Transnational Psychiatries

Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, *c.* 1800-2000

Edited by

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The origins of this volume date back to a conference organised by Waltraud Ernst and Thomas Mueller and held at Southampton University in September 2005. The conference, entitled "Comparison, Transfer and Histoire Croisée in the History of Psychiatry", brought together the majority of contributors to this book. It provided a platform for the presentation of work methodologically indebted to the different kinds of approach used in Anglo-Saxon research contexts and in Germanic and Francophone countries. In-depth discussions during the symposium and subsequent correspondence as well as feedback between the editors and individual authors have led organisers and contributors alike to suggest that an edited volume focusing on comparative and transnational histories of psychiatries would make an excellent contribution to a field of research that is still evolving. The scholarly exchanges resulting from this process have created an intellectually enriching cross-fertilisation of ideas and approaches, which is reflected in individual contributions. We greatly profited from the contributions to the discussions by Catharine Coleborne, Christiane Hartnack, Pamela Michael, Jim Mills and Paul Weindling.

The editors would like to thank The British Academy, The Wellcome Trust and the Society for the Social History of Medicine for their support at the various stages of the conference and the development of this book. Both editors have changed and extended their academic positions and research affiliations since the initial conference. We would like to express our gratitude to our former and current academic institutions: the University of Southampton, Oxford Brookes University, the Charité-Universitaetsmedizin Berlin, the Berlin School for Comparative European History, and the Centre for Psychiatry Suedwuerttemberg/Clinic for Psychiatry I at the University of Ulm. We are particularly grateful to Ruth Biddiss whose professionalism during the copyediting process has been invaluable. Finally, we extend our warmest thanks to the contributors for their patience and supportive enthusiasm for this shared project.

INTRODUCTION

WALTRAUD ERNST AND THOMAS MUELLER

Comparative approaches have become well established among historians since the 1990s.[1] This has been fuelled by an increased interest in issues of globalisation and ensuing concerns about the relationship between the global and the local.[2] In the specialist field of history of science and

[1] For earlier and more recent work see, for example, G. Fredrickson, "Comparative History", in M. Kammen (ed.), *The Past Before Us. Contemporary Historical Writing in the United States* (Ithaca: Cornell University Press, 1980), pp. 457-473; C. Tilly, *Big Structures, Large Processes, Huge Comparisons* (New York: Russell Sage Foundation, 1984); P. Rossi (ed.), *La Storia comparata. Approcci i prospettive* (Milano: Il Saggiatore, 1990); J. Breuilly, "Introduction: Making Comparisons in History", in J. Breuilly, *Labour and Liberalism in Nineteenth-Century Europe. Essays in Comparative History* (Manchester: University Press, 1992), pp. 1-25; H. Kaelble and J. Schriewer (eds), *Diskurse und Entwicklungspfade. Der Gesellschaftsvergleich in den Geschichts-und Sozialwissenschaften* (Frankfurt: Campus, 1999); M. Détienne, *Comparer l'incomparable* (Paris: Seuil, 2000/2009); J. Kocka, "Comparison and Beyond", *History and Theory* 42 (2003): 39-44; M. Espagne, "Sur les limites du comparatisme en histoire culturelle", *Genèses* 17 (1994): 112-21; H.-G. Haupt and J. Kocka, "Comparative History. Methods, Aims, Problems", in D. Cohen and M. O'Connor (eds), *Comparison and History* (New York: Routledge, 2004), pp. 23-40.

[2] Among German scholars, a further impetus for the refinement of comparative methodologies arose from the challenge of how the different socio-political and cultural trajectories of its western and eastern territories could be mapped prior to and in the wake of reunification in 1989. See, for example, J. Osterhammel, "Sozialgeschichte im Zivilisationsvergleich: Zu künftigen Möglichkeiten komparativer Geschichtswissenschaft", *Geschichte und Gesellschaft* 22 (1996): 143-64; J. Kocka, "Historische Komparatistik in Deutschland", in H. G. Haupt and J. Kocka (eds), *Geschichte und Vergleich. Ansätze und Ergebnisse international vergleichender Geschichtsschreibung* (Frankfurt: Campus, 1996), pp. 47-60; J. Paulmann, "Internationaler Vergleich und interkultureller Transfer. Zwei Forschungsansätze zur europäischen Geschichte des 18. bis 20. Jahrhunderts", *Historische Zeitschrift* 267 (1998): 649-85; H. Kaelble, *Der historische Vergleich. Eine Einführung zum 19. und 20. Jahrhundert* (Frankfurt: Campus, 1999); M. Espagne, *Les transferts culturels franco-allemands* (Paris: Presses Universitaires

medicine the scope of comparisons has also become recognised more widely and studies on knowledge transfer and the assessment of medical theories and practices within an international context have gained in popularity.[3] Within the sub-discipline of the history of psychiatry, early work focused on a variety of national and regional contexts in edited volumes, such as in Bynum, Porter and Shepherd (1985 and 1988) and Forsythe and Melling (1999).[4] More recently, the collections by Porter and Wright (2003) and Gijswijt-Hofstra, Oosterhuis, Vijselaar and Freeman (2005) have provided historical overviews of psychiatry and mental health in a range of countries in Europe and across the world, written by scholars indebted to inter- and multi-disciplinary perspectives.[5]

While clearly international in scope, these publications largely leave it to the reader to compare historical developments in the different regions, as individual chapters with a particular national focus are merely juxtaposed. Comparative and network-focused methodology has begun to feature in some of the chapters of the most recently published volumes, edited by

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de France, 1999); H. Kaelble and J. Schriewer (eds), *Vergleich und Transfer. Komparatistik in den Sozial-, Geschichts- und Kulturwissenschaften* (Frankfurt: Campus, 2003); J. Kocka, 'Comparison and Beyond', *History and Theory* 42 (2003): 39-44. On globalisation see, for example, J. N. Pieterse, *Globalisation and Culture: Global Melange* (Oxford: Rowman and Littlefield, 2004); P. O'Brien, "Historiographical Traditions and Modern Imperatives for the Restoration of Global History", *Journal of Global History* 1 (2006): 3-39; J. Osterhammel and N. P. Petersson, *Geschichte der Globalisierung* (Muenchen: C. H. Beck Verlag, 2003); A. Iriye, *Cultural Internationalism and World Order* (Baltimore: Johns Hopkins University Press, 1997).

[3] In respect to history of medicine see, for example, L. Sauerteig, "Vergleich: Ein Königsweg auch für die Medizingeschichte? Methodologische Fragen komparativen Forschens", in N. Paul and T. Schlich (eds), *Medizingeschichte: Aufgaben, Probleme, Perspektiven* (Frankfurt: New York, 1998), 266-91; T. Mueller, "Vergleich und Transferanalyse in der Medizingeschichte? Eine Diskussion anhand von Reiseberichten als Quelle", *Medizinhistorisches Journal. Medicine and the Life Sciences in History* 39 (2004): 57-77.

[4] W. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness*, 3 vols (London and New York: Routledge, 1985 (vols 1 and 2), 1988 (vol. 3)); B. Forsythe and J. Melling (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London and New York: Routledge, 1999).

[5] R. Porter and D. Wright, *The Confinement of the Insane: International Perspectives, 1800-1965* (Cambridge: Cambridge University Press, 2003); M. Gijswijt-Hofstra, H. Oosterhuis, J. Vijselaar and H. Freeman (eds), *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches* (Amsterdam: Amsterdam University Press, 2005).

Bivins and Pickstone (2007), Topp, Moran and Andrews (2007), and Mahone and Vaughan (2007).[6] In contrast to any of these publications, all contributors to this book share a focus on comparative methodologies. The tool box of comparative history, in its wider sense, consists of methods such as systematic comparison, transfer, shared history, connected history and histoire croisée or crossed history. Recent debates and publications on historical comparisons have indicated a preference for particular ones among these. Methodologically sophisticated scholars, such as Werner and Zimmermann, have drawn attention to the limits of systematic comparisons and transfer studies, although they acknowledge their continued value "for certain objects of study".[7] However, it seems that if comparison and transfer studies were *the* methods of choice during the 1990s, in the first decade of the twenty-first century connected, shared and entangled histories, along with histoire croisée, are being construed not so much as "alternatives" but as preferable if not superior approaches. This is partly due to the fact that the latter are seen to offer "new leads for getting beyond the stalemate in the debate between comparativists and transfer specialists" that has frequently produced more heat than light, especially among German scholars.[8] Within the field of medicine in colonial countries, they are seen to cut across and challenge such ideologically and conceptually fraught terms as medical "system", "centre" *versus* "periphery", "eastern" *versus* "western", "traditional" *versus* "modern" and even "global" *versus* "local".[9]

However, the individual contributors to this volume use a variety of different approaches from within the comparative methodological repertoire rather than championing any particular one. The perspectives of systematic comparison and transfer studies as well as aspects of histoire croisée are employed to varying degrees and always on the understanding that the selected approach needs to reflect adequately the requirements of the

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[6] R. Bivins and J. V. Pickstone (eds), *Medicine, Madness and Social History* (Basingstoke: Palgrave Macmillan, 2007) and some of the chapters in L. Topp, J. Moran and J. Andrews (eds), *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (London and New York: Routledge, 2007). See also S. Mahone and M. Vaughan (eds), *Psychiatry and Empire* (Cambridge: University Press, 2007).

[7] M. Werner and B. Zimmermann, "Beyond Comparison: Histoire croisée and the Challenge of Reflexivity", *History and Theory* 45 (2006): 30-50; p. 31, fn. 5; see also p. 32, fn. 6.

[8] Werner and Zimmermann 2006, p. 32.

[9] See W. Ernst, "Beyond East and West. From the History of Colonial Medicine to a Social History of Medicine(s) in South Asia", *Social History of Medicine* 20 (2007): 505-24.

chosen subject, questions and sources. "Self-reflectivity", rightly postulated as a vital component of critical history-writing ever since being mooted by Popper, and more recently again by Werner and Zimmermann, has thus been employed by all authors in relation to the choice of the method most appropriate to their topic—regardless of which methodological tool they favour.[10] Therefore, no single approach is here being mooted as the "royal road to truth", as it is recognised that each of them has particular strengths and weaknesses in relation to a chosen topic. While united by the ambition to go beyond the restricted scope of single-country case studies, the contributors resisted the temptation (and clear danger) of imposing or pushing one single approach to fit all. Just as a versatile and widely trained and informed psychiatrist or psychologist is "patient-centred" and always chooses the kind of therapy that works best with a particular patient, so the current authors' work is also methodologically and conceptually grounded but at the same time subject-focused and evidence- and source-driven.

A main issue that emerged from discussions during the conference preceding this book was the need for "historization". This implies authors' engagement with the issues raised by the varied comparative approaches they employ, as well as reflection on how different historiographic traditions and their favoured methodologies are embedded in specific scholarly and wider social, political and linguistic cultures. Ideally, this would result in a "double" or "layered" comparison whereby researchers compare issues of psychiatry and mental health in different geo-cultural locations as well as the historiographic methodologies that shape them. Attempts have been made in some of the chapters in this volume to achieve such historization.

The process of production of the edited volume brought into sharp relief the extent to which different scholarly conventions shape the approach to historical analysis and presentation. In contrast to almost all other earlier edited volumes that concerned themselves with the history of psychiatry and mental health, the current collection is not exclusively based on work by scholars from a predominantly Anglo-Saxon context. The challenges posed by translation into English were clearly not simply of a linguistic nature but concerned authors' preferred thinking styles and inherited "historiographic constitutions". The difficulties of a transnational approach have therefore been experienced keenly during the discussions at the conference and prolonged correspondence during the copy-editing and production process of the book—all of which was conducted in a language that constituted the linguistic and cognitive home of only one of the

[10] Werner and Zimmermann 2006, pp. 48-50.

contributors. The processes of linguistic, analytical and cognitive negotiation (and occasional aggravations) that resulted in the current volume have had a bearing on several chapters. If historization and self-reflexivity were to be pursued in a stringent way, these aspects would clearly deserve documentation.[11]

A further issue of debate concerned the extent to which the work presented here employs a "transnational" perspective. The transnational has joined the league of the many other approaches that have over the years been perceived as a new "Koenigsweg" or "ideal method" for historians.[12] There are two ways in which a transnational perspective can be employed. One attempts to reach beyond the conceptual and thematic confines of the single-country case-studies hitherto prevalent in most histories of psychiatry and mental health. The other takes issue with an *a priori* spatial focus on nation states, namely with histories that take the boundaries of modern nations as their main reference point and framework of analysis and thereby reify politically imposed borders and, in Benedict Anderson's sense, "imagined communities".[13] It is undoubtedly preferable to write a history that locates its subject beyond the confines of the nation state and is more than a history between nations—as long as adequate sources are available that enable us to write a richly textured and well contextualised history, without theory and methodological imperative running ahead of the evidence.[14] Perhaps at times erring on the cautious

[11] Werner and Zimmermann 2006, especially p. 49.

[12] For reflections in the ongoing search for a methodological silver bullet, see Sauerteig in Paul and Schlich (eds) 1998; H.-U. Wehler, Transnationale Geschichte—der neue Koenigsweg historischer Forschung?", in G. Budde, S. Conrad and O. Janz (eds), *Transnationale Geschichte. Themen, Tendenzen und Theorien* (Goettingen: Vandenhoeck und Ruprecht, 2006), pp. 161-74.

[13] B. Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism* (New York and London: Verso, 1983).

[14] On transnational history see, for example, J. Osterhammel, "Transnationale Gesellschaftsgeschichte: Erweiterung oder Alternative?", *Geschichte und Gesellschaft* 27 (2001): 464-79; S. Conrad and S. Randeria (eds), *Jenseits des Eurozentrismus. Postkoloniale Perspektiven in den Geschichts-und Kulturwissenschaften* (Frankfurt: Campus, 2002); M. Werner and B. Zimmermann: "Vergleich, Transfer, Verflechtung. Der Ansatz der «Histoire croisée» und die Herausforderung des Transnationalen", *Geschichte und Gesellschaft* 28 (2002): 607-36; P. Jackson, P. Crang and C. Dwyer (eds), *Transnational Spaces* (London: Routledge, 2004); Budde, Conrad and Janz (eds) 2006; S. Khagram, J. V. Riker and K. Sikkink (eds), *Restructuring World Politics: Transnational Social Movements, Networks, and Norms* (Minneapolis: University of Minnesota Press, 2002); G. Metzler, *Internationale Wissenschaft und Nationale Kultur: Deutsche*

side of "evidence-driven history", the chapters in the current volume pursue the "soft programme" of transnational approaches, whereby awareness of different localities' divergent and convergent trajectories, of overlaps and crossings, and of incommensurabilities and "non-transfers" guides the analysis.

The themes covered range from the different cultural meanings pertaining to the same term (Kitanaka); the transfer of treatment practices and institutional regimes (Leckie, Eraso, Ernst, Suzuki); localised practices and (re)-emerging forms of patient care (Hashimoto, Mueller); the circulation of early anti-psychiatrists' views (Fauvel); the impact of war and politics on patients' welfare and on psychiatric discourse (von Bueltzingsloewen, Wildgrube *et al.*); and the diversification of psychotherapeutic and physical practices (Fussinger and Ohayon, Suzuki).

The varied definitions of "psychological trauma" in psychiatric textbooks are at the centre of the chapter co-authored by a group of researchers based in Germany and the United Kingdom. The chapter looks at how trauma during and following military conflict has been represented in Serbia, Britain and the UK since 1945, a period that has not been covered in earlier work on trauma and post-traumatic disorders. In a systematic comparative analysis Wildgrube, Dimic, Kloocke, Schmiedebach and Priebe explore if and how dominant psychiatric discourse was affected by the varied political and societal conditions in the selected countries. The trauma concept is unusual in psychiatry as it links—unlike most other diagnoses—the description of symptoms with a distinct aetiology, the "trauma", making it particularly sensitive to socio-political processes. Whilst psychiatric textbooks might not capture adequately all aspects of ongoing debates, controversies and variations in actual practices, they represent the dominant and established professional consensus among practitioners. The authors' aims were to identify the varied terminologies and their underlying conceptual concerns and relate these to their wider medical, professional and socio-political contexts and historical trajectories. The chapter examines the medico-conceptual developments in post/communist nations ("East Germany", Serbia) and those in Britain and "West Germany". The study also scrutinises the international transfer of knowledge within the context of the globalisation of medical knowledge.

Physiker in der Internationalen Community, 1900-1960 (Goettingen: Vandenhoeck and Ruprecht, 2000); P. Chatterjee, "Beyond the Nation? Or Within?", *Social Text* 56, 16 (1998): 57-69; J. Osterhammel, *Geschichtswissenschaft jenseits des Nationalstaats. Studien zur Beziehungsgeschichte und Zivilisationsvergleich* (Goettingen: Vandenhoeck und Ruprecht, 2001).

The authors identified considerable variation over time and place in the conceptualisation of psychological trauma. This was more marked during the decades immediately after the end of the Second World War. Since the emergence of "post-traumatic stress-disorder" (PTSD) and its belated adoption in Germany, national differences diminished considerably—except for the persistent omission of reference to Selye's stress model in German textbooks.[15] However, while it had previously been suggested that the "holocaust survivor-syndrome" was adopted belatedly in Germany, the authors show that this concept in fact entered German textbooks in the 1970s, while it did not feature at all in British textbooks, and in Serbia only emerged from the early 1980s. A rigorous systematic comparison such as the one deployed by Wildgrube *et al.* lends itself particularly well to the identification of similarities and differences in relation to a particular issue, such as trauma, over time and in different locations.

In the chapter by von Bueltzingsloewen, the starvation of the mentally ill in France during the German occupation (1940-5) is at the centre of analysis. This topic is distressing and has previously been discussed in a highly politicised and polemic way. It concerns the death of 45,000 mentally ill people who suffered from hunger, cold and infection during a period of acute food shortages in occupied France. Von Bueltzingsloewen tries to introduce more nuance and depth into a debate that has been characterised by oversimplification. She challenges the position of the French psychiatrist Max Lafont who referred to the high death toll from malnutrition and starvation as "mild extermination".

Von Bueltzingsloewen's assessment is framed by reflection on how her chosen methodology engenders a more complex understanding of a highly controversial issue in French history. The author looks at the tragic fate of mental patients in different care settings in both occupied and unoccupied territories in France. In a first step, she compares the situation in mental hospitals in occupied France (which was jointly administered by the Germans and the Vichy government) with the conditions in mental institutions in the rest of France, the "zone libre". In order to identify the factors that could explain the differing death-rates in the areas under study, she sets the former data against the death-rates prevalent in other closed institutions (such as general hospitals, prisons, sanatoria and old people's homes). Then Bueltzingsloewen assesses the secondary literature for the death-rates reported for German psychiatric patients, many of whom suffered starvation, but also extermination by gas during the Nazi regime

[15] On Selye's model, see H. Selye, *The Stress of Life* (New York: McGraw-Hill, 1956); H. Selye, "Stress and Disease", *Science* 7, 122 (1955): 625-31.

in Germany. The aim of the last procedure is not so much to provide a systematic comparison of conditions in France and in Germany, but to identify if the deaths in occupied France were due to the enforcement of German policies by the occupying force, or to the measures and omissions of the French Vichy government.

In their chapter on psychotherapy in Switzerland and France during the 1950s, Fussinger and Ohayon map the role of psychoanalysis, within the context of the professional and institutional development of psychiatry. Very different solutions were found to similar debates and concerns in Switzerland and France. In both locations, psychoanalysis had established itself as a professional body (with its own journals, meetings and training opportunities) and there had existed a culture of intellectual exchange between (medically focused) psychiatrists, psychoanalysts and psychotherapists since the 1920s. Controversy emerged in the 1950s, focusing on the extent to which psychotherapy ought to figure in the training of psychiatrists and whether an analytical approach ought to be integrated into practices at psychiatric institutions. In Switzerland, analytical psychotherapy became formally recognised as an integral part of psychiatry. In France, psychotherapeutic training for psychiatrists was optional. This less formal arrangement seems to have resulted in a greater interest in and prominence of psychoanalytic therapy.

Fussinger and Ohayon proceed from the basis of a systematic comparison in relation to their assessment of the position of psychoanalysis in French and Swiss psychiatry. They switch analytical perspective in line with the tenets of histoire croisée when they focus on the ambivalence intrinsic to the psychoanalytic movement in regard to professional autonomy and self-determination on the one hand and wider institutional integration and recognition on the other. This results in a sensitive and rich assessment, as the histories of psychiatry and psychoanalysis are crossed with the varied historical developments of the wider medical professional and institutional cultures. Fussinger and Ohayon show that aspects from different methodologies can be employed fluidly in a fruitful and nuanced way in order to engender greater sophistication of analysis.

The advantage of comparative perspectives over single-country assessments is highlighted by Mueller's chapter on psychiatric family care in France, Belgium and Germany. The peculiar development of German family care emerges particularly clearly when set against other national contexts. Mueller first looks at French and German late nineteenth-century debates on psychiatric family care in relation to Belgian prototypes. He then shows that the structures and practices of care began to diversify in

these three countries in the course of the twentieth century, with considerable inter-regional diversity emerging. Psychiatric family care still exists in Belgium and France in a modernised version. In France, it dates back to 1892, while it has an even longer history in Belgium. The occupation of these countries by German troops during the Second World War caused difficulties for family care institutions in both countries. However, the administrative and medical structures of care were not totally destroyed. In Germany itself, however, National Socialist medicine and politics undermined family care provision. Its far-reaching impact was felt also during the post-war period until the 1980s, as hardly any larger-scale psychiatric family care facilities prevailed in the German states (FRG *and* GDR).

In relation to the historiography on psychiatric provision in the three countries, significant differences are identified by Mueller. He shows that the medical developments in post-war Germany correspond with German historiography in a distinct way as virtually no scientific publications on psychiatric family care can be found from the late 1930s until the early 1980s. To a certain extent, the long-term consequences of National Socialist health policies during the 1950s and 1960s, in addition to a societal and intellectual climate hostile to the institution of the *buergerliche Kleinfamilie* ("bourgeois nuclear family") during the 1960s and 1970s, engendered the continued neglect of a model of psychiatric care that had been obliterated for ideological rather than medical reasons. Political decisions and ideological distortions had suggested "progress"—within the framework of a racist worldview of a totalitarian regime.

Hashimoto's chapter focuses on the care of the mentally ill within host family settings. Hashimoto explores how the idea of psychiatric foster family care in the Flemish town of Gheel extended beyond the borders of Belgium and was received and transformed by health care agents in Japan during the late nineteenth and early twentieth centuries. His statistical analysis of the Gheel Visitors' Register for the period from 1892 to 1935 reveals that 512 foreigners visited the town and its facilities, attesting to its high-profile international reputation. Hashimoto looks at the various European models, in Germany as well as in Belgium, by which visitors from Japan were inspired. He maps the ensuing dynamic processes of reception, involving modification and omission, which led to the formation of varied care practices in Japan at different periods and localities. Within the wider context of the modernisation of Japanese medicine, which did not simply mirror western models, psychiatric family care evolved as an "invented tradition", rather than following any one particular European prototype.

Mueller's and Hashimoto's chapters benefited from each other's research on the transfer of care concepts to Japan and deal with the methodological challenges of comparing different cultures and social contexts. They also reflect critically on the concept of "modernisation" in historical writing. Hashimoto shows that the meaning and shaping of psychiatric family care in Japan was strongly linked up with Japanese traditions and cultural perceptions and preferences in particular locations. He contrasts initiatives that had varied success. For example, the introduction of German-style family care in 1902 at Matsuzawa Hospital in Tokyo by leading psychiatrist Shuzo Kure was not successful. At the time, the number of hospitalised patients in Japan was still small as most patients were cared for at home by their own families. The introduction of family care at mental hospitals was therefore not considered an urgent task. At Iwakura village near Kyoto, in contrast, the concept of family care was given a new interpretation as "a Japanese Gheel". Here, mental patients had traditionally lived in small home-style Japanese hostels. Local and central government repeatedly challenged provision for mentally ill people in these kinds of place, as they were not under direct medical control. However, they were allowed to exist until the Second World War, as the argument was successfully made that the hostels were part of modern family care, comparable to the Gheel system and thus in line with modern, western standards and developments.

If we are interested in the exploration of how particular material objects, such as medication, or expert knowledge and specific skills were adapted, reconstructed and appropriated within a different socio-cultural context, our method of choice might be a study of historical "transfer". Emphasis in this approach is on the processes and outcomes of transnational and transregional reception. In her chapter on the reception in Argentina of a particular work therapy system, Eraso explores the continuities and discontinuities and the significations and re-significations of work as therapy for mentally ill patients at a time of fluent academic exchange between German and Argentinean doctors. Eraso maps the development of occupational therapy in the largest Argentinean asylum during the 1920s and 1930s, focusing on how a particular system, developed by German psychiatrist Hermann Simon, travelled across national boundaries. She shows that Simon's ideas were debated by Uruguayan and Argentinean psychiatrists at a specialist conference in Buenos Aires in 1928 and implemented well before Simon published his renowned and influential book on "active therapy". What is more, the idea of labour as therapy had already been well established in Argentina as part of the "colony-asylum" model that involved agricultural work within an

open-door system in line with the wider premises of moral treatment. Reference to Simon's ideas therefore revitalised the therapeutic aspects of a well-established practice and underpinned the "scientific principles" on which the organisation of work for the mentally ill was based. Simon's method, or *Praxiterapia*, as it became known in Argentina, generated a new dynamics in the Argentinean colony-asylum by reducing the period of lying-in treatment (or *Clinoterapia*), elevating patients' capacity to work to an indicator of recovery, and leading to a refined system of classification that differentiated between those able and unable to work. The latter came to be perceived as a "burden to the state".

In Germany in the late 1920s, Simon's reforms were in line with the wider aims of welfare policy during the Weimar Republic. They also helped decrease the financial cost of maintaining the growing number of chronically ill patients at a time of economic crisis. The focus on economic efficiency, within the context of the radicalisation of politics and the pursuit of a "racial hygiene" programme under the Nazi regime, led to an alignment of "active therapy" with forced sterilization and euthanasia. In the Argentinean context, forced eugenic measures and euthanasia were not implemented, but eugenic ideas provided much of the rationale that drove the approach taken towards the mentally ill: economic categories prevailed over medical ones and *Praxiterapia* resulted in forced labour. Eraso provides a concise exploration of the transnational dimension of psychiatric ideas and closely examines the practical implementation of an inherently controversial system within the Argentinean context.

In his chapter on shock therapies, Suzuki examines how Japanese psychiatrists adapted some of the physical treatments that appeared in the 1920s and 1930s, such as continued sleep, insulin coma, malaria, metrazol/cardiazol and electro-convulsive therapy. These new practices restructured the entire field of psychiatric therapeutics, changing its priorities and goals. Suzuki's analysis is based on patients' case records from a semi-private psychiatric hospital in Tokyo. He shows that new treatments were introduced as soon as they were announced in medical journals and that all new developments (with the exception of lobotomy) were eagerly followed in Japan. One factor that facilitated the swift reception of shock therapies related to doctors' ambition to attract high-paying private patients to small-scale yet under-funded institutions. The prospect of treatment by means of the latest modern treatments appealed to well-off patients and their families and also to clinicians who worked within strongly research-focused institutions that followed the German model of university psychiatric clinics.

Local preferences, professional research aspirations and financial considerations not only ensured a swift transfer of (often highly expensive) European techniques, the ensuing focus in clinical practice on cure and symptom relief by means of physical therapies also affected the patient-doctor relationship. Suzuki shows that an investigation of psychiatric therapeutics offers an exciting window on to a social history of the psychiatric bedside that pays attention to doctors and patients and their families. He highlights also the importance of local factors that interweave with the rationale of global theories. Local medical practice subscribed to the newly developed methods of a global science of psychiatry, while at the same time its practitioners were concerned with the solution these offered for persistent financial problems as well as its career-enhancing aspect within a cutting-edge, research-focused clinical environment. The chapter therefore highlights the multiplicity and flexibility of meanings connected with particular treatments in different localities. These were framed by the socially and culturally conditioned clinical encounter, while the structure of the encounter was configured by the nature of the treatment—a complex dynamics between the local hermeneutics of a treatment and the universalisation of psychiatric culture.

In her chapter on the Ranchi Indian Mental Hospital, Ernst focuses on the implementation of particular treatment regimes during the 1920s, 1930s and 1940s. This was a period when the British encouraged the gradual "Indianisation" of the colonial medical service. Ernst shows that J.E. Dhunjibhoy, the Indian psychiatrist in charge at Ranchi, kept himself well abreast of scientific developments across the world and experimented with the latest therapies as soon as they were announced in scientific journals and at conferences. She argues that we need to look beyond the confines of colonial medicine and the colonial state and trace all the significant connections and scientific networks from which practitioners took their inspiration. Ernst also points up some of the limitations and possible pitfalls of studies guided by the notion of "transfer". These are not fully explored in the chapter, concerning as they do wider methodological issues that have particular salience in relation to colonial histories. They relate to the danger inherent in the focus on "transfer" of providing referential accounts, limited and skewed by the concerns and developments pertaining to the countries that give rise to the transfer. Ernst argues that attention needs to be paid also to ideas and practices that were *not* transferred and to those that prevailed independent of any existing international blueprints. It may in fact be preferable to explore psychiatric practice within colonial contexts on its *own* terms and in its *own* right, rather than merely as a derivative, mirror or local version of

psychiatry in western countries or in a global perspective (especially if the "global" is implicitly, as is so often the case, identified with "western"). We would need to attempt in the history of colonial medicine what Dipesh Chakrabarty mooted in relation to the writing of the history of South Asia more widely, namely "provincialising 'modern' psychiatry".[16]

Leckie's chapter presents a historical analysis of entanglements between community and state management and institutionalisation of the mentally ill in Fiji. This topic is of particular relevance not least because the Pacific Islands are often overlooked in global histories. Leckie assesses the dynamics between Fiji's indigenous and immigrant communities and the former Public Lunatic Asylum in Fiji, founded in 1884 and later operating as St Giles Psychiatric Hospital. She shows how mental illness became articulated and institutionalised in a colonial society segmented along ethnic, gender and class lines. The practices of community and state management of the insane are examined by considering community discourses and definitions of madness. Particular emphasis is placed on why and how local communities embraced western medical institutions. Very few Pacific Islanders were confined in the Fiji asylum, but once it had been established, communities began to access this new space for care and control.

Leckie traces the processes that were involved when mental abnormality became entwined in local constructions. As she shows, entangled histories point to linkages between the asylum, disordered minds, local communities and the state. She discusses the notions of the "encompassment" of the everyday and of local and "native" minds by colonial medical and legal projects; the "entanglement" of local communities with the asylum/ colonial state within Fiji (and in New Caledonia); the hybridisation of control and care and of the local with the global through colonial transfers in psychiatry and colonial health; and the asylum as the locus of entanglement between the institution and indigenous, migrant and settler communities, which are, in turn, themselves complicated by and entangled with class, race, gender and custom.

In her chapter on the circulation of anti-alienists' views in the late nineteenth century, Fauvel assesses in depth the case of Baron Raymond Seillière, who had several encounters with psychiatry in different countries and eventually attracted international public attention. This forced psychiatrists and institutional administrators in France and abroad to discuss and compare their positions on the management of the mentally ill.

[16] D. Chakrabarty, *Provincializing Europe. Postcolonial Thought and Historical Difference* (Princeton University Press, 2000).

Fauvel shows that Seillière's psychiatric wanderings across nations provide pertinent insights into patients' participation in the circulation of "anti-alienist" conceptions towards the end of the nineteenth century.

Fauvel takes issue with Foucault's analysis of "psychiatric power", as it led French historians of psychiatry to (mis)represent the insane as the great absence in history, being immured and silenced within the confines of both psychiatric discourse and the asylum. Although many aspects of Foucault's argument about the great confinement of the insane have recently received critical attention among French historians, the construction of the mentally ill as passive, silenced and pacified objects has not been challenged until very recently. Fauvel discusses this classic *a priori* of the French historiography of psychiatry against the background of more recent work that has shown that in France—as in other western European contexts—the mentally ill managed to express themselves actively and to a much greater extent than had hitherto been suggested. The case of Baron Seillière highlights particularly well how patients were actively implicated in the construction of counter-discourses and in the management of their lives as mental patients.

Kitanaka's chapter focuses on the varied meanings of depression in Japan. She engages with the historiographies of depression and the history of psychiatry more generally as well as debates in the anthropology of emotions, and traces the complex dynamics of the global medicalisation of depression. Kitanaka maps the latter as a series of creative local translations rather than as universal homogenising processes. As the global spread of medicalisation fuels a heightened concern with clinical depression in areas of the world where the ailment was once relatively unknown, the question of whether depression constitutes any universal illness that transcends cultural and historical boundaries has gained a certain urgency. Though Japan officially adopted German neuropsychiatry in place of traditional medicine in the late nineteenth century, Japanese psychiatrists have repeatedly wondered why the Japanese do not seem to suffer depression as much as people in western countries. Some suggest that the aestheticisation of depressed feelings—and a higher tolerance for those who suffer dejection—have prevented the Japanese from conceptualising depressed moods as pathological. It has even been speculated that depression did not exist in Japan prior to the concept being transferred from Europe in the nineteenth century. The rapidly changing status of depression since the late 1990s, when it emerged as a "national disease", signals the need for a re-examination of its alleged historical absence, which has often been merely postulated rather than historically investigated.

Contrary to long-held assumptions by Japanese psychiatrists, this chapter shows that "depression" was part of the traditional medical vocabulary in pre-modern Japan. "*Utsushô*", a medical term originally adopted from China, was defined as an "illness of emotions" in Japan's first known medical dictionary, published in 1686. It was used to describe the illness of those who appeared dejected and socially withdrawn, and the term began to appear in popular literature as early as the 1700s. Utsushô was also used to translate "melancholia", when the concept was transferred from Dutch medicine in the 1830s. These facts make claims about the alleged historical absence of depression in Japan rather puzzling. The key to resolving this puzzle lies, Kitanaka argues, in understanding the fundamental discontinuities in the Japanese conceptualisation of depression—and the subsequent psychologisation of *utsushô*—that arose from Japanese encounters with modern western psychiatry. In place of earlier Japanese notions such as *qi* (life energy), the new medical language brought new conceptual frameworks and specific dichotomies, in particular those connected with the adoption of German neuropsychiatry: the biological and the psychological, the objective and the subjective, the real and the metaphorical. This led to the invalidation of *utsushô* as a disease entity, relegating it to the rank of a mere psychological problem.

This collection presents both original historical analyses and conceptual reflections on comparative and related methodologies within a transnational research framework. The authors have deployed rich empirical material in focused and nuanced studies. With the application of conceptually and theoretically informed approaches they have attempted to break new ground in the history of psychiatry. Instead of one-dimensional perspectives, contributors have presented multilayered interpretations, emphasising commonalities and interconnections as well as contrasts and discontinuities. With its wide-ranging geographical focus and attention to conceptual issues, this collection of essays aims to assist in integrating and reconfiguring the historiography of psychiatry.

CHAPTER ONE

READING EMOTIONS IN THE BODY: TRANSLATING DEPRESSION AT THE INTERSECTIONS OF JAPANESE AND WESTERN MEDICINES [1]

JUNKO KITANAKA

> When doctors in the Neijing subsequently spoke of *qi* rising in anger, sinking in fear, sweeping away in sorrow, they weren't so much trying to explain emotions, objectively, as relating what they knew from their own bodies, describing what they felt, subjectively, within themselves. In anger, a sudden, explosive surge; in grief, a draining away. It was the intimate everyday familiarity of such sensations that made the traditional discourse of vital flux so compelling. The deepest certainties about *qi* were rooted in knowledge that people had of the body because they *were*, themselves, bodies.
> —Shigehisa Kuriyama (On Chinese traditional medicine) [2]

The Historical Absence of "Depression"?

Anthropologists of medicine have long asked how it is that some medical

[1] After Edward Said's *Orientalism*, anthropologists came to bracket the word "west" in order to signal that this is merely a representation, which risks reducing historical and cultural complexities and multiplicities into an essentialised entity. Nonetheless, I choose to use this term here because I am referring to what the Japanese around the time of and after the advent of modernity regarded and represented as "western" medicine(s).

[2] S. Kuriyama, *The Expressiveness of the Body and the Divergence of Greek and Chinese Medicine* (New York: Zone Books, 1999), p. 103.

concepts travel well—and become integrated into local knowledge—while others, when transferred to another culture, seem to remain alien, experience-distant, even incommensurable. While anthropologists have traditionally interpreted such a failure in translation as a sign of fundamental cultural difference, more recently they have questioned the cultural essentialism lurking behind such a claim and instead begun to explore the issue of power in translation. By historically investigating initial moments of concept transfer, anthropologists have asked what forces are at play in adopting a certain medical concept—or a language—and how such moments of transfer can be read as a site of power struggle among competing medical languages, each of which is used to represent, even construe, different modes of reality.

In this regard, the "rise" of depression in Japan since the late 1990s presents an intriguing case because, despite the nineteenth-century transfer of the psychiatric concept of depression from Germany, Japanese psychiatrists have long been puzzled about the seeming rarity of depression among the Japanese. While the depression concept itself is firmly entrenched in professional psychiatric knowledge in Japan, it seems to have had little salience or explanatory power for most Japanese for understanding their experiences, thereby suggesting a failure in translation. Some psychiatrists have thus speculated that, unlike in the west where depression—or its precedent melancholia—have had a long history, depression essentially did not exist in Japan before the advent of modern psychiatry.[3] Other prominent scholars such as Kimura Bin have also argued that a Japanese traditional tolerance for—or even aestheticization of—depressed feelings might have kept the Japanese from seeing depressive-like moods as pathological.[4] This belief in cultural difference

[3] T. Miyamoto, "Sōutsubyōsha no Mōsōteki Disukūru" ["Delusional Discourse of the Manic-Depressive"], in T. Miyamoto (ed.), *Sōutsubyō no Seishin Byōri* [*The Psychopathology of Manic Depression II*] (Tokyo: Kōbundō, 1979).

[4] B. Kimura, "Hikakubunkaronteki Seishinbyōri" ["Psychopathology from a Comparative, Cultural Perspective"], in R. Takahashi (ed.), *Gendai Seishinigaku Taikei Vol. 9-B: Sōutsubyō II* [*Modern Psychiatry Vol. 9-B: Manic Depression* II] (Tokyo: Nakayama Shoten, 1979). The essence of this cultural argument was crystallized in Gananath Obeyesekere's work on depression in Sri Lanka. He argued culture interprets the negative affect as a religious experience to the extent that the depressed are saved from being pathologised and socially excluded as mentally ill. These perspectives are important in illuminating the "work of culture" as a mediating force and examining how certain affects become bestowed with much anxiety in some societies more than others. See G. Obeyesekere, "Depression, Buddhism, and the Work of Culture in Sri Lanka", in A. Kleinman and B. Good (eds), *Culture and Depression: Studies in the Anthropology and*

was so strong that some psychiatrists successfully advised the Eli Lilly Company against selling Prozac in Japan for lack of a market.[5] Psychiatrists in Japan were thus confounded to find depression suddenly emerging from the 1990s as an everyday idiom of distress, with the media calling it a "national disease".

How can we interpret this sudden rise and the earlier alleged historical absence of depression? On the one hand, Kimura and other Japanese psychiatrists may be pointing to a salient difference when they state that, unlike in the west, where the notion of melancholia achieved an evocative, symbolic status not only in medicine but also in religion, philosophy and literature, there was no equivalent of melancholia-like insanity in the history of Japanese medicine. On the other hand, however, if we broaden the notion of depression to include its milder forms, psychiatrists may have been too presumptuous in thinking that the Japanese used to simply aestheticise—and never pathologised—depressed emotions. My research into the history of depression has revealed that not only did the same term that the Japanese now use for depression—*utsubyō* (鬱病)—exist in pre-modern Japan but that its antiquated forms—*utsushō* (鬱症 / 鬱証) and ki-*utsubyō* (気鬱病)—began to appear in popular literature by the eighteenth century as illness categories characterized by gloomy moods, lack of energy and social withdrawal. In fact, when the concept of melancholia was transferred from Dutch medicine in the late eighteenth century, some variants of "*utsu*" terms (such as *utsubyō* or *utsuyūbyō*) were eventually adopted as its standard translation. Why is it then that Japanese psychiatrists have come to assume that pre-modern Japanese had no concept of depression?

By drawing upon recent historiographies of the body in Japanese medicine by Kuriyama Shigehisa and others and using traditional medical texts and popular literature, I want to attempt a kind of semantic historiography of depression.[6] Instead of starting with a strictly defined

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Cross-Cultural Psychiatry of Affect and Disorder (Berkeley: University of California Press, 1985). Also see A. D. Gaines and American Anthropological Association, *Ethnopsychiatry: The Cultural Construction of Professional and Folk Psychiatries* (Albany, NY: State University of New York Press, 1992); Kleinman and Good (eds) 1985. From these perspectives, the current rise of depression documented in Japan might be regarded as yet another example of the encroachment of the west into the intimate realm of the sense of self.

[5] K. Applbaum, "Educating for Global Mental Health: American Pharmaceutical Companies and the Adoption of SSRI in Japan", in A. Petryna, A. Lakoff and A. Kleinman (eds), *Pharmaceuticals and Globalization: Ethics, Markets, Practices* (Durham, NC: Duke University Press, 2006).

[6] S. Kuriyama, "Katakori Kō" ["Reflection on Katakori"], in K. Yamada and S. Kuriyama (eds), *Rekishi no Naka no Yamai to Igaku* [*Illness and Medicine in*

cluster of depressive symptoms as we understand it today and examining how such a disease entity moved across history under different times, I want to trace the term "*utsu*" itself and examine what meanings and conditions were implicated at different moments of concept transfer. In so doing, I hope to illuminate how the previous psychiatric discussions about pre-modern depression have not fully taken into account that the kind of epistemological break that Foucault has described with regard to French modernity happened in Japan with far more decisive force—particularly in medicine.[7] By the late nineteenth century, the Japanese had come to largely abandon traditional ways of understanding themselves and instead adopt an entirely new language,[8] a language that began to constitute the modern self. This new, "global" medical language introduced to lay Japanese notions such as nerves (which did not even exist before) and the brain as the locus of control (an organ which previously was thought to have little importance).[9] This language further introduced the neuropsychiatric concept of depression as an abstracted reality that exists in and of itself, while serving to invalidate the traditional language for reading emotions in the body, of which the pre-modern notion of

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History] (Kyōto-Shi: Shibunkaku Shuppan, 1997*a*); Kuriyama 1999; E. Shirasugi, "Kakke to Edojidai no Hitobito no Shintai Keiken" ["Kakke and the Bodily Experience of the People in Edo Era"], in K. Yamada and S. Kuriyama (eds), *Rekishi no Naka no Yamai to Igaku* [*Illness and Medicine in History*] (Kyōto-Shi: Shibunkaku Shuppan, 1997).

[7] M. Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Vintage, 1973). See also S. M. Garon, *Molding Japanese Minds: The State in Everyday Life* (Princeton, NJ: Princeton University Press, 1997).

[8] The modern state officially adopted "western medicine" and effectively de-legitimised traditional medicine in 1874, though the latter has certainly survived into the twentieth century. See M. Lock, *East Asian Medicine in Urban Japan* (Berkeley: University of California Press, 1980).

[9] Within the paradigm of Chinese-derived traditional medicine, as Sakai Shizu (1982) writes, there was no concept of nerves, nor was the brain regarded as an important organ. Thus when Sugita Genpaku, the first Japanese doctor to have conducted official dissection, wrote *Kaitai Shinsho* (New Human Anatomy) in 1774, he literally had to create the Japanese word *shinkei* or nerve. See S. Sakai, *Nihon no Iryōshi* (Tōkyō: Tōkyō Shoseki, 1982); "Nerve" remained a highly technical term for the following century; its spread to lay people only happened after western medicine was officially adopted by the government in 1874. See K. Kawamura, *Genshi Suru Kindai Kūkan: Meishin, Byōki, Zashikirō, Aruiwa Rekishi no Kioku* [*Ilusions of Modern Space: Superstitions, Illnesses, Private Confinement, or Memories of History*] (Tokyo: Seikyūsha, 1990).

depression was a part.[10] Illuminating how the Japanese experienced the body and mind differently at different times, I will ask how it is that "depression", as people talked about it in the Edo Era had, via the nineteenth-century concept transfer of depression from German neuropsychiatry, became so unfamiliar and obsolete for most Japanese. So much so that psychiatrists even came to assume that such an illness experience never existed.

Utsushō as an Illness of ki-stagnation

A contemporary Japanese who hears that there existed an illness term called *utsubyō* or *utsushō* might readily assume that depression must have existed in pre-modern Japan. *Utsu* is a common term that has been used for a long time to connote a gloomy mood, and *shō* and *byō* indicate symptom and illness respectively.[11] Yet, this seeming transparency (referring to *utsubyō* and *utsushō*) is actually deceiving when we look at the original meaning of *utsushō*.[12] Before there was the medical concept of

[10] Cf. B. Zimmermann, "Histoire Croisée and the Making of Global History", based on a paper presented at Global History, Globally, Harvard University, 8-9 February 2008 http://www.iue.it/HEC/ResearchTeaching/20082009-Autumn/SS-reading-Zi mmermann.pdf (accessed 3 February 2009).

[11] Both in Chinese and Japanese literature, *utsu* has been used from early times as an expression for gloominess, sorrow, and pensiveness, as discussed below. See T. Morohashi, *Daikanwa Jiten* [*Kanji Dictionary*], vol. 12 (Tokyo: Taishūkan Shoten, 1984), 13261-5. In China, this word appears in literature dating back to BC. In Japan as well, pre-modern literature is rife with such words that referred to *utsu* in the dual meanings. See Shōgakukan Kokugo Jiten Henshūbu (ed.), *Nihon Kokugo Daijiten* (*Japanese Dictionary*), (Tokyo: Shōgakukan, 2001), p. 343. One term that often appeared in pre-modern literature was *ukketsu* (or *utsu* knot), as seen in Japan's first collection of poems of the eighth century, *Manyôshû* (*Ten Thousand Leaves*). One of the poems reads: "sorrow stagnating and knotting in one's heart". See S. Nakanishi, *Manyōshū* (*The Anthology of Myriad Leaves*) (Tokyo: Kadokawa Shoten 1995), 4247, suggesting the idea that ki depressed in one's heart causes dejected emotions. Another word *utsumu* (*utsu* fog), or stagnated fog, appears in a fourteenth-century school textbook. The expression was used to signify both an external, *physiological* condition of dense fog and a projected internal, *psychological* state of gloominess (note the metaphorical link between weather and depressive experience: see J. Tanaka-Matsumi and A. J. Marsella, "Cross-Cultural Variations in the Phenomenological Experience of Depression", *Journal of Cross-Cultural Psychology* 7 (1976): 379-96.

[12] The transparency refers to *utsubyō* and *utsushō*, both of which are sometimes used interchangeably to refer to depression. *Sho* (symptom) is apparently a milder term, which is preferably used by lay people when they mean *byo* (illness). This is especially the case when they refer to a mental illness but want to play down its

utsushō, *utsu* was an ordinary word which already had a long history. *Utsu* has dual meanings: first, as the character *utsu* (鬱) is graphically made up of trees "densely growing together", the term signifies a physiological state where things are rampant, densely overgrown, or stagnant. Second, in both Chinese and Japanese literature, *uts*u has been used from early times as an expression for gloominess, sorrow and pensiveness.[13] What united these seemingly separate meanings was the pre-modern belief in the phenomenon called ki (*qi* in Chinese). Ki was an essential aspect of pre-modern Japanese thought—the idea that not only all the living things but also the world, and the cosmic itself, are filled with this life energy.[14] Ki was invisible and intangible, and yet it could be felt in the form of wind when it moved in the atmosphere and in the form of breath when exhaled by the human body. As something that was constantly circulating, ki would change and was changed by both external and internal forces, one of which was the movement of emotions. Thus, when pre-modern Japanese talked about *utsu*, it was presumably ki itself that was being stagnated in the physiological sense, while the same ki—causing blockage in the human body—was thought to give rise to a psychologically depressed state. In fact, pre-modern literature is rife with words that referred to *utsu* in these dual meanings, suggesting that ki surging in anger, draining away in sorrow, knotted and blocked in prudence, were indeed common phenomena, which accounted for the sensations arising both in the mind and the body.[15]

While the word *utsu* itself had these two meanings, "*utsushō*" (sign of *utsu*) as a medical concept seems to have started with its first connotation; that is, to simply denote various sorts of pathological stagnation, before it came to acquire a predominant image of an illness of emotions. The concept was transferred from China at the turn of the sixteenth century by Tashiro Sanki (1465-1544). According to Tashiro, there were, under the category of *utsushō*, six different kinds of *utsu*, depending on what was stagnating: i.e., stagnations of ki, moisture, heat, phlegm, blood, and food. Ki-*utsu* would produce "sharp, stinging pain" in the chest, dizziness and headaches, or "swelling in the auxiliary region";[16] phlegm-*utsu* would

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stigmatising connotation.

[13] Morohashi 1984, pp. 13261-5.

[14] A. Arima, *Ki no Sekai* [*The World of Ki*] (Tokyo: Tokyo Diagaku Shuppankai, 1990); K. Maebayashi, K. Satō and H. Kobayashi, *"Ki" no Hikaku Bunkashi: Chūgoku, Kankoku, Nihon* [*Cultural Comparisons of "Ki": China, Korea, Japan*] (Kyoto: Shōwadō, 2000).

[15] Kuriyama 1999.

[16] S. Tashiro, in K. Ōtsuka and D.Yakazu (eds), *Tashiro Sanki* (Tōkyō: Meicho Shuppan, 1979), p. 151.