6 New Modes of Observation & the Psychologization of Opposition

The analysis of patient files that contain conflicting diagnoses is not only pertinent to analyzing modes of observation and writing, but it is also ideal to demonstrate the changes in perception that allowed the re-conceptualization of melancholia as either manic-depressive insanity or dementia praecox. As we have seen in chapter 5, Satō's melancholia was reinterpreted as dementia praecox, which suggests that the relationship between these two conditions was, in fact, closer than it is usually assumed to be. Even though one of them was defined as a temporary affliction and the other as an incurable, permanent illness, it was still possible for Kure to rewrite Satō's melancholia as dementia praecox.

As it happens, patients do not usually come with an "*incurable*" tag pasted across their foreheads, and unlike other states of mind such as sadness or fear, incurability is not a trait that doctors are traditionally used to recognizing by observing their patients' appearance and behavior. We also need to consider that the observation period in Japan's military hospitals was very short and that doctors did not have the luxury of drawing their conclusions from long-term records. In fact, the wartime setting often required an ad hoc diagnosis immediately upon admission. This situation was very similar to the conditions Kraepelin faced in Heidelberg when he had to decide whether a new patient should remain in the (constantly overcrowded) teaching hospital or be transferred to a long-term hospitalization facility for incurable patients. I will therefore draw upon the analysis from chapter 2 and show how the new system of "significant signs" propagated by Kraepelin was applied in practice in the Japanese setting.

Indeed, upon matching and examining Araki's and Kure's case histories, several other cases of conflicting diagnoses (other than Satō's) come to light, which allow the articulation of a more nuanced view of the relationship between the contemporary perception of melancholia and dementia praecox. In this chapter, I will demonstrate that at the time of the Russo-Japanese War, Araki's melancholia and Kure's dementia praecox were overlapping disease concepts. Thus, the two physicians could apply them to the same group of patients by emphasizing different criteria of illness identification. When examining medical literature from this period, one should, therefore, not treat these terms as if they

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represented distinct disease entities and referred to different patient populations. In fact, not even the use of the same medical term implied a shared understanding of its meaning.[1]

From a comparison of Kure's and Araki's cases, it can be observed that one effect of Kure's new diagnostic scheme was that several previously inconspicuous clinical signs (gestures, movements, attitudes) had suddenly been ascribed diagnostic value and thereby changed modes of observation. In cases that have been observed both by Kure and Araki, I will examine the changes in observation by focusing on three spheres of mental functioning, namely, affect, cognition, and volition. In focusing on these three categories, I enter into dialogue with Radden and Shorter, who have argued that the emergence of Kraepelin's disease concept of manic-depressive insanity was a result of "lumping mood disorders together."[2] Re-examining the case histories according to this tripartite division allows me to demonstrate that this was not the case and to propose an alternative explanation. Thus, the structure of this chapter suits my aim of making a historical argument on the genesis of the psychiatric concepts of manic-depressive insanity and dementia praecox. However, this is not to imply a division of mental faculties (as such) nor to suggest that the historical actors Kure and Araki actively used this subdivision as analytical categories. On the contrary, I will show that it was precisely the rejection of a division into affective and cognitive disorders that characterized Kure's approach.

6.1 Affect: Tears and Withdrawal

Although medical historians often characterized Kraepelin's manic-depressive insanity as an "affective disorder," there is little evidence in Kure's cases that "affect" actually played a decisive role in the diagnosis of his manic-depressive patients.[3] The cases of Akiyuki 秋元 and Hibara 檜原, two of Araki's melancholic patients who were subsequently rediagnosed with manic-depressive insanity by Kure, serve to illustrate the transformation process that provided them with new medical identities.[4] When their medical records are

1 This has been the most common approach to analyzing these historical texts. It is characterized by the absence of a contextualized examination of medical categories, an ignorance of their use in practice and their notoriously unstable meanings. The shortcomings of such studies become even more apparent when the analysis is limited to statistical data. Although acknowledging the limitations of his approach, Paul Wanke's assessment that at the time of the Russo-Japanese War, Russian military psychiatry was in a state of confusion is entirely based on statistics issued by different psychiatric hospitals (Wanke, *Russian/Soviet Military Psychiatry 1904–1945*, 20).

2 Shorter, *What Psychiatry Left Out of the DSM-5*, 167; Radden, "Lumps and Bumps," 131.

3 The representation of *manic-depressive insanity* as an "affective disorder" is the most common way of portraying the illness. See for example: Schmidt-Degenhard, *Melancholie und Depression*; Jackson, *Melancholia and Depression*; Berrios, "Melancholia and Depression during the 19th Century"; Hoff, *Emil Kraepelin und die Psychiatrie als klinische Wissenschaft*; Radden, *Moody Minds Distempered*; Somogy Varga, "From Melancholia to Depression: Ideas on a Possible Continuity," *Philosophy, Psychiatry, & Psychology* 20, no. 2 (2013): 141–155; Shorter, *What Psychiatry Left Out of the DSM-5*.

4 For Araki's data on Akiyuki see case 19 (23-year-old transport soldier) in Araki Sōtarō, "Seneki ni insuru

compared to Satō's case, the rationale behind Kure's differentiation of manic-depressive insanity and dementia praecox becomes more clearly visible. In fact, the plurality of complementary cases shows that Kure's gaze was guided by other determinants than the division of "affective" and "cognitive" symptoms.

Akiyuki had joined the Army in 1903, when he was twenty years old. During the spring of 1905, when most of the battles of the Russo-Japanese War had already been fought, he was stationed in Xiafeidi 下肥地, a small village in Liaoning province in Manchuria, where he worked as a transport soldier (*yusotsu* 輸卒).[5] On May 30, while on duty, Akiyuki experienced physical weariness and discomfort. At first, he ignored these symptoms, but when his condition got worse on the following day, he asked for a medical examination.

Araki recorded that Akiyuki seemed to be in a stuperous condition and could not give intelligible answers during the examination. In his article, Kure supplied the additional information that it had become apparent upon examination that Akiyuki was drunk, reeked of alcohol, and was muddle-headed, so that his comrades had to be questioned in his stead.[6] They assured the medical personnel that Akiyuki was mentally ill (*seishin ni ijō ari* 精神ニ異常アリ) and was apparently also experiencing hallucinations (*genkaku* 幻覺). He was known for his habit of sneaking into the neighboring villages in the evenings, was restless at night, and used to talk in his sleep.

Apart from the alleged "facts," this episode illustrates the involvement of third parties in identifying abnormal behavior and interpreting it as mental illness. Comrades, commanding officers, or the military police (*kenpei* 憲兵) often acted as mediators or complainants who initiated a person's commitment to a hospital.[7] However, it seems that in

seishinbyō ni tsukite," 153. There is no corresponding German version. As in all other instances, the name and date of birth of the patient is only mentioned in Kure's records, cf. case 36 (transport soldier Akiyuki of the transport unit [peasant], born February 1883) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 101–102.

For Araki's data on Hibara see case 27 (25-year-old transport soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 156. There is no corresponding German version either. For Kure's data on Hibara see case 38 (transport soldier Hibara [peasant], born May 1881) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 102–103.

5 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 153; Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 101–102.

6 Kure Shūzō, 101. Kure also mentioned that Akiyuki's father was known as a heavy drinker (*taishuka* 大酒家) and that the patient himself was fond of alcohol and was used to drink about 1.5 pints i.e. roughly 1 liter (*go gō* 五合) at a time.

7 In Araki's and Kure's case histories, these mediators were rarely named or even mentioned. Their involvement sometimes became apparent in the patient's fear of being arrested by the military police or when the patient record contained information about some offense or criminal behavior (absence without leave, desertion, theft, and others). The role of mediators, complainants, and family members in the process of hospitalization has been explored in Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961), 136–144. On the role of the family in the Japanese mental health system see Suzuki, "The State, Family, and the Insane in Japan, 1900–1945."

Akiyuki's case, none of these reported symptoms and anomalies had prompted the medical authorities in Manchuria to commission his transfer to a specialized hospital. It was only when he complained of diarrhea and abdominal pain (identified as colitis by Araki) on the 10th that he was immediately sent back to Japan along the established evacuation routes. After having passed Tieling, Liaoyang, and Dalian, he arrived in Hiroshima on Thursday, June 29, and was examined by Araki on the following Sunday, when he was on duty at the hospital. Araki's assessment proved rather short:

> 初診 七月二日、聯合作用抑制ノ状アリ、應答甚ダ不十分ナリ、
>
> 診斷 鬱躁狂
>
> 経過 七月八日東京豫備病院二轉送セラル、[8]
>
> **Status praesens:** July 2: Inhibition of associations, responds very poorly to questions.
>
> **Diagnosis:** Melancholia.
>
> **Further Developments:** Transferred to the Tokyo Reserve Hospital on July 8.

In his version of the anamnesis, Araki noted that Akiyuki had been depressed (*chinutsu* 沈鬱), inhibited (*yokusei* 抑制), and that he had hallucinated (*genkaku ari* 幻覺アリ) and talked to himself at night (*yakan dokugo wo nashi* 夜間獨語ヲナシ) when he was being examined in Manchuria. Unlike Kure, Araki did not mention the influence of alcohol as a possible cause for the hallucinations and self-talk, but Kure would later interpret them as *delirium* (*sengo* 譫語). When Araki examined the patient at Hiroshima, he seems to have focused on Akiyuki's verbal response and made his diagnosis based on his slow and unintelligible way of speaking, which to him suggested an inhibition of mental and physical processes. As for Kure, his observations were far more detailed:

> 病名 鬱憂状態
>
> 既往症 [...] 鐵嶺遼陽大連等ノ兵站病院ヲ経テ七月十日渋谷分院ニ収容セラル。

On the role of the police see Catharine Coleborne, "Passage to the Asylum: The Role of the Police in Committals of the Insane in Victoria, Australia, 1848–1900," in Porter and Wright, *The Confinement of the Insane*, 129–148. A more recent study is the article of Nellen and Suter who examined the role of the police and its informants—the innkeepers of the city of Basel—in the process of identifying, relaying, and processing cases of mental illness around 1900 (Nellen and Suter, "Unfälle, Vorfälle, Fälle").

8 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 153. Araki's use of punctuation marks is often inconsistent. He used the Japanese *tōten* "、" both as a comma and as a full stop, but sometimes did not indicate the end of a sentence at all.

現在症　顔貌沈鬱状ヲ呈シ舌震顫アリ、痛覺少シク鈍麻シ、胸腹部ニ異常ナキモ心悸亢進アリ、胃部壓痛アリ下痢アリ粘液状ニシテ血液ヲ混ス、倦怠及ヒ食思不振ヲ告フ。
沈鬱シ寡言ニシテ應答明瞭ナラス記憶不良ニシテ擧動不活溌ナリ。
體格營養共ニ中等ナリ、顔貌沈鬱状ヲ呈シ擧動緩慢ナリ、頭蓋異常ヲ認メス、瞳孔左右同大ニシテ光線反應存シ、舌震顫アリ、腱反射亢進セリ。
應答甚タ遲滞シテ簡単ナリ、時ニ答ヘサルコトアリ強テ問ヘハ流涕ス、病覚ナク、追想不良ナリ、寝臺上ニアルモ茫然トシ或ハ室隅ニ蟄伏シ、時々食事セス、之ヲ強テ勸ムルトキハ涕泣ス、明治三十八年八月十三日兵役免除退院ス。[9]

Diagnosis: Depressed state [of manic-depressive insanity].

Anamnesis: [...] After having passed through the line of communication hospitals of Tieling, Liaoyang, and Dalian, the patient was admitted to the Shibuya branch-hospital on July 10.

Present symptoms: His facial expression indicates a depressed state. Tongue tremor as well as a minor reduction of the sense of pain is present. There are no anomalies in chest and abdomen except for cardiac palpitation. He has pressure pain in the gastric region and diarrhea with mucinous stool mixed with blood. Complains about fatigue and loss of appetite.
The patient is depressed and silent, answering questions unassertively. His memory is impaired and his movements sluggish.
Physical state and nutritional condition are average. His facial expression indicates a depressed state, the movements are slow. No abnormalities of the cranium detectable. Pupils are of equal size and pupillary reaction is present. Tongue tremor, tendon reflexes increased.
He answers slowly and in simple words, sometimes not giving an answer at all. When pressed to talk, he cries. He has no insight into his condition and his memory has become corrupt. When he is in bed, he is absent-minded. Sometimes he holes up in a corner. Occasionally, he does not eat and when encouraged emphatically, he cries.
On August 13, he was exempted from military service and discharged from hospital.

9 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 101–102.

It is clear from this description that Kure tried to come to a conclusive diagnosis by excluding unlikely diagnoses and by conducting a series of medical tests. He auscultated Akiyuki's chest, palpated his stomach for pains in the abdomen, and had his stool tested. He examined his skull for signs of degeneration, tested his pupillary response to light, and checked his tongue and his tendon reflexes. Most of these physical examinations were aimed at excluding physical ailments and several serious neurological diseases or brain lesions.

Furthermore, he evaluated his facial expression and tested his memory and his verbal response. He observed the flow of his movements and his activities in the hospital, paying special attention to Akiyuki's sleep and appetite. The extent to which Kure tested Akiyuki for "negativistic" behavior, probing how he would react when pressured to talk or eat, is telling of the importance that he ascribed to this "symptom." Had Akiyuki given in to the pressure with a sudden movement or some unexpected remark, his actions could immediately have been interpreted as signs of "negativism," as in Satō's case (on page 162). However, since he reacted with tears and restraint, Akiyuki's passive behavior was read as a sign of inhibition instead. Whereas Satō averted his eyes when questioned and refused to eat when watched, Akiyuki apparently did not show such signs of opposition and reluctance.

Through his series of tests, Kure had ruled out "negativism" and with it the possibility of interpreting Akiyuki's condition as dementia praecox. Other signs, such as his depressed appearance, slow replies, and sluggish movements strengthened Kure's manic-depression interpretation. However, what turned Araki's melancholic patient into a manic-depressive patient in Kure's eyes was the combination of inhibition and disturbed affectivity with the absence of any behavior that he could interpret as catatonic. As Satō's and Akiyuki's cases exemplify, this chiefly concerned the patient's reaction to the medical examination and the medical setting in general. According to this logic, which still has some significance in present-day diagnostic practice, patients who cooperate or resign can be put in a different medical category from those who resist treatment.

The comparison of Satō's and Akiyuki's cases also shows that, in Kure's differentiation scheme between manic-depressive insanity and dementia praecox, "affective" symptoms were definitely less decisive than the presence or absence of "catatonic" signs, which indicated a dysfunction of the volitional impulse to Kure. In his general discussion of depressed and exalted states among the patients from the Russo-Japanese War, he noted that depressed states were not restricted to manic-depressive insanity. As for patients who exhibited alternate states of exaltation and depression, he even noted that most of them were suffering from dementia praecox, rather than manic-depressive insanity.[10] This approach to affective disorders was also reflected in Kure's case histories: among the twenty-nine dementia praecox patients, only four were explicitly recorded as having flat affect (*kanjō*

10 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 45.

donma 感情鈍麻), four were characterized as having changing moods (*kanjō henkansei* 感情變換性), and five others were referred to as depressed (*chinutsu shi* 沈鬱シ).[11]

Other behavior patterns than "negativism" that were ascribed high diagnostic relevance in Kure's scheme were those related to speech. In Satō's case, disturbed speech was associated with disturbed thought, but Satō also showed other cognitive disorders (delusions) and exhibited behavior that Kure interpreted as a dysfunction of volition (negativism). It is therefore plausible that Kure's catatonia diagnosis should have rested more upon these other symptoms and that the presence of incoherent speech had not been deemed to be equally decisive.

The relevance of speech for diagnostic judgment is more prominent in another case. On the same day that Satō was admitted to the Hiroshima hospital, another patient who had been reported to show incoherent speech was hospitalized in Tokyo. Hibara, like Akiyuki, was a transport soldier who had been stationed in Manchuria in the summer of 1905. He had been known as a quiet and diligent worker, but on August 4, he suddenly approached the platoon leader and proclaimed that no matter how hard they would punish him, he just could not observe public order and military discipline.[12] When he was asked why he should say this, he remained silent and did not answer. On another occasion, he had claimed that he was a hindrance on the road the Army was supposed to pass.[13]

Araki reported that Hibara had given unintelligible answers (*ōtō yōryō wo ezu* 應答要領ヲ得ズ), had been depressed (*chinutsu* 沈鬱), had refused to eat, and had had trouble sleeping in Manchuria. On the 6th, he had been admitted to the line of communication hospital at Fushun 撫順, and after passing through Liaoyang and Dalian, he had reached Hiroshima on August 17.[14] By the time Hibara was examined by Araki on the 20th, his symptoms seemed to have improved:

> 初診 八月二十日、著シキ精神病徴ヲ認メス、
>
> 診斷 沈鬱狂—現時ハ治セリ、[...]
>
> 經過 發狂後一ケ月以内ニシテ治セリ—八月二十一日東京豫備病院ニ轉送セラル、[15]
>
> **Status praesens:** August 20: No prominent symptoms detectable.
>
> **Diagnosis:** Melancholia—now already cured. [...]

11 In fourteen cases the mood was not mentioned. Also note that Kure's report only provides twenty-nine case histories for his sixty-five dementia praecox patients.

12 This incident is described in Kure's report, see Kure Shūzō, 101–102. In Araki's version, the episode is not mentioned, but both Araki and Kure noted that Hibara suffered from a headache two days prior to the event and was depressed and taciturn afterwards (Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 153).

13 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 101–102.

14 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 156.

15 Araki Sōtarō, 156.

Further Developments: Recovered within a month after the illness broke out—transferred to Tokyo Reserve Hospital on August 21.

It becomes apparent from Araki's diagnosis and the outlook he noted under the rubric "further developments" that when Hibara was transferred to Tokyo on the day after the examination, Araki believed him no longer to be ill. However, based on the reported symptoms and quite possibly due to the automated conviction that no healthy soldiers were ever admitted into hospital care, he diagnosed Hibara's former condition as melancholia. Kure, on the other hand, went even further and not only re-diagnosed Hibara with manic-depressive illness but, in doing so, returned him to his original role as a sick man:

病名 鬱憂状態

既往症 [...] 遼陽、大連等ヲ経テ八月二十一日東京豫備病院ニ収容セラル。

現在症 體格榮養共ニ中等ナリ、憂愁ノ色面ニ露ハル、瞳孔散大シ舌ニ白苔アリ、脈搏頻數ニシテ百二十至ナリ、心悸亢進ノ他ニ胸部ニ異常ナシ、膝蓋腱反射亢進ス。倦怠頭痛ヲ告フ。
言語明瞭應答確實ナルモ感情沈鬱シ、恐怖心ヲ有シ、被害罪業妄想アリ、自分ハ罪悪ノ為メニ死刑ニ處セラルルトカ、他人カ自分ヲ咀フトカ、或ハ郷里ニ帰レハ村民ニ復仇ノ念アリテ己ニ危害ヲ加フルトカ、又ハ舊師（剣術）ノ娘ヲ娶リ離縁セルタメ怨マレ、其為メニ暗殺セラレントスルトカ又ハ父ハ區長ニシテ村民ニ嗾サレテ職務上ノ失策ヲナシ村ノ者カ訴訟ヲ起シ、為メニ家ニモ帰レス等ト語レリ。明治三十四年十月二十七日兵役免除退院セリ。[16]

Diagnosis: Depressed state [of manic-depressive illness].

Anamnesis: [...] After having passed through Liaoyang and Dalian, the patient was admitted to the Tokyo Reserve Hospital on August 21.

Present symptoms: Physical and nutritional state are average. Sadness is clearly shown on his face. The pupils are of equal size and the tongue is furred. He has a frequent pulse reaching 120 beats. Except for cardiac palpitation, there are no anomalies in chest and abdomen. He has increased tendon reflexes and complains about weariness and headache.

16 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 102–103.

> He speaks clearly and gives accurate answers, but his mood is depressed. He is anxious and has delusions of persecution and self-accusation:[17] He says that he will be sentenced to death for some crime, or [he says that] others have cursed him. [He says that] should he return to his native village, the townspeople would surely harm him driven by thoughts of revenge, or they would treacherously murder him because they got angry when he got divorced from the daughter of his former teacher (a fencing master). Or else [he says that] his father, the mayor of the village, would commit some disciplinary offense at the instigation of the villagers and that thereupon a lawsuit would be raised against him, so that Hibara would not be able to return to his family. On October 27, 1901 [1905], he was exempted from military service and discharged from the hospital.

According to Kure's observations, Hibara neither recovered from melancholia nor ever suffered from it in the first place. But Kure also observed that there were no longer any anomalies in Hibara's way of talking. For Araki, for whom the presence of slowed speech (indicating inhibition) had played an important role in diagnosing melancholia, this change in the patient's condition had been crucial. Kure, on the other hand, based both his conviction that the patient was indeed mentally ill and his actual diagnosis on two completely separate symptoms. Thus, he explicitly noted Hibara's depressed look and paid great attention to his miscellaneous fears and worries, which in his observation he interpreted as delusions.

Furthermore, in Kure's opinion, the illness had already begun in 1901, because in that year Hibara had become extremely anxious and had started to develop delusions of self-accusation after a quarrel with a friend. This information is completely missing from Araki's report, and it is quite likely that Kure learned about it from Hibara himself during the latter's lengthy stay at the Tokyo hospital. Moreover, it is possible that what Kure identified as delusions after an observation of more than two months had not been readily observable in Hiroshima at all, where Hibara had only stayed for five days. It could also be the case that what Kure perceived as delusions, Araki merely interpreted as worries and fears.

17 In the German version of Kure's general discussion, both *higai mōsō* 被害妄想 and *tsuiseki mōsō* 追跡妄想 are translated as "Beeinträchtigungswahn" (Kure Shūzō 呉秀三, "Über die im japanisch-russischen Krieg beobachteten Geistesstörungen" [On Mental Disorders Observed during the Russo-Japanese War], *Neurologia* 4 [1913]: 16, 26, 28), although the former literally means "delusions of harm" or "delusions of control" and the latter "delusions of persecution." Similarly, *higaiteki* 被害的 is sometimes translated as "persecutorisch" (persecutory) and sometimes as "beeinträchtigend" (impairing). It seems that Kure used these terms interchangeably. However, he clearly preferred *higai mōsō* and seems to have referred to *tsuiseki mōsō* only as a subtype of the former. In English, I translate both terms as "delusions of persecution," as this is the more common expression in modern day usage as well as in contemporary English texts (as for example in Diefendorf, *Clinical Psychiatry*).

Be that as it may, for Kure, a previous occurrence of a depressed phase clearly fitted the conceptual profile of manic-depressive illness, which was characterized by its recurrent nature. This was the fundamental difference between Kraepelin's conception of manic-depressive insanity and dementia praecox. Whereas the former was characterized as recurrent (*periodisch*), the latter was seen as the expression of a debilitating process (*Verblödungsprocess*). This notion had already been introduced by Kraepelin at the Heidelberg Conference of 1896 (see section 1.1). Here, he had explicitly stated that there could never be a periodic catatonia.[18] In any case, in Kure's diagnostic scheme, indications of a recurrent or periodic course of an affliction were more decisive for his diagnosis than the presence of affective disorders, which were to be found in many forms of mental illness.

6.2 Cognition: Foxes and Electricity

Another aspect that becomes clear from Hibara's case is that for Kure, the division of manic-depressive illness and dementia praecox did not rest upon the presence or absence of "cognitive disorders." Delusions were considered to be cognitive symptoms, and just like "affective disorders," they were not restricted to any particular mental illness. Among Kure's cases, forty-one patients had exhibited delusions, and he had divided them up into the following groups: twenty-six cases of dementia praecox, nine of *manic-depressive illness*, two of *general paresis*, two of *epileptic psychosis*, one of *hysteric psychosis*, and one of *psychosis after an infectious disease*.[19] Considering the total number of cases for the two illnesses (sixty-five of dementia praecox, twenty-two of manic-depressive illness), it appears that about 40% of the patients in both groups suffered from delusions.

In Kure's collection of cases, the different kinds of delusions were not unswervingly linked to particular illnesses. Delusions of persecution, for instance, appeared both in patients diagnosed with dementia praecox and in patients diagnosed with manic-depressive illness. Likewise, delusions of self-accusation were equally common in both illnesses. These rather fluid mechanics become obvious in the following couple of cases that deal with patients who suffered from distinctly Japanese visitations, but were diagnosed with a whole range of different diseases by Kure and Araki. In fact, all four patients believed themselves to be harassed by foxes (*kitsune* 狐) or raccoon dogs (*tanuki* 狸), vicious creatures that have long been associated with mischief and manipulation in Japan.[20]

18 Kraepelin, "Ziele und Wege der klinischen Psychiatrie," 843.

19 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 42.

20 There is a German monograph on the topic of fox-possession published shortly after the Russo-Japanese War: Erwin von Bälz, *Über Besessenheit und verwandte Zustände: Auf Grund eigener Beobachtungen* [On Possession and Similar States: Based on Personal Observations], Separatdruck aus der "Wiener Medizinischen Wochenschrift" Nr. 18 bis 22. 1907 (Wien: Moritz Perles, k. und k. Hof-Buchhandlung, 1907). The phenomenon of possession has already been studied extensively by Japanese historians and anthropologists. See for example the works of Kiyoshi Nozaki, *Kitsuné: Japan's Fox of Mystery, Romance & Humor*

On the one hand, Kure diagnosed the thirty-one-year-old soldier Chiba 千葉 with catatonia.[21] He had tried to commit suicide because he believed he was possessed by a fox, and during his examination, he had insisted that since "it was a shameful thing for a soldier of the Japanese Army to be fooled by such creatures, he would rather kill himself."[22] On the other hand, Corporal Kibashi 木橋 was diagnosed with the depressed state of manic-depressive illness.[23] He suffered from the nagging worry that his tea might have been poisoned and also constantly sensed the presence of a dog or racoon dog.[24] However, he proved "unable to tell exactly which of the two creatures it was."[25]

There were also some cases that involved foxes among Araki's patients. For instance, one patient was diagnosed with mania because he felt an anxiety that was caused by the belief that he had seen foxes passing in front of the army's lodgings.[26] In his analysis, Araki had interpreted this as a sign of false perception (*mōkaku* 妄覺).[27] Another case involved a patient who had been suffering from typhus and had afterwards developed psychotic symptoms.[28] He was convinced that foxes and cats entered his belly through his feet at night and rose to his throat to choke him. Araki diagnosed this patient with hallucinatory insanity (*mōkakukyō* 妄覺狂) and referred to this particular type of delusion as "delusions of possession" (*hyōi mōkaku* 憑依妄想).[29]

(Tōkyō: The Hokuseido Press, 1961); Okada Yasuo 岡田靖雄, "Kitsune tsuki kenkyushi: Meiji jidai o chūshin ni" 狐憑き研究史：明治時代を中心に [History of Studies on Fox Possession: Focusing on the Meiji Period], *Nihon ishigaku zasshi* 29, no. 4 (1983): 368–391; Okada Yasuo 岡田靖雄, "Tsukimono no geshōron: Sono kōzō bunseki" 憑きものの現象論：その構造分析 [The Phenomenology of Possession Symptoms: An Analysis of Their Structure], *Nihon ishigaku zasshi* 44, nos. 1;3 (1998): 369–384; Shegeyuki Eguchi, "Between Folk Concepts of Illness and Psychiatric Diagnosis: Kitsune-tsuki (Fox Possession) in a Mountain Village of Western Japan," *Culture, Medicine, and Psychiatry* 15, no. 4 (1991): 421–451; Hyōdō Akiko, *Seishinbyō no Nihon kindai* Watarai Yoshiichi, *Meiji no seishin isetsu* 95–153.

21 Case 16 (first-class soldier Chiba of the infantry corps of the reserve army, born July 1874) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 79–80.

22 "日本軍人カ獣類ニ憑カルルカ如キハ恥辱ナリ寧ロ自殺スルニ如カス" (Kure Shūzō, 79–80).

23 Case 41 (corporal Kibashi [train conductor] of the corps of engineers, born January 1880) in Kure Shūzō, 104.

24 Kure Shūzō, 104.

25 "何レカ狸カ犬カ分カラス" (Kure Shūzō, 104). In a case of *epileptic psychosis*, it was not the patient, but the people in the neighbourhood (*kinrin* 近隣) who considered him to be possessed by a fox (*kitsunetsukisha* 狐憑者) when the patient was 16 years old (Kure Shūzō, 112). This refers to case 48 in Kure Shūzō, 120–121, see footnote 76.

26 Case 56 (22-year-old infantry soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 165–166.

27 Araki Sōtarō, 165–166.

28 Case 132 (28-year-old infantry soldier) in Araki Sōtarō, 191. There is a corresponding German version, see Fall 20 (28 jähriger Infanterist) in Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 635–636.

29 In the German version, *hyōi mōkaku* was translated as "Besessenheitswahn" (Araki Sōtarō 荒木蒼太郎, 636). Araki had had some previous experience with spirit-possessions when he investigated such cases in Tokushima prefecture (Araki Sōtarō 荒木蒼太郎, "Tokushima-ken no Inugami-tsuki oyobi Tanuki-tsuki ni tsukite" 徳島縣下ノ犬神憑及ヒ狸憑ニ就キテ [On Dog-Spirit Possession and Racoon-Dog

As opposed to the fairly common but rather unspecific fox sightings, patterns that were qualified as *systematized delusions* were rather rare. In fact, there was only one patient in Kure's report who exhibited pronounced delusions that focused on one particular theme over a longer period of time. Unlike the patients who attributed their conditions to mystical creatures from Japanese folklore, Sergeant Major Sutō 須藤 was haunted by a more modern phenomenon: electricity.[30] Indeed, his preoccupation with electricity was so prominent that both Araki and Kure saw it as a defining element of his condition.

Sutō had arrived in Manchuria on August 4, 1904. Due to overwork and poor hygienic conditions, he had become exhausted, and in the summer of 1905 he suffered from weariness, headache, nausea, heaviness in the head, and bad sleep. He had continued to work, but when his symptoms became worse at the beginning of July, he was finally examined and deemed unfit for duty.[31] Hence, he was sent to the rear and passed through Hiroshima, where he was first examined by Araki:

Possession in Tokushima Prefecture], *Okayama igakkai zasshi* 12, no. 124 [1900]: 121–130; Araki Sōtarō 荒木蒼太郎, "Tokushima-ken no Inugami-tsuki oyobi Tanuki-tsuki ni tsukite" 徳島縣下ノ犬神憑及ヒ狸憑ニ就キテ, shōzen 承前 [On Dog-Spirit Possession and Racoon-Dog Possession in Tokushima Prefecture (Continued)], *Okayama igakkai zasshi* 12, no. 125 [1900]: 24–37). In this study he drew on the theories of Max Dessoir (1867–1947) to account for symptoms of depersonalization and memory loss in some of the patients. Araki's explanation strategy was a rare attempt to include the patient's personal experience into the interpretation of the phenomenon: He assumed that these people experienced a splitting of the personality (*jinsei bunretsu* 人性分裂) as a result of some triggering exciting cause. He then explained the symptoms associated with possession by suggesting that the idea of spirit possession that was present in their subconscious (*ka-ishiki* 下意識) gained prominence when the subconscious part of the mind gained control (*shuken wo nigiri* 主權ヲ握リ). When the person returned to its former self, he or she had no memory of the incident (Araki Sōtarō, 37). Please note that although *bunretsu shō* 分裂症 is the present Japanese translation term for *schizophrenia*, this concept only emerged around 1907 and had a completely different meaning, originally referring to "a splitting of mental faculties." Max Dessoir relied on the works of Pierre Janet (1859–1947), Wilhelm Wundt, William James (1842–1910), Hugo Münsterberg, and others (Max Dessoir, *Das Doppel-Ich* [The Double-Ego] [Leipzig: Ernst Günthers Verlag, 1896]), but did not mention Freud. Although Freud popularized the idea of the subconscious, he did neither invent it, nor was he the only scholar interested in hypnotism and the interpretation of dreams in the 19th century, see Henri F. Ellenberger, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* (New York: Basic Books, 1970); Andreas Mayer, *Mikroskopie der Psyche: Die Anfänge der Psychoanalyse im Hypnose-Labor* [Microscopy of the Psyche: The Beginnings of Psychoanalysis in the Hypnosis-Laboratory] (Göttingen: Wallstein, 2002). Araki's study is also mentioned in Susan Burns' article, but Araki is referred to as "Aragi" (Susan L. Burns, "Constructing the National Body: Public Health and the Nation in Nineteenth-Century Japan," in *Nation Work: Asian Elites and National Identities*, ed. Timothy Brook and Andre Schmid [Ann Arbor: University of Michigan Press, 2000], 39).

30 Case 79 (32-year-old non-commissioned officer of the artillery) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 173–174. There is no corresponding German version. Kure's data on Sutō is to be found in case 29 (sergeant-major Sutō [government official] of the artillery corps, born January 1873) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 86.

31 Kure Shūzō, 86.

初診 七月二十三日、顔容憔悴、貧血、頭重、時々頭痛、時トシテハ全頭ニ電氣ヲ通ゼラル、ノ感覺ヲナスアリ —— 異常感覺 —— 不眠、夜間種々ノ聲チ聞ク、自ラ謂ヘラク、是レ聽覺ノ甚ダ過敏ナルニヨルト、精紳不快ニシテ、食欲振ハズ、談話序次アリ、聯合抑制ヲナスコト著シカラズ、

診斷 妄覺狂 [...]

經過 七月二十四日東京豫備病院ニ轉送セラル、[32]

Status praesens: July 23. Gaunt face, anaemic, [complains about] a heaviness in the head, at times headaches. Sometimes he has a feeling as if electricity is conducted through his whole head—paraesthesia. He does not sleep and hears all sorts of voices at night. He himself thinks that it is because of this hypersensitivity of hearing that he has become mentally unstable. Loss of appetite. His speech is coherent, inhibition of associations not very prominent.

Diagnosis: Hallucinatory insanity [...]

Further Developments: Transferred to Tokyo Reserve Hospital on July 24.

Araki's observation did not mention delusions but interpreted Sutō's experiences as a case of false perception of which the patient was painfully aware. In the anamnesis, Araki had mentioned that Sutō seemed to have suffered from acoustic hallucinations (*genchō* 幻聽) since the medical examination in Manchuria.[33] This statement is followed by a question mark in Araki's text, indicating that the information available from Sutō's medical record was not conclusive in this regard. During the examination in Hiroshima, Araki seems to have attached some importance to Sutō's own assessment of his condition. That he interpreted Sutō's description of an electricity-like sensation as paraesthesia (a particular disturbance of skin sensation) shows that Araki was inclined to ascribe the condition to a physical cause. From this point of view, Sutō's fears and worries were secondary symptoms that resulted from the patient's demand to explain his experience. With the added observation that the patient's speech was coherent and his thought process little affected, his diagnosis of hallucinatory insanity seems convincing.

Hallucinatory insanity, also referred to as *Amentia* in the German version of Araki's article, was characterized as an illness that could lead to full recovery.[34] In the general remarks on his experience with this illness during the Russo-Japanese War, Araki noted

32 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 174.

33 Araki Sōtarō, 173.

34 Araki Sōtarō, *Seishin byōri hyōshaku* 180.

that most cases of hallucinatory insanity tended to improve.[35] However, diametrically opposed to Araki's rather favorable prognosis, Kure identified signs of a beginning mental deterioration which put Sutō's case within the broader category of dementia praecox:

病名 妄想性癡呆 [...]

既往症 明治三十八年七月三十日東京豫備病院本病ニ転送セラル。

現在症 體格榮養中等度ナリ、胸腹臓器ニ異常ナク、脈搏九十至、體温常、舌白苔アリ、手指震顫アリ膝反射亢進ス。頭痛眩暈胸内苦悶、不眠等ヲ告フ。
記憶普通幻覺アリ幻視トシテハ人或ハ蛇ヲ見、幻聽トシテハ已ヲ嘲弄スルカ如キ声ヲ聽キ重ニ女声ナリ、妄想ハ被害妄想及ヒ電氣妄想ニシテ何者カ自分ヲ罪ニ問ハントスルカ如ク思ヒ、又ハ電氣ヲ掛ケテ自分ヲ苦シムルモノアリト信ス。其所謂電氣ハ両耳ニ感スルコトアリ又ハ胸腔ニ感スルコトアリト云フ。之ニヨリテ擧動モ不安ニシテ又猥ニ人ヲ疑フカ如キ状アリ。
又嚬眉アリ、顔貌苦痛性ナリ。
明治三十八年八月十八日兵役免除ニヨリテ退院ス。[36]

Diagnosis: Paranoic dementia [...]

Anamnesis: On July 30, 1905, the patient was transferred to the Tokyo Reserve Hospital.

Present symptoms: Physical and nutritional state are average. No anomalies in chest and abdomen. Pulse rate of 90 [beats per minute], body temperature normal, tongue furred, tremor of the hands, tendon reflexes increased. The patient complains about headache, nausea, precordial anxiety, and insomnia.
Memory is normal. He has hallucinations. Visual hallucinations encompass the seeing of people and snakes. Acoustic hallucinations consist of hearing voices that seem to scold the patient. These are female voices for the most part. The delusions are mainly delusions of persecution and delusions of electrical influence. He thought that someone would accuse him of a crime, that he was being tortured by electricity. He believed he sensed this so-called electricity in both ears and also in his chest. Because of this, his behavior became restless and he started accusing people without cause.

35 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 145.
36 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 86.

> At times he knits his eyebrows and has a tormented expression.
> On August 18, he was exempted from military service and discharged from the hospital.

Apart from the symptoms noted by Araki, Kure observed that the patient grew suspicious of other people. Sutō had apparently expressed the fear that someone applied electricity to his ears and chest either experimentally (*shikenteki* 試驗的) or out of mischief (*akugi no tame ni* 悪戯ノ為メニ). Kure identified this condition as "delusions of electrical influence" (*denki mōsō* 電氣妄想).[37] Even though Araki did not observe delusions himself, his diagnosis of hallucinatory insanity would not have been affected by their presence. In the introductory part of his article, he remarked that, among patients with this diagnosis, many developed different kinds of delusions as a cause of hallucinations.[38] However, it seems likely that Araki's and Kure's understanding of what constituted a delusion was slightly different. As in the case of Hibara, whom Araki had considered sane when he left Hiroshima, Kure identified all worries and fears that Sutō uttered as direct evidence for delusions. All in all, his threshold for diagnosing this particular symptom seems to have been much lower than in Araki's case. This difference merely had negative consequences for the prognosis of Sutō, whereas it meant the difference between sanity and insanity for Hibara.

However, as we have already seen, the presence of cognitive disorders alone was not a sufficient condition for the diagnosis of any one form of dementia praecox in Kure's classification. He could simply have diagnosed Sutō with paranoia, which had been defined as a chronic form of insanity marked by a prominence of delusions but without leading to mental deficiency.[39] As with depressed forms of dementia praecox and manic-depressive

37 Kure Shūzō, 69. These details are mentioned in Kure's general discussion of symptoms in *dementia praecox* patients. As there was only one patient with *paranoic dementia*, the whole section must necessarily refer to Sutō's case. In the corresponding German section, the "delusions of electrical influence" are translated as "Wahnideen von elektrischer Verfolgung" (Kure Shūzō, "Über die im japanisch-russischen Krieg beobachteten Geistesstörungen," 29).

As we have seen in most of the discussions so far, the idea that the body could be affected by invisible forces such as electricity was not restricted to Japan. European patients exhibited similar fears and in some textbooks, fear of electricity appeared as a subtype of "somatic delusions of transformation" next to fear of magnetism, hypnotism, X-rays or telepathy. See for example Kraepelin, *Klinische Psychiatrie*, 191; Diefendorf, *Clinical Psychiatry*, 40–41. Ishida follows Kraepelin's categorization and lists "delusions of electrical influence" under *butsuriteki tsuisekimōsō* 物理的追跡妄想 (physikalischer Verfolgungswahn), see Ishida Noboru, *Shinsen seishinbyōgaku* 34–35. Weygandt regarded a categorization of delusions according to their content as unnecessary, as in his opinion the objects of fear were often arbitrary and a classification by type had no diagnostic value, see Weygandt, *Atlas und Grundriss der Psychiatrie*, 70.

38 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 145.

39 Kure did not diagnose *paranoia* in the Russo-Japanese War, and in Ishida's textbook it is described as a rather rare illness amounting to less than 1% of the hospital population (Ishida Noboru, *Shinsen seishinbyōgaku* 110). As has been noted earlier, all the statistic data in Ishida's book actually refers to Kraepelin's

insanity, the distinction between paranoid forms of dementia praecox and paranoia rested upon the presence of other symptoms than affective and cognitive disorders.

In the description of Sutō's condition, the knitting of eyebrows (*hinbi* 顰眉) is one of the few indications that pointed to dementia praecox in Kure's interpretation of symptoms.[40] It was also mentioned by Araki in his version of the anamnesis, but had no diagnostic value for him.[41] In Kure's discussion of symptoms, on the other hand, knitting of eyebrows was also often listed as indicative in catatonic patients.[42] However, in most of these cases, this inconspicuous sign had been accompanied by some other catatonia-related symptoms that to Kure indicated a dysfunction of volition.

6.3 Volition: Sword Dances and Drill Movements

Two more of Kure's patients who showed the same symptom of eyebrow-knitting had been diagnosed with melancholia by Araki only to be re-diagnosed with catatonia a few days later. As in Satō's case, they had both tried to commit suicide before they were hospitalized and had thereby drawn the attention of psychiatrists. Ono 小野 was a young transport soldier with a weak constitution who was among the last to be mobilized for the war in Manchuria.[43] Two weeks after he had received his call, when his division was about to leave Hiroshima on August 1, 1905, he had fainted for no apparent reason. Since then, he had been reported to show abnormal behavior with suicidal propensity.[44] Miyako 宮古, an infantry soldier of the reserve army in his late thirties, had frightened his comrades-in-arms when he had surprisingly fired his rifle in the barracks in the middle of the night.[45]

Heidelberg clinic. The exact same numbers for the occurrence of *paranoia* can therefore also be found in his textbook: Kraepelin, *Klinische Psychiatrie*, 443.

40 If one were to follow Kraepelin's textbook, several other aspects of Sutō's condition could have been considered in the differential diagnosis. By putting more emphasis on the fact that Sutō's illness seemed to have been the result of physical exhaustion, one might for example have argued for *amentia*, which was described as presenting similar symptoms. On the other hand, Sutō's unimpaired memory would then have seemed to support the *dementia praecox* interpretation (Kraepelin, 206–207). To rule out the diagnosis of *paranoia*, one might have argued that Kraepelin considered hallucinations to be more prominent in *dementia praecox* (Kraepelin, 211). If one had followed Ishida's textbook, where the section on differential diagnosis was based on Weygandt's *Atlas und Grundriss der Psychiatrie*, in which he stressed the importance of "characteristic signs of the disturbance of volition," one would rather have diagnosed him with *dementia praecox* (Weygandt, *Atlas und Grundriss der Psychiatrie*, 433, 451).

41 Araki recorded that there were wrinkles between his eyebrows (*miken shūheki wo shōji* 眉間皺襞ヲ生ジ), see Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 173.

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

43 Case 26 (auxiliary transport soldier Ono [peasant], born March 1884) in Kure Shūzō, 84–85. Kure mentioned at the beginning of the case history that Ono had been born with a weak constitution and he also noticed Ono's poor physical state when he examined him in Tokyo. For Araki's data on Ono, see case 39 (22-year-old transport soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 160.

44 Araki Sōtarō, 160.

45 Case 17 (first-class soldier Miyako [fisher] of the infantry corps of the reserve army, born February 1868)

It seemed that he had attempted to shoot himself while lying in bed, and despite being continually watched thereafter, he had still repeatedly tried to kill himself. Only when he had started to eat grass and feces and tried to swallow his campaign medal (*jūgun kishō* 従軍徽章) was he eventually sent to the rear and admitted to the mental health section.

Both Ono and Miyako were first examined by Araki and diagnosed with melancholia. According to Araki's report, Ono had shown the symptom of depression (*chinutsu*) when he had been examined in Korea in August 1905, had avoided talking to other people, had given incorrect answers, and had been unable to sleep.[46] In Hiroshima, Araki first saw him on October 8. He noticed Ono's sad face (*ganyō taishū* 顔容帯愁) and inhibited movements (*undō yokusei* 運動抑制) and reported that he did not talk at all (*mugon* 無言). As Ono's division was garrisoned in the north of Japan, he was to be transferred to the Hirosaki Reserve Hospital and left Hiroshima on October 16.[47]

Two days later, Ono passed through Tokyo, where he was examined by Kure before traveling further north. Kure did neither detect any signs of depression on Ono's face, nor did he comment on affectivity at all. Instead, he noted that his facial expression was indifferent (*ganbō fukansei* 顔貌不管性) and that his eyebrows were knitted (*hinbi*).[48] Ono was still uncommunicative and avoided other people's company, but his movements were no longer described as inhibited:

> 現在症 [...] 不潔ニシテ終日臥床ス。感情鈍麻シ、同一姿勢、衒奇症アリテ舞踊ノ如キ真似ヲナシ、喇叭ノ譜ノ真似ヲナシ、室外ニ突然駈ケ出シ、空笑シ、又拒絶症アリ。[49]
>
> **Present symptoms:** [...] The whole day he lies in bed dirty. His spirits are blunted. He shows stereotypy and mannerism, imitating a dance or the playing of a trumpet. Sometimes he suddenly storms out of the hospital room, laughs without motivation. Apart from this, there is also negativism.

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in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 80. Apparently, the first shot had been a miss. This is mentioned in the German version of Araki's report: Fall 64 (38 jähriger Infanterist) in Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 656. The corresponding Japanese version is: Case 29 (38-year-old infantry soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 156–157. When people hurried to see what had happened, Miyako attempted firing a second shot, but was hindered and burned his left hand (Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 80).

46 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 160.

47 This hospital (*Hirosaki yobi byōin* 弘前豫備病院) was receiving wounded soldiers of the 8th division of the Imperial Japanese Army (Nihon Sekijūjisha, *Meiji sanjūshichi-hachi nen seneki Nihon Sekijūjisha kyūgo hōkoku* 780).

48 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 85.

49 Kure Shūzō, 85.

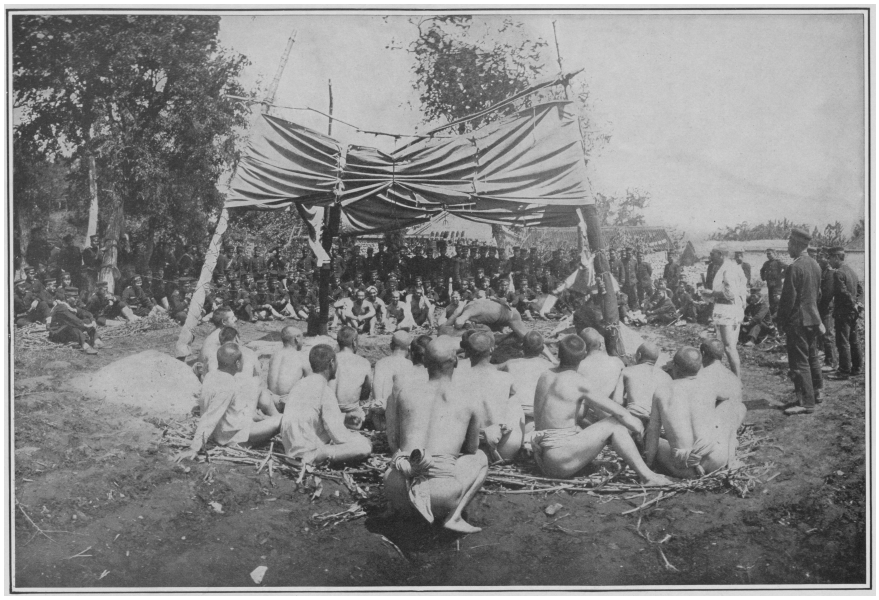

Figure 6.1: Sumo tournament, between battles

It seems that within only a few days, an exemplary melancholic patient who had shown both depression and motor retardation had been transformed into an exemplary catatonic patient with the characteristic "knitting of eyebrows," "negativism" (probably referring to Ono's refusal to speak), and two other signs related to volition and associated with catatonia, namely, "mannerism" (*genki shō* 衒奇症) and "stereotypy" (*dōitsu shisei* 同一姿勢).[50] These concepts had already become established terms in the psychiatrist's vocabulary, and Kure rarely elaborated on the kind of movement his patients were exhibiting. For one, "mannerism" referred to ordinary movements (like greeting, eating, or walking) that were marked by an unnatural or exaggerated manner. "Stereotypy," on the other hand, was defined as a series of repetitive movements not usually performed in everyday life. It could, for instance, be identified in the repetition of dance movements and trumpet-playing, as in Ono's case, or in the imitation of battle or drill movements, or in the performance of sumo 角力 (i.e. Japanese wrestling) or sword-dance moves—a form of expression that we have already encountered in Mrs. Kurosawa's story in chapter 3 (see section 3.2).

50 Sometimes Kure also referred to "stereotypy" as *jōdō sei* 常同性 or *jōdō shisei* 常同姿勢. The former is the more general expression comprising both movement and speech, whereas the latter specifically refers to repetitive movement. In Ishida's textbook, it is translated as *sasshutsushō* 刷出症 (Ishida Noboru, *Shinsen seishinbyōgaku* 44). In his textbook on the methods of clinical diagnosis, Kure uses *jōdō shō* 常同症 (Kure Shūzō, *Seishinbyō shinsatsuhō* 72).

However, this kind of behavior was not in all cases interpreted as catatonic. When facial expressions and body movements disagreed with each other, Kure usually diagnosed dementia praecox. In the case of infantry soldier Kobayashi 小林, his imitation of drill movements (*renpei no mane* 練兵ノ真似) was accompanied by an indifferent, blank face (*ganbō fukansei hyōjō ni tobashiku* 顔貌不管性表情ニ乏シク) and deemed indicative of catatonia.[51] In the case of the transport soldiers Kawanabe 川鍋 and Uchida 内田, on the other hand, their artistic performances were seen as expressions of the manic state of manic-depressive insanity.[52] As sumo was regularly seen by the soldiers in the Russo-Japanese War (see Figure 6.1), it is not surprising that Kawanabe was able to prove his familiarity with this sport when he displayed his skills in the Tokyo Reserve Hospital.[53] Apparently not an amateur of sumo, the sword-dancing Uchida was described as cheerful (*sōkai* 爽快), talkative (*tagen* 多言), singing marching songs, and yelling. Both Kawanabe and Uchida were described as having an astute look (*gankō ga surudoku* 眼光が鋭く), which meant that both their bodily expressions and their facial expressions were considered to be exalted. Since matching facial and bodily expressions were more likely to be seen as a sign of manic-depressive insanity, these two were categorized as manic by Kure.[54]

Apart from the general uncertainty about the diagnostic value of the "symptoms" of mannerism and stereotypy, Ono's diagnosis as a catatonic patient did not only rely on the presence of "stereotypy" and "flat affect" (a failure to express feelings). Other symptoms included unmotivated laughter, the refusal to talk or interact with other people, and the general impression that he seemed uninterested in his environment and current situation and spent most of his time in his hospital bed. A similar picture presented itself in the aforementioned case of Miyako, the soldier who had tried to shoot himself with his rifle. When Miyako was in Hiroshima on August 27, Araki found that he answered poorly (*ōtō fujūbun* 應答不充分), that his conduct lacked vigour (*taido fuyō* 態度不揚), and

51 Case 23 (second-class soldier Kobayashi [teacher] of the infantry corps of the conscript reserve, born May 1884) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 83.

52 For Kure's data on Kawanabe see case 30 (transport soldier Kawanabe (peasant), born May 1882) in Kure Shūzō, 98.

For Araki's data on Uchida see case 50 (22-year-old transport soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 164. There is no German version. For Kure's data on Uchida see case 32 (transport soldier Uchida [miner] of the transport unit, born May 1884) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 99.

53 Sumō was frequently practised in the evenings and "nearly every village in which troops were billeted possessed its wrestling ring" (Kuhn, "Report of Major Joseph E. Kuhn, Corps of Engineers," 13). See also Macpherson, *The Russo-Japanese War*, 507. The image in Figure 6.1 showing the Sumō tournament can be found in Richard Harding Davis et al., eds., *The Russo-Japanese War: A Photographic and Descriptive Review of the Great Conflict in the Far East*, Gathered from the Reports, Records, Cable Despatches, Photographs, Etc., Etc., of Collier's War Correspondents (New York: P. F. Collier & Son, 1905), 106.

54 Uchida had formerly been diagnosed with *mania* by Araki as well (Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 164).

that his movements were sluggish (*dōsa fukappatsu* 動作不活發).[55] He also noted that the suicidal propensity (*jisatsu kito* 自殺企圖) was still present and concluded that the patient was suffering from melancholia.[56]

On September 1, Miyako left Hiroshima for Hirosaki and arrived in Tokyo on the 3rd.[57] Here, the patient's diagnosis was changed from melancholia to catatonia:

> 病名 緊張病 [...]
>
> 現在症 體格中等ニシテ心音不純心悸亢進アリ左ノ前膊ニ疼痛アリ、脊柱中部以下ニ壓痛アリ、兩下肢感覺鈍麻シ、膝蓋腱反射缺如ス。
>
> 顔貌不管性ニシテ顰眉アリ、常ニ小聲獨語ス、指南力記憶及ヒ判斷能力不良、觀念經過遲滞、感情鈍麻シ、常同性、強梗症、反響言語ノ痕跡等アリ。終日多クハ無為ニ就床スルモ時ニ裸體トナリテノ寢臺ノ下ニ臥スコトアリ。[58]
>
> **Diagnosis:** Catatonia [...]
>
> **Present symptoms:** Physical and nutritional state average. Impure heart sounds and cardiac palpitation. He has pain in the left forearm and pressure pain below the middle section of the spine. Sensibility is suspended in the lower limbs, the tendon reflexes are missing.
>
> His facial expression is indifferent and the eyebrows are knitted. All the time he talks to himself in a low voice. Orientation, memory, and judgment are impaired. The thought process is slowed, emotions blunted. He shows signs of stereotypy, catalepsy, and echolalia. The whole day, he lies in bed doing nothing [and] sometimes he lies under the bed with his clothes off.

Kure's description contains many of the typical catatonic symptoms. Apart from the ones already discussed earlier in this chapter, he also observed "catalepsy" and "echolalia."[59]

55 Araki usually translated *taido fuyō* 態度不揚 as "Bewegungshemmung" (inhibited movements) or "Körperbewegung träge" (sluggish movements) in his German version (Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 646, 656). A more literal translation would be "a general lack of vitality in a person's demeanour."

56 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 156.

57 Araki Sōtarō, 157; Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 80.

58 Kure Shūzō, 80.

59 Although I do not intend to suggest a retrospective diagnosis of Miyako's case, I would like to point out that some of the symptoms in Kure's description could also have been regarded as indicative of *syphilis*: Almost 10 years before the described events, Miyako had developed an ulcer on his penis which healed after about ten days. In May 1905, he had an adenoma in the inguinal region and a rash on both thighs.

"Echolalia" (*hankyō gengo* 反響言語) referred to the patient's "involuntary" imitation of someone else's, e.g. the doctor's, speech. Patients could and would actively be tested for this kind of symptom. In his textbook on diagnostic methods, Kure suggested that one should loudly enounce short words such as *ichi* 一 (one), *ni* 二 (two), *hi* 火 (fire), *mizu* 水 (water), *kaze* 風 (wind), *ame* 雨 (rain), *ten* 天 (sky), *tsuchi* 地 (earth) in front of the patient and observe if they would repeat them.[60] "Echopraxia," a related symptom involving the imitation of movements, could be provoked by using a similar technique. Knitting eyebrows, sticking out one's tongue, nodding or shaking one's head, raising one's arms, and like movements were to be performed in front of the patient in order to test them for echopraxia.[61] These so-called "echo-symptoms" were considered typical of dementia praecox, and Kure invariably diagnosed patients who presented them either as catatonic or hebephrenic.

In early-twentieth-century medical literature, "catalepsy" could refer to anything from muscular tension to an extreme rigidity of the body.[62] It could also refer to a phenomenon called *flexibilitas cerea* [waxy flexibility], where the limbs of the patient can easily be moved and remain in any position that they are placed in for a long time.[63] As Kure never gave any details regarding the particularities of this symptom, it is difficult to tell what he might actually have observed. In his case histories, "catalepsy" is mentioned in six cases, all of which were diagnosed with catatonia, so that it would seem that Kure regarded this symptom to be characteristic of catatonia.

Conversely, this was not the case in Araki's diagnostic practice. In his report, he also gave examples of dementia praecox cases including catatonia, but his version of the illness was much more narrowly defined. As a result, he could merely identify eight such patients among his 211 cases. For Araki, dementia praecox was characterized by an advanced state of dementia (*shinkō seinshin suijaku* 進行精神衰弱), i.e. a profound mental enfeeblement,

Numbness in the lower extremities, lack of reflexes, impaired memory, and disorientation also point in the same direction. However, regardless of Miyako's actual affliction, it is remarkable that both Araki and Kure selectively emphasized those and only those symptoms that supported their respective diagnosis.

60 Kure Shūzō, *Seishinbyō shinsatsuhō* 100.

61 Kure Shūzō, 99–100. In his lectures, Kraepelin furthermore recommended to raise or to clap one's hands in front of the patient to see whether he would imitate the movement and thus show "echopraxia" (Kraepelin, *Einführung in die psychiatrische Klinik*, 26).

62 In the report, Kure uses both *kyōkō shō* 強梗症 and *kyōkō shō* 強硬症 as a translation for catalepsy (Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 68, 78). In other sources, the phonetic transliteration (*katarepushī* カタレプシー) is also common, see Kure Shūzō, *Seishinbyō shinsatsuhō* 91; Ishida Noboru, *Shinsen seishinbyōgaku* 42.

63 In Japanese, this term was literally translated as *rōkusshō* 蠟屈症 or *rōyō kukkyoku shō* 蠟様屈曲症. See Ishida Noboru, 42–43; Kure Shūzō, *Seishinbyō shinsatsuhō* 91; Araki Sōtarō, *Seishinbyōgaku sūki* 31.

whereas "catalepsy" played no decisive role.[64] In one case of catatonia, Araki described the symptom of *flexibilitas cerea* in sufficient detail to be recognizable:

> 上肢ヲ動スニ抗抵セズ、試ニ或位置ニ來シテ之ヲ放却スレバ、暫ク其位ニ留り、漸々奮位二復ス[65]
>
> When an arm is moved, there is no resistance. If one puts it in some position and leaves it as it is, it remains there for some time before it slowly returns back to its former position.

However, Araki's diagnostic practice shows that he did not regard this symptom as an exclusive sign of dementia praecox. A case in point is that he also noted *flexibilitas cerea* (*rōkusshō* 蠟屈症) during the melancholic phase of a case of circular insanity (*kaikikyō* 回歸狂).[66] That unnamed patient had shown alternating phases of melancholia and mania, which lasted for several months in each case. For conceptual reasons, there could not have been any cases of circular insanity in Kure's classification of mental disorders. A case like this might have been classified under manic-depressive insanity, but it seems that Kure generally gave more weight to catatonic symptoms when affective disorders were involved. This also becomes evident in the case of officer's batman Nakatsuji 中辻, whom Araki had diagnosed as manic-melancholic, but whom Kure in turn re-diagnosed with dementia praecox.[67]

Nakatsuji was said to have a nervous and cowardly disposition (*shisei shōshin ni shite* 資性小心ニシテ), but as the battalion commander's batman, he still had to run back

64 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 146. This does not mean that Araki recognized cases of mental deterioration with more certainty than Kure, but his criteria were much more strict. In the case of the transport soldier Kobayashi, Araki had made the tentative diagnosis of *dementia paralytica* (*mahikyō* 麻痺狂) with such typical symptoms as disturbance of speech, staggering gait, tremor of the hands, and severe impairment of memory and judgment. Apparently, the patient was not able to perform the simplest calculations (Araki Sōtarō, 214). In Araki's diagnostic scheme, not being able to calculate indicated an impairment of judgment and therefore Kobayashi's case fitted the criteria for *dementia* (for Araki's definition of *dementia* see section 4.1). However, after Kobayashi had been transferred to Tokyo, most of his symptoms receded and left him with nothing but a slight headache (Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 137). Therefore, Kure speculated that Kobayashi had probably suffered from psychotic symptoms after an infectious disease (*netsubyōsei seishinbyō* 熱病性精神病).

65 Case 182 (21-year-old infantry soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 210. Although no differentiation between different kinds of *dementia praecox* is made in the Japanese version, this case is specified as *catatonia* in the German text, see Fall 88 (21 jähriger Infanterist) in Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 667.

66 Case 75 (23-year-old infantry soldier) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 172. In the German version, the Latin expression is used, see Fall 74 (23 jähriger Infanterist) in Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 660.

67 For Araki's data on Nakatsuji see case 74 (27-year-old officer's batman) in Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 171–172, and Fall 9 (27 jähriger Pferdeknecht) in Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 631. For Kure's data see case 12 (officer's batman Nakatsuji [telegraph construction

and forth to his master under heavy gunfire (*dangan uchū* 弾丸雨注, literally "hail of bullets").[68] He was terrified by this experience (*kyōgaku* 驚愕) and continuously suffered from anxiety attacks (*shintsū* 心痛).[69] During a melee, he once lost his master's saddle and had been blaming himself ever since. At about that time, his colleague, who had been in charge of the battalion commander's auxiliary horse, was substituted by a mere transport soldier for heavy loads. Nakatsuji felt inferior to this worker and thought that the others regarded him with contempt (*ta yori besshi seraruru* 他ヨリ蔑視セラルル).[70] He became depressed and had suicidal thoughts. On the night of May 9, he left the barracks and was completely covered in mud (*zenshin deido ni mamirete kaereri* 全身泥土ニ塗レテ歸レリ) upon his return.[71] It was assumed that he had tried to drown himself in a puddle.[72] Consequently, Nakatsuji was sent to the rear and admitted to the Hiroshima Reserve Hospital on May 22. Upon admission, he showed a depressed face (*ganmen chinutsu wo shimeshi* 顔面沈鬱ヲ示シ), gave unclear answers, and complained about headaches. He was generally depressed but would sometimes start to sing or perform a sword-dance.[73] When Araki examined him, he observed:

> 初診 五月二十八日、態度少シク尊大ニシテ、運動亢奮示シ、放歌、吟詩、剣舞ヲナス、多辯ナラス、時々沈思スルコトアリ、
>
> 診斷 鬱躁狂
>
> 誘因 過勞
>
> 経過 五月三十日東京豫備病院ニ轉送セラル、[74]
>
> **Status praesens:** May 28. Somewhat haughty, exalted. He is singing, reciting, and sword-dancing. He is talkative, but sometimes he just sits in silent thought.
>
> **Diagnosis:** Manic-melancholia
>
> **Exciting cause:** Exhaustion.

worker], born 1879) in Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 76–77.

As a *basotsu* 馬卒 (German: Offizierspferdeknecht), Nakatsuji was in charge of the officer's main horse, but was also acting as a "runner." Nakatsuji was a civilian formerly employed as a telegraph construction worker.

68 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 171–172.

69 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 77.

70 Kure Shūzō, 77.

71 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 172.

72 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 77.

73 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 172.

74 Araki Sōtarō, 172.

Further Development: Transferred to the Tokyo Reserve Hospital on May 30.

Although Araki identified Nakatsuji's condition as manic-depressive insanity (*Manisch-depressives Irresein*) in the German version of his article,[75] I would like to propose translating the German term as manic melancholia (*utsusōkyō* 鬱躁狂), since it becomes clear from his report that this illness was conceptually different from Kure's manic-depressive illness (*sōutsubyō* 躁鬱病). In his description of the illness in the general introduction of the Japanese text, he writes the following:

躁鬱狂　鬱躁狂 沈鬱狂ノ経過中ニ、數時間至數日ニ彌リテ、躁狂證候タル發揚、亢奮ヲ斜挿シ、又躁狂経過中ニ、數時間至數日ニ彌リテ、沈鬱狂證候タル沈鬱、昏迷ヲ斜挿シ、兩狂疾證候ノ相錯綜シテ経過スルアリ、之ヲ躁鬱狂若クハ鬱躁狂ト云フ —— 第七十二ヨリ第七十四ニ至ル三例[76]

Manic melancholia—Melancholic mania When there are any symptoms of manic exaltation or agitation for [at least] several hours up to a maximum of a few days in the course of *melancholia*; or when there are any symptoms of melancholic depression or stupor for [at least] several hours up to a maximum of a few days in the course of *mania*; or when the symptoms of both conditions are interwoven in the course of the illness, this is referred to as *manic melancholia* and *melancholic mania*—3 cases, numbers 72–74.

This conception of the illness is consistent with the definition that Araki provided in his textbook, discussed in chapter 4. Judging from that description, it would certainly seem that the definition theoretically comprised the manic, depressed, and mixed states of Kure's manic-depressive illness, but this turns out to be misleading in practice. This is evidenced in Kure's assessment of Nakatsuji's case:

病名 破瓜病 [...]

現在症 體格榮養共ニ佳良、眼光鋭く、独語シ沈思默考シ、幻覺妄想アリ自殺念慮ヲ抱ク。[77]

Diagnosis: Hebephrenia [...]

Present state: The patient is in a good physical and nutritional state. He has an astute look, talks to himself, and is lost in deep thought. He has hallucinations and delusions and harbors suicidal thoughts.

75 Araki Sōtarō 荒木蒼太郎, "Beobachtungen," 631.

76 Araki Sōtarō, "Seneki ni insuru seishinbyō ni tsukite," 144.

77 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 76–77.

This short assessment of Nakatsuji's condition makes it difficult to estimate how Kure came to his diagnosis of dementia praecox.[78] It could be that the hallucinations, whose presence and content are not further explained, led Kure to classify the patient as hebephrenic. But it could also be that the contradiction between his relatively cheerful state of mind on the one hand and his suicidal inclinations on the other were seen as the main indicator of dementia praecox. Be that as it may, the case clearly shows that the relationship between what constituted melancholia, manic-depressive insanity, and dementia praecox was a much more complicated matter in practice than it might appear superficially.

The comparison between Araki's and Kure's diagnostic methods has shown that the introduction of new diagnostic criteria destroyed the integrity of the earlier melancholia concept. It also became clear that the relationship between melancholia and dementia praecox can best be described by examining the signs that allegedly belonged to the mental sphere of volition. The newly introduced signs of negativism, echo-symptoms, catalepsy, knitted eyebrows, stereotypy, and mannerisms that presumably allowed the recognition of dementia at an early stage were conceptualized as revealing a dysfunction in the sphere of volition. Being a proponent of the associationist theory, Araki did not recognize the existence of a faculty of volition, nor did he pay much attention to this group of "symptoms." For him, most of these signs, which assumed the status of objectively observable symptoms in Kure's diagnostic practice, had no diagnostic relevance.

Another major difference between Kure's and Araki's diagnostic practice was that they disagreed in their assessment of well-established symptoms such as delusions and hallucinations. Kure's threshold for identifying delusions was much lower than Araki's, which affected not only their choice of diagnosis but also their perception of sanity. Apart from this, Araki's evaluation of delusions mainly comprised a distinction between self-centered ideas and outwardly-directed ideas, which was important for his differentiation of mania and melancholia. Kure's treatment of delusions, on the other hand, also involved a judgment on the patient's rationality, as he distinguished between rational and irrational, or silly, delusions. This short comparison also reveals in which areas the conceptual shift did not occur. It shows that symptoms perceived as belonging to the sphere of affect or cognition neither played a role in the disintegration of the melancholia concept, nor were they crucial in distinguishing between manic-depressive insanity and dementia praecox.

Generally speaking, Kure's definition of manic-depressive insanity rested upon the absence of those signs that indicated a dysfunction of volition. But as these signs were very common, he had a tendency to identify more cases of dementia praecox than manic-depressive insanity. This is not only expressed in his statistical results for the mental health patients in the Russo-Japanese War but also in his statistical reports for Sugamo Mental

78 Hebephrenia was considered a sub-form of dementia praecox.

Hospital. During the Russo-Japanese War, he diagnosed 49% of his patients with dementia praecox and 16% with manic-depressive insanity. The difference was all the more telling because the patient population that he examined during the war was exceptionally homogeneous. As a matter of fact, all of his patients were male, most were between the ages of twenty and twenty-four, and many had been peasants in their civil lives.[79]

Although Kure was an outspoken partisan of Kraepelin's "psychiatric revolution," it is pointless to evaluate his diagnostic methods against Kraepelin's original text. The disease descriptions presented in Kraepelin's textbook are in many ways ambiguous and have been interpreted in different ways by different people. Without guidelines for how to weigh the different symptoms, there was ample room for dissent even among psychiatrists who tried to follow Kraepelin's classification method. However, even though Kure's diagnostic practice was certainly not representative of all adherents of Kraepelin's new diagnostic scheme, it does show some tendencies that indicate changes in observation and in rationalizing symptoms in different ways. In Kure's approach there is a strong tendency to psychologize the patient's reaction to the medical environment. There is also an inclination to evaluate degrees of rationality and to distinguish between "silly" delusions in dementia praecox and "understandable" delusions in manic-depressive insanity.[80] But the most significant changes occurred in the formation and naturalization of symptoms that allegedly showed a dysfunction in the volitional sphere. It was the invention and elaboration of these new symptoms that laid the foundation for the disintegration of the concept of melancholia.

The experience of the Russo-Japanese War had further spurred debates on the etiology of mental disorders. With the healthiest and fittest men of the country suddenly experiencing mental states which medical textbooks defined as hereditary illness, debates on the relationship between war and mental illness were bound to emerge. Although Araki and Kure could not agree on one diagnosis in the case of Nakatsuji, they both believed that his condition had been triggered by mental and physical exhaustion (*karō* 過勞). The social and discursive context of these etiological debates will be the subject of the next chapter.

79 Kure Shūzō, "Nichiro seneki chū ni okeru yo no jikken seru seishin shōgai ni tsukite," 22, 26.

80 Many of these developments had a lasting effect on the diagnostic practice of later generations of psychiatrists. For example in the Diagnostic and Statistical Manual of Mental Disorders the differentiation between bizarre and non-bizarre delusions was only abandoned 2013 (American Psychiatric Association, ed., *Highlights of Changes from DSM-IV-TR to DSM-5*, leaflet, 2013, 3).