosis.[75]

After having dismissed depressed mood as a minor episode in the course of the illness, Kure immediately proceeded to his most powerful argument in favor of catatonia: his description of Satō's behavior when questioned or given meals. He observed that Satō used to close his eyes when questioned and refused to eat when people were watching him. Unlike Araki, who merely noted the fact that Satō did not respond well to questions and did not eat, Kure paid attention to the manner in which Satō expressed his refusal to cooperate. Thus, Kure psychologized these actions and interpreted them as "catatonic signs" belonging to the category of "negativism" (*kyozetsushō* 拒絶症).[76]

Negativism was another technical term (still used in present-day psychiatry) that in theory referred to a patient's mental activity, but in practice was only observable in his movements and actions. Supposedly resulting from a diminished susceptibility of the

with the corresponding case history by process of elimination and by comparing the list of symptoms in both sections.

74 In the case of Satō, there is no indication of the duration of his treatment in Tokyo, but a survey of Kure's other cases reveals that his patients were hospitalized for about a month on average.

75 Both Karl Ludwig Kahlbaum and Kraepelin (the main promoters of the concept of *catatonia*) considered the presence of a typical course a necessary criterion for a conclusive *catatonia* diagnosis (Wübben, *Verrückte Sprache*, 71).

76 Kure's categorization of such behavior as "negativism" is also expressed in his general discussion (Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 68). It also becomes clear from other cases that in practice, Kure used to equate refusing food with "negativism" without even observing the patient personally. In the case of the superior soldier Hamada, the medical record says that he had been "cheerful, talked and laughed to himself, and refused food" 快楽性ニシテ獨語獨笑シ、食事ヲ拒ミ (Kure Shūzō, 120–121) when he was 16 years old. However, in his general discussion, Kure summarized the patient's symptoms as "became cheerful, talked and laughed to himself, and showed negativism" 快楽性トナリ獨語獨笑拒絶症等アリ (Kure Shūzō, 112). See case 48 (superior soldier Hamada of the corps of engineers, born 1883) in Kure Shūzō, 120–121.

faculty of volition, "negativism" denoted the involuntary suppression and subsequent reversal of impulses in reaction to external stimuli. According to this mechanistic definition, "negativism" was not triggered by voluntary opposition but was the expression of a morbid functioning of a mental faculty. However, the distinction between pathological and normal opposition was dependent on the physician's assessment of its "appropriateness" in relation to a given situation. That such judgment calls are complicated in nature is evident, as sociological research into the doctor–patient relationship has shown.[77] Their reification as diagnostic primary facts should be considered with extreme care.

With regard to the medical practice of diagnosis, the introduction of "negativism" significantly altered the patient's observation by the doctor. Its abstract character obscured the underlying logic of equating a person's mental functioning with his physical reaction to the medical setting. It also masked the involvement of social norms in guiding the physician's gaze and medical judgment. Satō's reinterpretation as a catatonic patient was, therefore, not due to a sudden change of his symptoms, but rather relied on a reinterpretation of his behavior. This reinterpretation was mediated through the introduction of new interpretative patterns (such as the concepts of "negativism") that effectuated a change in the doctor's mode of seeing. Although Kure reported almost the same symptoms as Araki, he imbued them with different meanings and reconfigured their interrelations.

In the text, the transformation of meaning was accomplished through a number of structural and stylistic modifications. Compared to Araki's account, one finds the order of symptoms rearranged. Some symptoms are emphasized by being discussed in minute detail (hallucinations, irrational thoughts); others are marginalized by being mentioned merely in passing (depressed mood, inhibition of associations). To illustrate Satō's disordered state of mind, Kure employs a narrative device reminiscent of an interior monologue. Satō's various thoughts and fears are hereby presented collectively without any context or coherence, suggesting a lack of coherence in Satō's train of thought. Furthermore, the rearrangement of symptoms unravels the close connection between suicide and depressed mood—found in Araki's text—and re-links suicide to irrationality. Likewise, the "absence of appetite" is de-contextualized from the domain of physical symptoms to become a main indicator of a dysfunctional mental faculty. All of these structural moves reconfigure Satō's initial characterization as a melancholic patient to present him as exemplarily catatonic.

Satō's case has served as an exemplary illustration to show how a diagnosis of melancholia was first deconstructed and then replaced with catatonia. However, on its own, it cannot give a full picture of the disintegration and vanishing of melancholia. Although Kure himself stressed the fact that most of the so-called melancholias belonged into the

77 Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society* 14, no. 2 (1985): 175–198.

category of dementia praecox, a detailed examination of his case records reveals a more differentiated approach. Indeed, the patients who were originally diagnosed with melancholia by Araki were not all systematically re-diagnosed with dementia praecox by Kure. Rather, some of them were re-conceptualized as cases of manic-depressive insanity. Tracing the rationale behind the division that eliminated melancholia from the psychiatrist's conceptual toolbox and provided melancholics with new medical identities is the subject of the next chapter.