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Classic Text No. 71

‘On the Question of Degeneration’ by Emil Kraepelin (1908)¹

Introduction and translation by

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The introduction to this Classic Text draws on a new consensus among researchers in the history of eugenics to assess how Kraepelin articulated his eugenic ideas and put them into practice. It analyses his article ‘On the Question of Degeneration’ and finds him not just giving voice to his deep concern for the German Volk, but also espousing neo-Lamarckian views and building a large-scale, clinically oriented, epidemiological research programme. The introduction situates this research programme in the context of Kraepelin’s work in Munich before World War I.

Keywords: *degeneration; Emil Kraepelin; eugenics; neo-Lamarckism; psychiatric epidemiology; racial hygiene*

Emil Kraepelin: a neo-Lamarckian epidemiologist

Some years ago Michael Shepherd published an article in the *British Journal of Psychiatry* entitled ‘Two faces of Emil Kraepelin’ (Shepherd, 1995).² In it he cited the cubist George Braque’s dictum that everyone has at least two faces, meaning in Kraepelin’s case that of the professional scientist and that of the political reactionary. Placing Kraepelin in this Manichean bind between disinterested science and political engagement has been par for the historiographic course for many decades now. Indeed, we can and should be grateful that such dichotomous perspectives have generated so much

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probing historical research in recent years. And Shepherd was certainly right in attempting to deflate not only the hagiographic enthusiasm emanating from historically challenged neo-Kraepelinians in North America, but also the self-satisfaction which that enthusiasm helped bring out of some unreconstructed corners of psychiatry in Germany.

That said, however, Shepherd underestimated the many facets of Kraepelin's visage. For Kraepelin had far more than just the two faces that Shepherd chose to examine in his article. Of course Kraepelin is best known to us as a nosologist who delineated dementia praecox and manic-depressive illness, and as a sponsor and early advocate of racial hygiene. Less well known, however, is his work as a clinical practitioner, diagnosing patients and documenting their illnesses. Virtually forgotten is Kraepelin as an experimental psychologist, who to his dying day remained committed to Wundtian precepts. Only recently unveiled is another facet: a scientific manager and a political operator in professional circles. And Kraepelin as a bourgeois citizen and temperance activist – to say nothing of his private life – has been largely consigned to the realm of anecdotes and jokes.

Another barely known side of Kraepelin is as a neo-Lamarckian epidemiologist. The fact that we do not generally associate Kraepelin with either epidemiology or neo-Lamarckian tenets is hardly surprising, for the historiographic landscape in which the narratives of his legacy have been forged has not been conducive to either perspective. Nevertheless, a careful reading of the Classic Text below can help explore these facets of his work. Moreover, the Text points to a convergence of Shepherd's two faces, morphing them into a likeness that challenges traditional assumptions about Kraepelin and helps us articulate an historiographically more sophisticated, less dichotomous picture of his life and labours.

A new historiographic consensus

Kraepelin the neo-Lamarckian epidemiologist has become more visible in the wake of a new historiographic consensus in the history of eugenics that has been emerging over the past decade. Thanks largely to a growing body of comparative research in various countries, it has become evident that earlier accounts that posited a direct linkage between eugenics and the rise of national socialism in Germany have been teleologically overdetermined. Historians have come to stress that eugenics was a fundamental part of the development of virtually all modern societies and to reject 'the simple teleological assignment to the "Third Reich" and its crimes of a phenomenon that, from 1890 on, occupied intellectuals and scientists of every orientation [*couleur*] and nationality' (Michael Schwartz as cited in Dickenson, 2004: 8). Recently, Edward Ross Dickinson (2004: 8) has summarized this new consensus succinctly:

Eugenics was discussed widely throughout most of the ideological and social communities making up a very diverse society; it was given varying inflections and interpretations in each; and it could be compatible with virtually any political or ideological position. In fact, what emerges from the literature of the 1990s is a picture of a varied, complex, and diffuse body of discussion and discourse, rather than a focused or coherent set of ideas – much less a ‘movement’.

One of the most important consequences of this new consensus is a heightened interest, not so much in eugenic ideas per se, but rather in the way in which those ideas were inflected in different ideological and cultural milieus. Historians have become keenly interested in the various manifestations of eugenics and the uses to which it was put in different local settings and value-systems (Dikötter, 1998). Given the indisputably great influence of eugenic ideas, attention has turned to how those ideas unfolded across more specific regimes of practice and belief.

In the specific case of Kraepelin, the advantage of this new historiographic consensus is that it opens up another interpretive perspective on his work. In particular, it encourages us to situate his article ‘On the Question of Degeneration’ not so much in the context of larger debates on eugenics, but rather in the context of the practices and priorities of his own research agenda. And if we accept this invitation to read Kraepelin with greater teleological abstinence, interesting nuances in his position emerge: for beyond simply venting his deep concern for the degeneration of his race, we find him also – and perhaps surprisingly – advocating neo-Lamarckian views and an epidemiological research agenda. It is these inflections which can deepen our understanding of how Kraepelin’s views evolved and which I wish to describe briefly in this introduction.

Towards racial hygiene? Trajectories of Kraepelin’s research

It has often been noted – by Kraepelin himself, among others – that his move from Dorpat to Heidelberg in 1893 inaugurated a new phase of clinical research. The story of this transition and Kraepelin’s subsequent use of the so-called *Zählkarten* is known and need not be recounted here (see Berrios and Hauser, 1988; Burgmair, Engstrom and Weber, 2005: 35–50; Engstrom 2003a: 135–46; Kraepelin, 1983: 142–3). But it is worth emphasizing that the purpose of these clinical research tools was to summarize as much data as possible on the course of a patient’s illness. As such, the *Zählkarten* can be seen as a clinical response to the deficiencies of Kraepelin’s own earlier laboratory research that had never been able to capture more than the immediate psychological *status praesens* of his experimental probands. At the point where psychological examination failed as a diagnostic tool, Kraepelin deployed the *Zählkarten* to provide fuller documentation of the clinical picture that patients manifested on the psychiatric wards and to capture whatever additional

clinically useful anamnestic and catamnestic information might be gleaned from relatives or public officials. Furthermore, the *Zählkarten* were but the pinnacle of a far more extensive clinical inscription regime that included ward reports, patient records, diagnostic lists and research cards. Taken together, all these documents and the practices associated with them comprised an entire economy of clinical information that Kraepelin deployed and exploited in constructing his nosologies (Engstrom, 2005).

Although Kraepelin's reorientation towards clinical research work in Heidelberg is well known, an equally significant shift in his views – dating roughly from his arrival to Munich in 1903 – has received far less attention. In Munich Kraepelin turned increasingly to social policy issues and questions of eugenics and racial hygiene. A quick glance at his publications shows him expounding on topics such as alcoholism, crime, degeneration and hysteria. And in terms of the content of these writings, we find him advancing more substantial and explicitly eugenic demands designed to preserve and enhance the health of the German populace, or the *Volkskörper* (Roelcke, 1999: 138–79; Weber, 2003). In Kraepelin's eyes, syphilis and alcohol counted among the most devastating public toxins (*Volksgiften*). He saw their effects manifested daily in the rising number of paralytic and alcoholic patients in his clinic – effects that to his mind threatened the 'existence of our *Volk*' and the 'convalescence of our race'. It was therefore the responsibility of psychiatrists to determine where the German *Volk* was headed and 'whether the forces of degeneration or those of sustainability and progressive development have the upper hand in our people, and finally whether and how it is possible to respond to the very real present dangers.'

It has long been recognized that there was a deep affinity between Kraepelin's views and Morellian degeneration theory in its more secular derivatives (Hoff, 1994; Wettley, 1959). To ward off degeneration, Morel had advocated much the same social programme as Kraepelin: educating the population, eradicating the 'poisons' of alcohol and syphilis, improving living conditions, helping the poor. This Morellian influence can be found throughout much of Kraepelin's work. After 1903, however, there is a shift in the superordinate unit which is endangered by the forces of degeneration: a shift from the individual, the family or the lineage, to the larger body politic, or *Volkskörper*. One way of conceptualizing this transition is to see degeneration theory being overlaid and augmented by metaphors of the *Volk* and *Volkskörper*.

Many observers have noted that the emergence of more explicitly eugenic views coincided with Kraepelin's trip to the island of Java in colonial Dutch East India in 1903. He had embarked upon that journey in an effort to explain the low rates of psychiatric illness among indigenous populations and to study cases of progressive paralysis and dementia praecox (Bendick, 1989). In this regard, the trip to Java was undertaken in explicit support of Kraepelin's clinical efforts to improve differential diagnosis and demarcate the liminal boundary space between mental health and disease. In prophylactic terms, Kraepelin concluded from his findings that battling alcohol and syphilis,

as well as ‘reasonable policies of racial hygiene (*verständige Rassenhygiene*)’ were key to warding off the effects of degeneration (Kraepelin, 1904: 469).

The question of degeneration also became a focal point of much other psychiatric research carried out at Kraepelin’s clinic in Munich. His own research on the deleterious effects of alcohol can be seen as an attempt to shed light on the weight of degenerative forces bearing down on the German people. Felix Plaut’s work on syphilis and progressive paralysis in the clinic’s serological laboratory had potentially important diagnostic implications for Kraepelin’s degeneration hypothesis. The histopathological work of Alois Alzheimer was dedicated, among other things, to differentiating aetiologically between simple processes of aging, pathological processes in the brain and more deeply seated degenerative conditions. And the work of Ernst Rüdin on racial hygiene aimed to clarify the mechanisms of genetic inheritance and facilitate a so-called ‘empirical genetic prognosis’. Kraepelin thought particularly highly of Rüdin’s work and supported it generously.

It would be a mistake, however, to interpret Kraepelin’s interest in degeneration simply as a scientific programme of psychiatric genetics. Indeed, what is most surprising about this Classic Text is that Kraepelin delves barely at all into the dangers that genetic factors or biochemical toxins posed to the germ plasm. Instead, his argument was decidedly socio- and psychogenic: he was interested chiefly in the dangers posed by culture and civilization, believing that they imposed heavy, even debilitating burdens on human evolution. High culture and ‘life-experiences’ threatened not only to countermand Darwinian laws of natural selection by shielding human beings from their environment, but also to impinge directly on the development of germ cells. Kraepelin viewed the effects of culture as contributing to a deterioration, indeed to the degeneration of the individual and the ‘race’. In other words, he was advancing not Mendelian, but neo-Lamarckian views to support his hygienic agenda. This should not be surprising. Indeed, as one commentator has recently remarked, it was:

not the evolutionism of Darwin, but the Lamarckian version that was most influential in the debates around moral insanity and degeneracy. Lamarck posited the evolutionary mechanism as the transmission of culturally acquired moral and physical characteristics between generations; in this version evolutionism was compatible with the doctrine that the sins of the fathers were visited upon their progeny. Degeneration theory expressed the growing fears concerning the primitive within civilization and the potential dangers of evolution descending into an uncontrollable and regressive movement. (Dollimore as cited in Rimke and Hunt, 2002: 76)

Expanding clinical technologies

But it is not just the neo-Lamarckian cast of Kraepelin’s argument that makes this Classic Text so significant.³ It is also the research agenda that he outlines. He calls for ‘extensive, careful, decades-long studies’ of entire

regions by 'specially trained commissions'. Kraepelin's aim is to 'gather knowledge *by means of expert analysis of individual cases* – knowledge that we can never acquire through regular, large-scale population statistics'. In other words, Kraepelin was advocating an epidemiological research project that, interestingly enough, relied less on population statistics than on incisive and widespread clinical observations.

Kraepelin was not one to propose projects and then not follow them through. Indeed, his trip to Java five years earlier had already put this project on the agenda. He had justified the trip on the grounds that an expert clinician was needed to document the cases. However, this was but an initial step in a larger research programme that saw Kraepelin investigating progressive paralysis and dementia praecox in other countries as well. In 1905 he embarked on a well-prepared research trip to the Balkans, Greece and Turkey, visiting asylums and examining patients along the way. Since he could not travel everywhere, he also began soliciting psychiatrists around the world for data on psychiatric disorders (Burgmair, Engstrom and Weber, 2006: 208–13, 222–4; Kraepelin, 1983: 160–3). Moreover, at the International Congress of Mental Health Care in Berlin in 1910 he proposed (together with Ernst Rüdin) building an international network of psychiatrists to collect statistical data on a global scale (Alzheimer, 1911: 244). Like the trip to Java, all these undertakings, far from founding transcultural psychiatry (Steinberg, 2002: 23⁴) let alone inaugurating a 'psycho-dynamic' turn in his clinical approach (Bendick, 1989: 98), were part and parcel of an epidemiological research agenda aimed at comparing clinical symptoms and weighing different aetiological factors.

In developing this epidemiological project, Kraepelin targeted not just an international audience of experts. In fact, he pitched his project first and foremost to an audience of Bavarian alienists at a conference in Erlangen in 1908.⁵ These he had assiduously courted from the outset of his tenure in Munich, initiating exchange programmes for asylum doctors, 'scientific evenings' and co-operative research endeavours (Kraepelin, 1905: 589–90; 1983: 136).⁶ In this way Kraepelin went about building a network of personal contacts across the system of regional psychiatric care. And given the importance he placed in compiling catamnestic data on patients who had been transferred out of his clinic, cordial relations with Bavarian alienists were an essential element of his research agenda.

Nor did Kraepelin's efforts stop here. He deployed a variety of strategies and means of data collection in order to expand the range of his clinical observations. In his own clinic he had already established a ward to study 'idiot children'.⁷ He had also succeeded in acquiring access to court defendants who were being held pending psychiatric evaluation (Engstrom, 2001). In order to advance the study of juvenile delinquents, he applied for and received permission to collect information on their mental states from the files of juvenile detention and re-education facilities.⁸ In support of Rüdin's

demographic and genealogical research, Kraepelin was able to requisition the files of Bavarian schools.⁹ And to glean additional information on the 'military fitness' of patients in his clinic, he was allowed to evaluate the files of the Bavarian army recruitment offices.¹⁰

In short then, Kraepelin's epidemiological research project was embedded in a complex network of social relationships and administrative jurisdictions. Its implementation demanded heightened co-operation and co-ordination between psychiatrists and various other interest groups such as hospital administrators, public health officials and other psychiatric professionals. Of course, these efforts complemented and were in addition to the sophisticated information-gathering techniques that he had already implemented and fine-tuned in his own clinical practice. Taken together, the result of these measures was a 'massive influx of clinical observation material' which demanded that clinical work be conducted 'on a grand scale' (Kraepelin, 1983: 141–2).¹¹

A number of points are striking about Kraepelin's effort to expand the range of 'clinical' data at his disposal. One is the sheer diversity of measures taken to acquire clinically relevant patient data. Kraepelin turned to local and regional asylums, juvenile detention facilities, Bavarian schools, military recruitment offices, and to the courts. This reminds us that, as important as Kraepelin's *Zählkarten* were, his clinical research also relied on other institutions and their respective inscription regimes. This breadth of information resources needs to be accounted for when assessing his work. A second noteworthy aspect of Kraepelin's research is that he appears to have had few qualms about drawing on the observations of officials not trained in psychiatry. His use of information that could never have satisfied his own critical standards of clinical observation suggests internal tensions within his own work and contrasts sharply, for example, with his insistence on gathering knowledge 'by means of expert analysis of individual cases'. Finally, Kraepelin's research agenda illustrates that whatever other disagreements he may have had with public policy,¹² when it came to exploiting the state's resources in order to acquire research data, he actively sought out state agencies and worked closely with them.

Conclusion: morphing Janusian faces

Kraepelin's answer to the challenge posed by the spectre of degeneration was a broad-based epidemiological research project. As he conceived it, however, that project was an extension of his clinical research methods. In other words, the spectre of degeneration was put to use in order to expand the reach of clinical technologies he had already developed to document cases of mental illness. Viewed from this perspective, there is a coherent and expansive progression or continuity¹³ in the trajectory of Kraepelin's clinical research work that sees him moving from Wundtian psychological

tests (in Dorpat), to strategies of clinical observation and documentation using *Zählkarten* (in Heidelberg), and finally to large-scale epidemiological studies (in Munich).

There is little doubt that eugenics and racial hygiene inflected especially powerfully in the third stage of Kraepelin's research work. But it is worth considering the relationship between two component vectors in the trajectory of that work: on the one hand, a clinical and diagnostic vector that insisted upon more comprehensive collection of patient data; and on the other hand, a eugenic vector driven by the socio-political and hygienic spectres of degeneration theory. Instead of juxtaposing these two component vectors as two faces of Kraepelin, we might instead be better served if we try to morph them into more subtle and plausible explanations of his work. By illustrating the fuller range of the motives, practices and utilities driving Kraepelin's psychiatric research, this Classic Text can help us to avoid easy Janusian polarities and give us instead a richer picture that accounts for his neo-Lamarckian and epidemiological concerns. And finally, for those wont to describe Kraepelin as a 'psychiatric Mendel', this text suggests that he was more of an epigeneticist than we have hitherto assumed.

Notes

1. Kraepelin, Emil (1908) Zur Entartungsfrage. *Zentralblatt für Nervenheilkunde und Psychiatrie*, 31: 745–51; reprinted in Burgmair *et al.*, 2006: 61–70.
2. See also Shepherd's remarks to Nancy Andreasen cited in Healy (1998: 248): 'I was very sad to see that you've turned [Kraepelin] into an icon. He was a monster who has done a great deal of harm.'
3. Elsewhere I have dealt with other important factors such as the *fin-de-siècle* challenges facing the profession's public image and psychiatrists' efforts to recast their work in more socially useful terms; see Engstrom, 2003a.
4. The claim of Steinberg and others that Kraepelin can be considered the 'founder' of transcultural psychiatry has been forcefully rebutted by Oda, Banzato and Dalgarrondo, 2005.
5. A summary of Kraepelin's presentation was published in the nationally circulated medical journal *Münchener Medizinische Wochenschrift* (1908), and was printed as a special offprint for wider distribution.
6. See also Ministry of Culture to University Administration, 24 May 1905, Bayerische Hauptstaatsarchiv [henceforth cited as BHStA]: MK 11245.
7. See the Ministry of Culture to University Administration, Feb. 1906, BHStA: MK 11288, vol. IV.
8. According to Kraepelin, the files often provided 'a good picture of the prior mental condition of the juveniles'. In conjunction with later clinical observation, he hoped to delineate 'specific groups of mental illness according to their common course and thus be able better to determine the best means of training, correction and accommodation'. See Ministry of the Interior to Royal Governments, 15 Dec. 1912, BHStA: MK 11288, vol. IV.
9. It is worth noting that, 'in order to avoid disturbances in the local communities', the Bavarian government decided not to inform local school officials of Kraepelin's research

- project. Kraepelin was instructed simply to show schools the ministry's letter of approval. See Kraepelin to Ministry of Culture, 17 Feb. 1912, BHStA: MK 11158, and Ministry of Culture to Kraepelin, 28 Feb. 1912, BHStA: MK 11288, vol. IV.
10. See Ministry of the Interior and State Ministry to Recruitment Office III, 29 April 1912, BHStA: MK 11158.
 11. Kraepelin remarked that this increase of 'material' resulted in an 'extraordinary expansion of his scientific horizon' and enabled him to explore new fields such as progressive paralysis, psychopathy, paranoia, hysteria and dreams.
 12. Kraepelin was highly sceptical of the state's ability to address the dangers that he believed threatened the German *Volkskörper*. There were two basic reasons for his scepticism: first, his own Darwinist convictions meant that the state was as likely to impede as to enhance the very processes of natural selection which he believed were crucial to strengthening the *Volkskörper*. He feared all state initiatives which might countermand the laws of nature. Second, Kraepelin's expectations with regard to the state evolved in response to his own experiences with it – and these experiences were, in his eyes, not always salutary. On Kraepelin's ambiguous attitudes towards the state, see Engstrom 2003b.
 13. Kraepelin had called for a 'mass psychiatry' prior to 1900, but his aim then had more to do with diagnostic and nosological precision than with public hygiene; see Engstrom, 1997.

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