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THE HISTORICAL ORIGINS OF *KATAKORI*

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There is perhaps no physical complaint more common among Japanese than *katakori*, or 'congealed shoulders'. This paper examines the historical origins of this affliction. It traces the beginnings of katakori to the Edo period ailment called *katakori*, and points to three major factors of Edo times that contributed to the formation of this ailment: 1. medical theories that saw stagnant flow as the prime source of human sickness; 2. the 'industrious revolution', in which hard work and an active life emerged as key virtues; and 3. the diagnostic and therapeutic practices of abdominal palpation and amma massage. The paper then examines some possible analogues to the notion of *kori* in 19th and 20th century Western medicine, and concludes with some observations about the relationship between the body and time.

Key words: HISTORY OF THE BODY, DISEASE, MEDICINE, EDO PERIOD, ECONOMIC THOUGHT, REGIMEN, RHEUMATISM, FIBROSITIS, INDUSTRIOUS REVOLUTION.

For most of my life I took *katakori* for granted. In Japan, it is the most common, the most everyday, the most banal of complaints.

For three years even, as an aspiring acupuncturist, I honed my needling and moxa skills on the katakori of friends and relatives. I would say, "I'm studying acupuncture," and they would volunteer, "Can you treat my katakori?" They were clearly desperate, asking a novice to needle and burn them. But at the time, I thought their desperation perfectly natural.

Then one day, years later, I began to think it odd.

How can a bodily affliction be so taken-for-granted, so utterly ordinary in one culture, and appear alien and exotic to others?

Traditional Japanese medicine owes its core vocabulary to China; but katakori has no ready Chinese translation. Modern Japanese medical dictionaries regularly give *stiff shoulders* and *Schulterspannung* as the English and German equivalents. Yet again, these are artificial phrases, contrived *faute de mieux*. Unlike katakori, they don't name an ache that all understand, right away. And they mislead about the quality of discomfort: the decline in mobility implied by "stiff shoulders" is at best peripheral to katakori; the tension of Schulterspannung comes closer, but still misses the heart of the matter.

When I mentioned katakori to friends and colleagues, not a few reacted by complaining of their own nagging cases, simultaneously pounding or rubbing themselves on the arms, and neck and shoulders, almost reflexively, as if merely hearing the word revived the hurt. One sees the gesture daily here.

So I was more struck by those who said, "I don't suffer from katakori." For they typically announced this with a tinge of pride, or sheepishness, or vague bewilderment — as if they thought themselves possessed of some special virtue, some peculiar luck. As if the burden of katakori were the norm.

"I once spent more than three years in Germany," writes Ōtsuka Yasuo, "but no matter how I explained katakori, I couldn't get people to understand" (Ōtsuka, 1994: 97). Japanese who have

lived abroad occasionally bring back tales of this sort. But their listeners are sometimes skeptical, even incredulous. When I floated the idea of katakori as a distinctly local disease, citing my own experience in America and the evidence of words — the lack of equivalents in local vernaculars — some friends still resisted. People everywhere *must* get katakori, they protested. Its absence is surely only apparent.

As if to think otherwise was to think the impossible.

Perhaps people elsewhere *just don't realize* that they have katakori. This was one popular theory — that of a gap between the affliction and the awareness of it. After all, a friend pointed out, a person can have arteriosclerosis or even cancer, and for a long time be unaware, still feel 'normal'. When pressed, though, about whether one could still speak of katakori in the absence of any felt discomfort, my friend wavered. Perceived pain was definitely not all there was to katakori, but it seemed essential.

Then there was this possibility: perhaps other cultures knew katakori, but in a different guise. Perhaps they organized their sufferings differently. Perhaps, instead of identifying katakori as a discrete entity, they encompassed its symptoms within another, more comprehensive disease. Or, alternatively, they parcelled out katakori into a few disparate complaints. Perhaps.

What are the facts? How local, or global, really, is katakori? No sooner do we contemplate a survey, than we falter on the criteria of factuality. How do we judge the presence or absence of the affliction? What signs tell us that here is a people who suffer from katakori, and there a people who don't?

In short: What *is* katakori?

Reflecting on the incomprehension of German friends, Ōtsuka muses whimsically about peoples who shrug their shoulders and those, by contrast, who get stiff shoulders. The former, forward-looking, active, shrug off worries; the latter sigh, resigned, and shoulder their burdens (Ōtsuka, 1994: 97). His punning distinction echoes a common association.

There are books that cause katakori *(kata ga koru yomi mono),* and books that don't *(kata ga koranai yomi mono);* that is, difficult monographs that demand intense concentration, and light, casual reading. There are also "katakori-causing situations" *(kata ga koru ba)* — tiresome gatherings in which one has to stand or sit straight, rigid, on one's best behaviour, ever-careful not to give offense. The expressions are figurative, but name real consequences. Social pressures, protracted grappling with rebarbative texts — these literally cause the neck and shoulders to ache.

The Nanzandō dictionary of medicine identifies katakori as "subjectively, an extremely uncomfortable feeling, accompanied by dull, heavy pain in the muscles of the neck and shoulders," and lists as its chief causes fatigue, poor posture, psychological stress. One is tempted to say: katakori is mental tension manifest as muscular tension.

But tension is inexact. To appreciate the distinctive feel of kori it may be useful to reflect upon what happens, sometimes, when longtime friends fall out. Harsh words are exchanged; feelings are hurt; ties are severed. Later, the friends begin to speak to each other again, but their conversations are no longer the same. Though they pretend a return to their former casualness, both know that it is only a pretence. The intense antagonism and tension that both felt at the time of the argument have long faded; but the resentments of the time have hardened into *shikori* — a term closely cognate with kori, and often used interchangeably with it — blocking all easy exchange. There are awkward silences. Communication no longer flows. The pain of katakori is

not unlike this dull and heavy ache of suffocated words, of feelings congealed and unable to 'get through'.

Why do so many Japanese suffer from this affliction of congealed blockage? The list of factors thought relevant is long — stress, aging, menopause, long hours spent on tatami mats (or, contrarily, long hours sitting on chairs), heredity, diet, and poor circulation. But there is no consensus on any of these as the decisive reason, katakori's core truth.

In fact, many people accept their own katakori as ultimately beyond explaining. It has become part of who they are. They resort regularly to traditional therapies, and eagerly test new medicines, but few expect a permanent cure. Most assume that all relief will be temporary, and that after a while they will need to get treated, or treat themselves, again. The ache is of such long standing. It feels so deeply rooted.

Kenpeki

And yet the word katakori seems unknown prior to Meiji times (1868-1911). This fact has led Tatsukawa Shōji to speculate that the malady became widespread only recently (Tatsukawa, 1986: 46-49). But in fact the history is more complex. Though the noun katakori seems to become common only near the turn of the century, the verbal phrase *kata ga korite* (the shoulders get kori) appears already in medical texts of the Edo period (1600-1868). People in Edo times also already complained commonly of their shoulders being 'blocked' *(kata ga tsumaru)* or 'clogged' *(kata ga tsukaeru).*

Moreover, there is the pervasive complaint of *kenpeki* 痃癖. (Sōda, 1984) Ashikawa Keishū's nosological lexicon, the *Byōmei ikai* (1688), explains:

> KENPEKI. This is what is popularly called *uchikata.* It is a tightening up of the neck and shoulders. Some hold that it is called uchikata (*uchi* = to hit; *kata* = shoulders) because when one pounds (*utsu* 打) the shoulders with the fists, it feels pleasurable. Others explain that it is called uchikata because it afflicts the area between (*uchi* 内) the shoulders (kata) (Ashikawa, 1982: 394-5).

It is hard for a Japanese today to read this constellation of symptoms — tightness in the neck and upper back, especially between the shoulder blades, pleasure when these areas are pounded and massaged — and not recognize katakori. The Japanese-Portuguese dictionary of 1630 explains both *Qenbeqi* (kenpeki) and *Feqi* (*heki* 癖) as "A shoulder affliction," and adding for *Fequio vtcu (heki o utsu):* "To pound with the hand the area of the shoulders that aches or ails" (*Vocabulario,* 1630: 150v, 350v). And indeed, in scenes of daily life depicted in Edo literature and illustrations, we glimpse people treating their shoulders in ways that katakori sufferers would still find familiar: they rub on salves, they burn moxa, they ask others to massage them, or pound themselves with objects at hand.[1]

So it appears that what we now call katakori existed already in Edo times, but under another name — kenpeki, also pronounced kenheki, kenbeki, kenbiki. But then we read Kaibara Ekiken (1630-1714), who observes, "It is wrong to speak of kenheki in reference to pain in the shoulders" (Kaibara, 1911: 876). And Keishū himself warns, "The popular belief that the

affliction affects only the shoulders is a mistake" (Ashikawa, 1982: 394-5).

Kenpeki is the Japanese reading of *xuanpi*, a Chinese disease name. But xuanpi in China was a technical term, known only to doctors, labelling a relatively faceless affliction to which no one attached any special moment, one disease among hundreds. Kenpeki was different.

Edo Japanese complained of it in casual, daily conversations everywhere — in homes, in the public baths, in the pleasure quarters. The word and the affliction were matters of common knowledge. Common knowledge, though, diverged from the definitions of experts. In 1639, the medical lexicon *Byōron zokkai shū* identified kenpeki as a tightening up, due to undigested or stagnant food, of some part of the abdomen — a tense hardness above or below the umbilicus, or to the right or to the left. This essentially repeated the original meaning of the term: in China, xuanpi was an abdominal affliction, and had nothing to do with the back. So the anonymous Japanese author added: it is a mistake to speak of kenpeki in reference to tightness in the neck and shoulders (*Byōron*, 1979: 98).

There was thus a gap between popular and 'correct' usage. Laymen displaced to the shoulders an affliction that doctors versed in the Chinese sources placed in the abdomen. Keishū was torn. He begins, in the *Byōmei ikai* passage cited above, by describing kenpeki in precisely those terms — neck and shoulder tightness — that the *Byōron zokkai shū*, half a century later, had explicitly rejected as error. But then he hedges, and comes close to recanting. To think of kenpeki as *uniquely* a neck and shoulder ailment, he qualifies, is a mistake. Actually, "*Heki* afflictions can arise anywhere. The majority occur in the abdomen and along the ribs" (Ashikawa, 1982: 395). He thus ends by repeating what doctors in China would have said, mindful, one suspects, to preempt charges of vulgar ignorance.

So xuanpi, an obscure abdominal affliction in China discussed only among educated doctors, was transformed into kenpeki, a Japanese shoulder affliction about which even illiterate laymen complained. The talk of error in both the *Byōron zokkai shū* and the *Byōmei ikai* shows that doctors were still freshly alert to this disparity, and intimates that in the seventeenth century the 'mistake' was relatively new — that kenpeki as a shoulder complaint perhaps first crystallized in early Edo times. Certainly we note a suggestive shift of emphases between the two works. The error rejected in the lexicon of 1639 was the association of kenpeki with the shoulders. For Keishū in 1688 the error was to identify kenpeki as an affliction of *just* the shoulders. The 1639 lexicon begins with the traditional description of xuanpi and refers only at the end to the popular misconception that it is a shoulder problem; the 1688 compilation, by contrast, first speaks at some length of the symptoms and treatment of kenpeki as a shoulder complaint, before qualifying, almost as an afterthought, that the ailment also afflicts the abdomen.

Both works accused popular misunderstanding. But this explanation hardly satisfies. Calling a neck and shoulder problem by the name of a abdominal problem is not a confusion that one makes inadvertently, without motivation, by sheer carelessness. If kenpeki had no connection whatsoever to the Chinese affliction of xuanpi, there would have been no reason to call it kenpeki

1 Two examples from Edo verse:
"Rubbing each other
With kenpeki salve:
The public baths"

"Pounding, pounding my kenpeki
As I return
With the storeroom key"

in the first place. Some hidden logic must have linked them, at least originally, at least in Edo Japan, for them to have been called by the same name.

The ken of kenpeki combines the disease radical with the graph for a string stretched taut, thus suggesting pathological tightness. The character was obscure, and rarely used except in the compound kenpeki. Some Japanese writers substituted in its stead the character for shoulder — also read ken (and also read kata, as in katakori — Japanese characters typically have two or more readings). This made explicit the popular understanding of kenpeki as a heki of the shoulders. The affliction that concerns us then is heki.

In China, heki (Chinese, *pi*), like the compound xuanpi, designated a tightness in the abdomen and under the ribs. But Edo period doctors tended to use the word almost interchangeably with other terms like *shaku* 積, *chō* 癥, *ketsu* 結, and not least, *kori*. These weren't exact synonyms. Each suggested a different emphasis. Shaku evoked accumulation; ketsu, knotting; kori, congelation. They could be invoked interchangeably, however, because they were bound together by a unifying intuition about sickness, because they represented diverse facets of a single, dominant preoccupation.

* * *

"Most people today," Gotō Konzan (1659-1733) asserted, "regardless of whether they be old or young, depleted or plethoric, have congested vitality *(shakki)* knotted up (ketsu) in the abdominal organs." In lecturing to disciples, in corresponding with other physicians, Konzan repeated this lesson again and again. In contrast to the complex Chinese system of yin-yang/five-phase balances and interactions, Konzan advanced a simpler guiding principle. "The hundred diseases," he taught, "all arise from the stagnation (*ryūtai* 留滞) of vitality *(genki)*" (Gotō, 1985: 155).

From the end of the seventeenth century and throughout the eighteenth, Japanese medical thought was marked by increasing skepticism about — and soon, explicit rejection of — a major part of Chinese etiological analysis. Decrying the complex Chinese schemes of yin and yang and the five phases as too overwrought, too abstract, too far removed from actual experience, Japanese doctors began to articulate their own, distinctly different vision of sickness and the body. Gotō Konzan was one of the first and most influential proponents of this alternative vision. The pathology of stagnation was his central tenet.

"Regardless of whether they be depleted or plethoric ..." Though dropped casually, by the by, this is an extraordinary remark. Over the centuries, Chinese doctors elaborated an expansive theoretical system; but the core intuition, always, was the paradigm of depletion and plethora. Depletion meant drained vitality, diminished powers; plethora followed as a consequence of depletion, when pathogens like wind and cold took advantage of a person's emptied state and invaded, filling the body with disease. The essence of regimen thus lay in preventing depletion — in retention, preservation, the avoidance of wasteful expenditure.[2] The logic of depletion and plethora was absolutely basic.

Konzan promoted stagnation into a threat equal or even greater than depletion. Life hinged on vitality coursing smoothly, ceaselessly, dynamically, around the body. Sickness owed less to

2 For a comparative perspective on the history of depletion and plethora in China and in Europe, see Shigehisa Kuriyama, "Interpreting the history of bloodletting," *Journal of the history of medicine and allied sciences 50* (1995): 11-46.

depletion, less to the *outflow* of vital essences, than to hampered circulation, sluggish flow *within* the body. The stagnation of vitality produced congestions, congelations, accumulations, hardenings, knots — all those conditions named by terms like heki, kori, chō, shaku, ketsu — and this regardless of age, regardless of depletion or plethora. Most contemporaries were sick, Konzan asserted. Sick with congealed accumulations.

Konzan's many disciples insured that the later histories of medicine would always link the theory of stagnant vitality with his name. But in fact the theory was a leitmotiv of contemporary discourse on sickness. It is impossible to say how much he shaped, or merely reflected, current perceptions. Kaibara Ekiken, for example, born some thirty years before Konzan, also advanced a theory of "two harms" *(gai)*, in which he identified two main menaces to health. One was depletion of vital energy *(genki)*, the other its stagnation (Kaibara, 1981: 30).

Let me be clear. By itself, there was nothing new in the idea that afflictions could arise from disrupted flow. References to the pains and spasms caused by obstructed conduits already appear in the *Huangdi neijing*, and shaku, chō, ketsu, kori and heki were all notions with roots in ancient China. More recently, the influential Yuan dynasty doctor Zhu Zhenheng (1281-1358) had even devoted a full chapter of his *Danxi xinfa* to congestive *(yu)* ailments, declaring that "The various ailments mostly arise from congestion."

But for Chinese doctors the problems of obstructed flow were never on the same level as the menace of depletion — and this in part because more often than not the former ultimately arose from the latter. Inner depletion invited the intrusion of wind and cold and other external pathogens; blockages and stagnant congestions were typically the result of these intruders from without. Thus Zhu's remarks on congestive disorders appear only in the fourteenth chapter of the *Danxi xinfa*, and this is the only chapter on congestion. The early part of the book — no less than the first five chapters — concentrates on the damage caused by wind and cold. So we cannot read Zhenheng's remarks in isolation: in the context of his medicine considered as a whole, congestion still belonged to a second tier of considerations. It was a significant factor, but just one of several, and not among the most important.

Ekiken's theory of two harms, by contrast, casts stagnation as a threat equal to, and independent from, depletion. Stagnation might arise from the intrusion of wind and cold, but it could also occur by itself, from overeating, indolence, oversleeping — from, in short, a life of pampered leisure. Kagawa Shūan (1683-1755) went even further. Even afflictions caused by wind or cold, he asserted, regularly involved congealed obstructions, so just treating wind and cold wouldn't do. And this held for all other ailments as well.

> In each, what has to be concerned about first and foremost are the obstructions of chō. The harm wrought by chō are absolutely ubiquitous (Kagawa, 1982: 129).

Shūan in effect reversed the traditional priority of depletion over congestion. We see this in the very organization of his chief treatise, the *Ippondō kōyoigen*. Whereas Zhu Zhenheng's chapter on congestion comes late in the *Danxi xinfa*, well after the opening chapters on wind and cold afflictions, Shūan's chapter on chō afflictions comes immediately after the opening chapter on the general principles of medicine — before the discussion of any other diseases. One finds nothing like this in the long history of Chinese medicine. This is what was distinctive about the Japanese discourse of stagnation. The urgent insistence. The obsession.

Edo period writers were self-conscious of their departure from tradition. In his *Kokon dōin shū* (1709), for example, Ōkubo Dōko presented disrupted flow as a major blind spot in earlier conceptions of regimen. The pathology of stagnation explained, among other things, why people who seemed to lead healthy lives could nonetheless fall ill.

> *Question*: There are rich and powerful people who are careful about how they live, who are moderate in their eating and drinking, and do not labor. They don't harm themselves through emotional or sexual excess, and manage all things with steady calm. And yet as the days go by their bodies become sicker and sicker. Is this because they had weak constitutions to begin with? Have they contravened against the rules of sound regimen? Or is it simply the work of fate? I beg to hear the reason.
>
> [*Answer*:] This is not due to weak constitution, or contravening against sound regimen, or even to fate. It is due to blockage and stagnation in the flesh, and imbalance in the stomach and intestines. Even with the most marvelous of medicines, there is no hope of making the body vigorous unless one dissolves the knotted flesh and regulates the intestines.

Everyone knew the traditional rules of moderation in food and drink and sex, and the importance of rest and calm. Yet one could follow all these prescriptions and still be sickly. Why? Because none of these precautions addressed the problem of stagnant flow and knotted flesh. And that problem was absolutely critical. And pervasive.

> *Question*: These are all ideas that we don't hear about in ancient China. Is it because the times are different? Or is it due to a difference in geography?

To which Dōko answered, "In the world today, eight or nine out of every ten people suffer from ailments like blockage and colic."

> As I scrutinize society [today], people without disease are rare, and the sick are ever increasing. Why is this? It is all due to blockage and stagnation, and the disruption of vitality (Ōkubo, 1709).

For Dōko as for Konzan, the primacy of stagnant knotting was as much an observation as a theory. It was less a hypothesis about disease in general than an assertion about the particular pathology of mid-Edo Japan.

I've said that in China xuanpi would have been obscure to all but learned doctors. Most Japanese today have never heard of kenpeki. But in Japan of the seventeenth and eighteenth centuries images of stagnation, congelation, knotting, accumulation constituted the very heart of thinking about — and experiencing — sickness. Terms like heki and chō, shaku, ketsu, and kori proliferated because all manners of afflictions were linked or reduced to sluggish flow and its consequences. This is the world in which we must situate kenpeki, the heki of the shoulders, the ancestor of katakori.

The Imagination of Flow and the Industrious Revolution

What were the sources of this obsession? A recent collection of essays highlights a decisive feature of the time, namely, dramatic economic development. The world in which Ekiken, Konzan, Dōko, and Shūan all lived, was one marked by rapid urban expansion, the rise of a dynamic market economy, and the establishment of nationwide network of trade. It was a time, too, in which economic thinking became, for the first time in Japanese history, a major feature of thinking about society — whence the collection's title: *The formation of economic society. The 17th and 18th centuries* (Hayami et al., 1994).

A number of the book's chapter headings — "The production of commercial goods: the dynamics of flow," "The structure of circulation in the Tokugawa economy" — remind us that this period witnessed an unprecedented fluidity in the movements of peoples, goods, and capital. And they lead us to wonder: was the medical preoccupation with flow somehow related to the formation of an economic society?

There is ample evidence to suggest that the theme of circulation belongs not just to modern appreciations of Edo economy, but also to the economic consciousness of Edo times. Kaibara Ekiken's stress on the circulation of vitality in the body, for example, was matched by a similar stress on the circulation of wealth. It is by making wealth go around, he explained, that the merchant makes a living. Every delay in this circulation means a loss of profit (Kaibara, 1911: 457). The astronomer Nishikawa Joken (1648-1724) — a denizen of the port city of Nagasaki — offered more detailed elaboration of this theme. In the *Chōnin bukuro* (1719), his widely-read grabbag of advice for merchants, Joken approvingly cited an anonymous contemporary promoting flow as the preeminent principle of economic life.

> You can have saved a hundred million pieces of gold and silver, but if you leave it just piled up in the vault, then it becomes a dead treasure: being put to no special use, the gold and silver then become worthless to both yourself and to others.

Money's value lay in its use, its circulation; accumulated in storehouses — and here Joken uses the same character that doctors used to describe the accumulations (shaku) at the root of all sickness — it serves no vital function and becomes 'dead treasure' *(shihō).* So to perpetuate wealth one is forced to move this money and make it work *(kore o ugokashi hatarakashite).* These movements may well result in losses; but then, this is a natural law: when wealth reaches an extreme, it begins to decrease. The decrease in my holdings, though, means an increase in someone else's. Wealth circulates. The yin and yang are constantly flowing everywhere, and never stagnate (ryūtai) for long in one place. If they stagnate for long in one place, then the vital breath becomes unbalanced and inevitably brings disaster.

> Gold and silver are the same way. They circulate among all the people, and never stagnate for long in one place...This is the way of nature (Nishikawa, 1975: 101).

In the economy of the body politic as in individual bodies, accumulation and stagnation were contrary to nature. The life of currency, like the life of the body, lay in flow. Gold and silver had to be moved and made to work.

* * *

Movement and work. These are the critical notions. Joken's analysis of monetary circulation exactly parallels the medical stress on flow, but the connection here reflects only a shared preoccupation, a common metaphor. With movement and work, however, we glimpse a more direct link between economic life and the pathology of stagnation.

Kaibara Ekiken's *Yōjōkun* (1713) became the most popular guide to regimen in Japanese history. And yet much of its advice echoed the rules of regimen long taught in China: avoid excess in food and drink, don't overindulge in sex. But in one respect, Ekiken thought that Chinese precepts easily lead one astray.

There are those who hold, he observed, that the art of cultivating vitality is embodied by the retired old man passing his days in peaceful leisure, or, in the case of the young, by the hermit who lives far away from the toilsome cares of society. And thus they believe that the samurai who devotedly serves his lord and his parents, and who works his body to master the martial arts, and the farmers, craftsmen, and traders who labor day and night at their calling and scarcely have time to rest — that these people cannot care properly for their health. But these, Ekiken asseverated, are the foolish doubts of those ignorant of true regimen. The art of cultivating life does not lie in relaxed ease. It requires bodily activity. Leisure, rather than fostering vitality, causes it instead to stagnate and block up. The easy life makes one sick (Kaibara, 1981: 37).

Ekiken thus rejected the Chinese ideal of the retired, eremitic existence. This was the ideal of a cultural elite which saw social life ruled by a frantic, exhausting rush for wealth, power, and pleasure, and who blamed the drain of this senseless frenzy for bodies broken by sickness, lives cut short. Chinese philosophers and poets endlessly praised the virtues of withdrawing from this rush, sitting tranquilly in the mountains, by rivers, celebrating cosmic wonder. And while an influential tradition of regimen *yangsheng* theorists advocated subtle breathing and stretching exercises to stimulate circulation, vigorous physical exertion was always regarded with suspicion: all too easily it became depleting, demeaning labor *(lao).*

For Ekiken, though, labor *(rōdō)* represented the royal path to vigorous long life.

> If one constantly makes the body work, then the blood and ki will circulate, and digested food will not stagnate: this is the crux of the cultivation of life (Kaibara, 1981: 44).

Ekiken recognized, of course, that there were dangers in overexertion. But he saw indolence as a far more pressing threat. The *Yōjōkun*'s prescriptions for a healthy life thus went beyond traditional admonitions against lust and gluttony, and warned just as vociferously against the pernicious craving for sleep *(minyoku).* If one relaxes or sleeps too much then [one's vitality] will stagnate and become blocked. Conversely, shortening one's sleeping time will prevent sickness. What ensures vigorous, vital flow is less sleep and constant work (Kaibara, 1984: 30, 38).

Industry is a modern virtue. Prior to Edo times, we find no parallels to Ekiken's exhortations. The glorification of labor reflected both new incentives, and new pressures. New incentives, because those who tilled the manors of medieval Japan toiled for others; no matter how hard they toiled their sole reward was survival. On the family farms of Edo times, by contrast, increased productivity meant increased wealth (Hayami et al., 1994: 4-84). And this held all the more for

merchants and craftsmen in the expanding marketplace of the cities. Contemporary advertising for the *Yōjōkun* thus appealed directly to the connection between vitality and economic gain:

> Those who read this book will learn the art of cultivating vitality. And thus they will be strong and healthy, samurai, farmers, artisans, and merchants will each be able to pursue their family calling without hindrance; and because they will be able to work happily at their family calling they will prosper and enrich themselves (Inoue, 1989: 299).

Yet hard work was also a necessity. The economic historian Hayami Akira has persuasively detailed how a population explosion in seventeenth century Japan resulted in a reduced individual access to land, capital, and animal power, and forced ever-increasing reliance on human labor. The central reality of Edo economy was the ever greater pressure to produce more out of less. It is no accident that a flurry of agricultural manuals *(nōsho)* began to be published from around the end of the seventeenth century: Japanese farmers were striving to achieve the same or greater returns while working plots of ever-diminishing size, often now with no animal help. (The reduced plots made animals too expensive to maintain). Unlike in early modern England, Hayami explains, economic growth in Edo Japan was not fueled by capital investment, but by the intensification of labor. Whereas England underwent an industrial revolution, the economic growth and the transformation of Japanese society in the Edo period turned on what Hayami has dubbed the 'industrious revolution' *(kinben kakumei)* (Hayami et al., 1994: 20-31).

The Chinese surgeon Hua Tuo had urged already back in the second century that "The body desires to exert itself (*laodong* = Japanese rōdō)." But in the Chinese tradition, praise of laodong was the odd exception. Moreover, Hua Tuo's laodong referred, concretely, to a series of yogic stretching exercises imitating the movements of animals. Unlike Ekiken's rōdō, it had no implications of laboring in society, industriously, fulfulling one's station in life. In Edo Japan, the social implications were key (Yokota, 1989).

Not all were industrious, of course. On the contrary: motivating the exhortations to industry was precisely the perception of pervasive, pernicious indolence. The epidemic of stagnant accumulations and congelations, of shaku, heki, chō, was proof. They occur only in peacetime, asserted Gotō Konzan, the affliction is unknown in periods of chaos (Gotō, 1985: 10). Kagawa Shūan explained more fully:

> Peace has reigned now for over a hundred years. All is calm within the four seas, and the populace enjoy rich abundance. People are frivolous and idle, overfed, overheated. Their bodies pursue relaxation and pleasure, while their minds labor with worries. They work themselves up over how much they can accumulate over their lifetime, they worry and scheme about the revenues that will sustain them through life. Add to these an inexhaustible thirst for wine, and bottomless lust, and it is no wonder that people's vitality is debilitated — life being treated so cavalierly. As vitality declines, its flow cannot but become sluggish, and this is how stagnation and knotting arises. And so among the people of today, regardless of station or wealth, there are none who don't suffer from knotting, congelations, or colic (Kagawa, 1982: 128-129).

After this sweeping indictment, Shūan immediately qualified: among the poor and lowly who

toil in pinched poverty, running around to make ends meet, very few suffer from this problem. Or if they are afflicted, their case is light. But among the mighty and wealthy who busy themselves only with indolent pleasures, pampered and overfed, none escape. Or if there are those who are not afflicted, they number only one or two out of a hundred (Kagawa, 1982: 129-130).

In his *Kōshoku ichidai onna* Ihara Saikaku describes the lazy extravagance fostered by urban prosperity. The dashing playboy, for instance, dons new sandals each time he goes out, and whiles away hours at the pleasure quarters.

> Though the stone basin may already be full of water, he has it filled afresh; then he washes his hands in a leisurely fashion, gargles softly and performs his other ablutions with like elegance. Having completed his toilet, he bids one of the girl assistants fetch his tobacco, which his attendant has brought along wrapped in white Hosho paper. After a few puffs he lays a handkerchief of Nobé paper by his knees, uses it with artless elegance and throws it away.
>
> Next he summons an assistant courtesan, and telling her that he would fain borrow her hand for a moment, he has her slip it up his sleeve to scratch the moxa scar left from his kenpeki treatment (Ihara, 1963: 145-146).[3]

The playboy's scar attests to the inevitable consequence of the indolent life: he has been treated for the ache of kenpeki, of stagnation. But he is too lazy even to scratch the scar himself. Shūan's assertion of a link between sickness and congelation represented less an attempt to theorize about disease in general than a perception of contemporary pathology, "direct observation of the people of today."

The Claims of the Hand

The pathology of sluggishness and stagnation was thus infused with social meaning. Kori, heki, shaku, chō, ryūtai articulated an affliction both of the body and of the times. But the resonance of medical and social concerns was not the only reason for the Edo insistence on knotting and congelations. Crucial, too, was the culture of palpation.

Zhu Zhenheng relied on two factors to diagnose congested flow: the complaints of the patient, and feel of the pulse. From these one *inferred* the congestion. For Kagawa Shūan, by contrast, knotting and congelations were entities that the healer grasped directly. Alluding to the fact that the character chō combines the radical for disease with a character meaning 'to manifest' — also pronounced chō — Kagawa explained, "Chō is a clump inside the abdomen. It is manifest (chō) to the hand." To recognize the pervasiveness of this affliction, he urged, one had but to palpate people's abdomens (Kagawa, 1982: 123, 129). Chō was not so much an abstract etiological theory as a palpable reality, felt right there, under the fingers, accumulated indolence made manifest to the touch.

Gazing, listening and smelling, questioning, and touching: these were the four methods of diagnosis identified by Chinese medical theory. In practice, Chinese doctors tended especially to stress the last. They prided themselves on the sensitivity of their fingers, their ability to diagnose

3 I have modified the last sentence to make clearer the reference, in the original, to kenpeki.

without even asking questions, just by feeling the pulse. But the wrist was regularly the limit of what they touched. Indeed, according to legend, upper-echelon patients typically sat hidden behind a curtain, thrusting out their wrists alone for examination.

The practice of the eighteenth century German doctor Johann Storch reveals similar restrictions on physical contact. As Barbara Duden describes his practice, patients might provide Storch with graphic *verbal* accounts of personal secretions and excretions; but he could directly palpate, or for that matter see, their uncovered bodies only in rare, extraordinary circumstances. "Suffering in Eisenach had to be verbalized before a *medicus* could deal with it." Wealthier patients seeking advice, in fact, might not even come in person, but just send their servants to report their symptoms. Or alternatively, they solicited diagnoses through the mail (Düden, 1991: 83-87).

The situation in Edo Japan could scarcely be more different. For many doctors nothing was more revealing than slow, careful palpation of the patient's chest and abdomen (Kagawa, 1982: 36). Their emphasis on *fukushin*, abdominal palpation, was in fact the most striking difference between the practice of medicine in traditional Japan and China. (Plate)

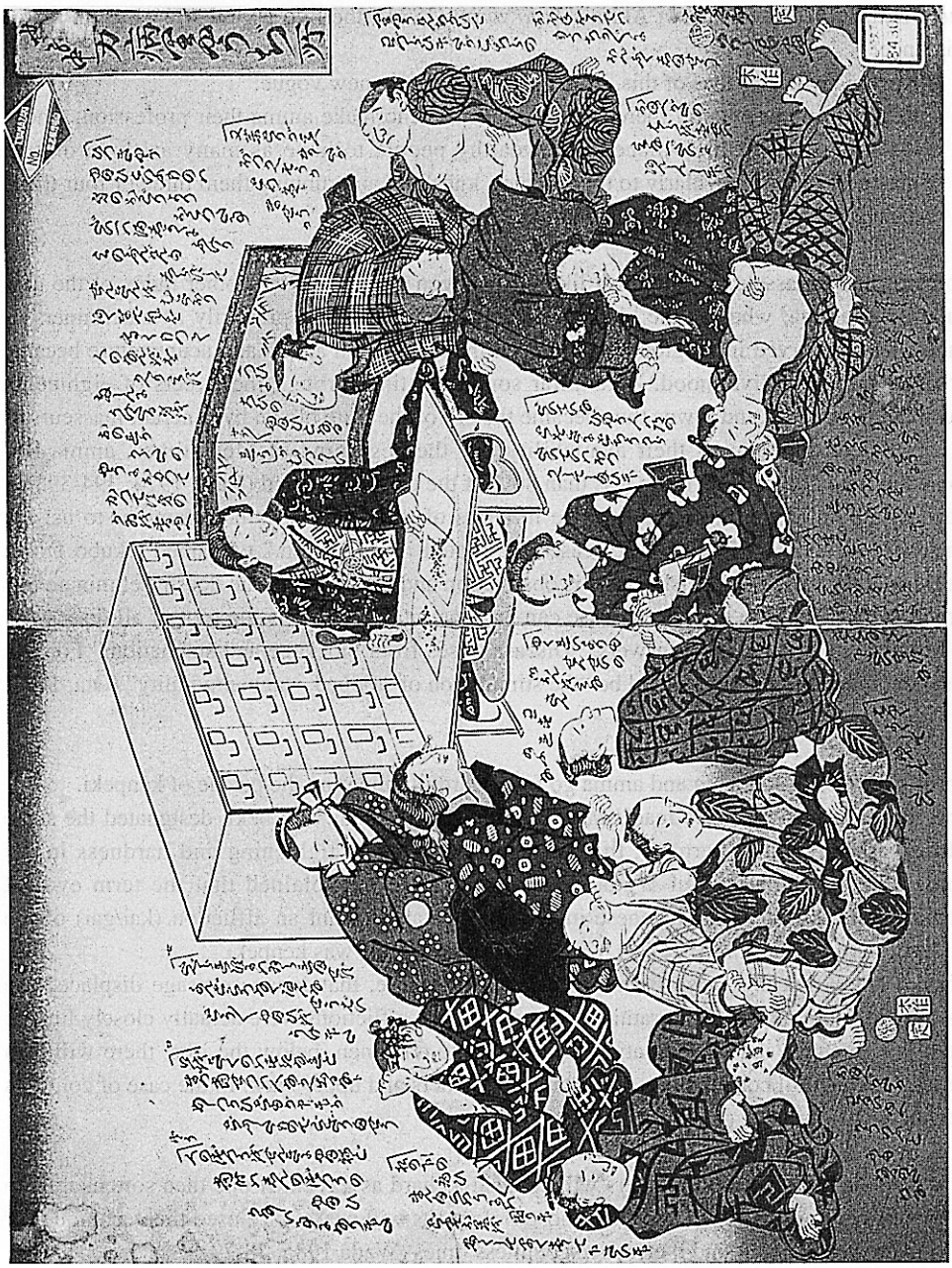
To be sure, brief descriptions of palpating the abdomen can already be found in the medical classics of Han times — the *Neijing*, the *Nanjing*, and the *Shanghanlun* — and early Japanese writers on fukushin invariably cited these Chinese antecendents. But in China this was a peripheral technique, practiced only irregularly. Most postclassical expositions of diagnosis don't even mention it, and one has to search far and wide to cull scattered references. By contrast, doctors in eighteenth-century Japan devoted dozens of treatises to the subject, articulating and illustrating in detail the subtle nodules, pulsings, indurations and soft spots that appeared on the surface of the abdomen, and that spoke so eloquently to the practiced hand (Ōtsuka, 1981).

The technique would not have been possible, of course, without a remarkable willingness on the part of patients to bare themselves and be touched. From a comparative perspective, this easy acquiescence may be the most striking aspect of the history of fukushin — not the assumption that the abdomen revealed sickness, nor the particulars of its hermeneutics, but the mere fact that touching and being touched could occur so casually, that body-consciousness turned so importantly around haptic exploration. To repeat: heki, kori, and chō were not theoretical inferences, but palpable facts, knottings and indurations made familiar, plain, undeniable, by habits of touching.

If it was the hand that grasped the presence of heki, it was also often the hand that relieved its ache. Both the practice and the practitioners of *amma*, traditional massage, were often referred to by the compound amma-kenpeki — as if unknotting kenpeki were their whole raison d'être. The entry 'amma' in Terashima Ryōan's *Wakan sansai zue* (1712), the first Japanese encyclopedia, is illustrated by a picture that Japanese even today would immediately recognize as a scene of someone being treated for katakori. The caption is explicit: "Amma is the art of preserving health by rubbing along the conduits [of acupuncture], and drawing away kenpeki" (Terashima, 1989: 103).

Amma was an old art. The Chinese *Huangdi neijing* already recommended it for the treatment of paresthesia, and in Heian Japan, amma specialists formed part of the medical hierarchy. But we encounter only occasional, passing references to it until the last quarter of the seventeenth century.

Then suddenly, people begin to write about it. Kusakari San'etsu devotes a chapter to the



(From the collection of KURAKATA Hiromasa)

On the right hand side of the illustration are depictions of abdominal palpation and acupuncture. On the left is a blind masseur treating the shoulders, and a man burning moxa on his leg.

technique in his *Ikyō seii* (1678), and this is followed by a small flurry of books. From Hayashi Masakatsu's *Dōin taiyō* (1684), Takenaka Tsūan's *Kokon yōsei roku* (1692), Ōkubo Dōko's *Kokon dōin shū* (1709), and Miyawaki Chūsaku's *Dōin kuketsushō* (1713), through Ōta Shinsai's *Anpuku zukai* (1827) and Suzuki Akira's *Yōjō yōron* (1834), the Edo period witnesses an amma renaissance.

> Kazuki Gyūzan writes of this, in 1716, as a relatively new vogue:
> Recently in our country there are many people who make amma their profession. And it isn't unusual for high-placed and wealthy people to have as many as three or five masseurs coming regularly to their homes, kneading and rubbing them three or four times a day (Yoshihara, 1971: 41-42).

Some of these masseurs would most likely have been blind. This is another index of the new popularity of amma: whereas the blind in medieval Japan worked primarily as entertainers or fortunetellers, or served in religious functions, in the Edo period amma and acupuncture became their chief means of livelihood. A familiar sound floating through the streets of eighteenth century Japanese cities and towns thus became the cry of the flute blown by itinerant masseurs as they circulated, announcing their availability. By the beginning of Meiji times, amma had become the stated occupation of no less than 80% of the employed blind (Katō, 1974: 394-398).

Edo writers on amma theorized practice in terms of a lesson that is now familiar to us: the harmfulness of sluggish flow. "All diseases are rooted in stagnation," explained Okubo Dōko, and again, "The cause of all misfortunes is obstruction and blockage. If one doesn't eliminate this obstruction and blockage then the disease can become fatal." "What is the root of all diseases?" asks Miyawaki Chūsaku, then answers, "Disease arises from blockage and stagnation." For Ota Shinsai the function of amma would be "the stimulation of stopped, stagnant vitality" (Ōta, 1887: 6).

These practices of fukushin and amma go far toward illuminating the puzzle of kenpeki.

The character heki was also read *katakai*, and at first, katakai, like heki, designated the same condition as the Chinese term pi; that is, it named an acute tightening and hardness in the abdomen, below the ribs. But Wada Tōkaku (1742-1803) explained that the term evoked something quite different for Japanese in his time: katakai meant an affliction (kai/gai) of the shoulders (kata) (Wada, 1985: 78-79). Katakai, in other words, was kenpeki.

Tōkaku knew that this wasn't what pi meant in Chinese, that Japanese usage displaced the locus of pain. But this wasn't a gratuitous error. The two afflictions were actually closely linked: if there is tightening and accumulation (shaku) in the abdomen, below the ribs, there will also necessarily be painful congelations (kori) in the shoulders and upper back. In the case of colic fits in infants, he goes on,

> the area between the shoulders will congeal as hard as a rock. If one then softens this up with vigorous massage, even the most violent fits will cease. I've used this technique for many years, and found it effective countless times (Wada 1985, 78-79).

Ōta Shinsai makes a similar observation in his remarks on abdominal palpation: the best way to treat the pulsings, spasms, and knotted congelations discovered in the abdomen, he advises, is

patiently to massage and dissolve the corresponding knotting in the back (Ōta, 7).

Kagawa Shūan thus spoke of six diagnostic methods: to the four standard Chinese techniques, and the Japanese method of abdominal palpation, he added palpation of the back. In chronic ailments, he taught, it is imperative to study the back.

> Why? Light cases of abdominal chō are superficial, immediately accessible; heavy cases are sunken and deep. Deep, heavy cases sink to the pit of the abdomen, and appear as kori in the back. At times, this causes the flesh in the back to form depressions; at other times, the flesh swells up. Sometimes the vertebrae are bent to the left, sometimes to the right, and sometimes they jut out high. Sometimes they hurt, sometimes they are tense. These are all displacements caused by the pressure of chō (Kagawa, 1985: 40-41).

Since the nineteenth century, Western chiropractors too have suggested links between chronic illness and spinal deformation. But note the difference: in chiropractic discourse, the deformations represent the cause; here, it is the result. In the former, the body's pivot lay in the nerves. For Shūan, it was the abdomen that mattered most.

Once we situate kenpeki in the context of Japanese practices of palpation, as diagnostic method and as therapy, the name ceases to seem strange. What we conceive today as two unrelated problems — knotting in the abdomen and knotting in the shoulders, xuanpi and kenpeki — were in Edo times just the front and back, as it were, of one and the same affliction.

My argument, then, is that at the very core of the history of kenpeki, we find the claims of the hand. Techniques like abdominal palpation and amma responded ostensibly to the prevailing disorders of the time. They became popular because of their usefulness in diagnosing and healing congelation disorders. But causation likely operated simultaneously in the opposite direction as well. As careful palpation of abdomen and back became standard practice, healers became increasingly convinced of the prevalence of congelation. For there, under their fingers, was palpable proof.

To patients, meanwhile, the experience of being regularly palpated both in diagnosis and in amma therapy almost certainly fostered a keener awareness of the stagnant congelations within themselves. It was above all this interaction, I suggest, between stagnation as a theory (medical, economic, and moral), and stagnation as something grasped, literally, by the hand, that kori crystallized as a medical truth and an intimate experience.

Close ties, I should add, bound the rise of palpation to the economic developments described earlier. It was the new leisure and surplus wealth of the cities, after all, that supported the new profession of massage. Masseurs flourished notably in the pleasure quarters and in the hot spring resorts. Furthermore, we have seen how contemporaries often perceived the epidemic of congelation disorders as the consequence of a new indolence, a reflection of Tokugawa peace and prosperity. One might argue, in this sense, that the formation of an economic society created not just the possibility, but also the need for a medicine of palpation.

In any case, the importance of the claims of the hand naturally suggest an intriguing question. Massage was, of course, by no means unique to Japan. To some degree one finds it in nearly all

healing traditions.[4]

* * *

The nineteenth-century diagnosis of chronic, or muscular rheumatism — as opposed to articular rheumatism, or arthritis — named pains that had no discernible anatomical basis. The archetype was lumbago, but the affliction also frequently affected the neck and shoulders, the limbs, and the ribs. The term rheumatism — from the Greek *rheô*, 'I flow' — reflected the hypothesis that the pain was caused by the local influx and build-up of acrid humors. Like kori, in other words, the disease involved disordered flow and accumulation.

The similarities go further. As early as 1816, C. Scudamore's *Treatise on the nature of gout and rheumatism*, the first systematic study of chronic rheumatism, noted thickenings, hardenings and knottiness in aching muscles, and blamed the local inflammation of white fibrous tissue (Scudamore, 1816). Froriep reported in 1847 that out of a hundred and fifty cases of chronic rheumatism he failed to note characteristic indurations *(rheumatische Schwiele)* in only two (Stockman, 1904: 112). And by 1900 Idler could observe:

> With some practice in palpating muscles, and after attention has once been directed to these muscular lesions, it is not very difficult to convince one's self of the existence of these infiltrations, indurations, and swellings in every case of muscular rheumatism (Idler, 1900).

Were Western doctors here feeling what the Japanese called kori? One thing is certain: there is nothing in Western medical literature that comes as close. In a 1904 article that definitively established nodules and indurations as central to the diagnosis and theory of muscular rheumatism, the Glasgow physician Ralph Stockman described how these typically started off as tiny, transient inflammations, but over time they became hardened, entrenched, and grew — to the size of a split-pea or an almond, and sometimes larger like half a walnut (Stockman, 1904: 109). We shall see in a moment that Kagawa Shūan's description of stagnant congelations is uncannily similar.

Like kori, these nodules had therapeutic as well as diagnostic meaning. For Froriep, for Idler, for Stockman, the observation of indurations went hand-in-hand with the recommendation to eliminate them through massage (Idler, 1900: 534). In 1871, E. Dally reported on a successful treatment center in Edinburgh founded on the principle — so reminiscent of Gotō Konzan — that *all* chronic afflictions owe to obstructions. The center employed no less than ten 'rubbers', i.e., massage specialists. By literally rubbing out these obstructions, the center's director proclaimed, one could make the diseases spontaneously disappear (Dally, 1871: 571). Although other doctors may have been skeptical of the generality of this paradigm, most accepted the special significance of nodules in chronic rheumatism. As late as 1941, Halliday reported as the accepted

4 An old, but still useful history of massage can be found in Douglas Graham's essay on "Massage," in Albert Buck ed., *Handbook of the medical sciences* (New York: William Wood, 1894), 643-668. See also A.W. Randall, "Massage through the ages," *Physiotherapy* 308-314. On massage in China, see Luo Jinghong, ed., *Zhonghua tuina yixue zhi. Shoufa yuanliu* (Chongqing: kexue jishu wenxian chubanshe, 1987). Indeed, modern massage, as opposed to traditional amma, came to Meiji Japan from Europe — though that is another tale. So we might ask: did the practice of massage outside Japan result in the awareness or experience of something like kori?

view the assumption that,

> Massage, especially if deep and if it hurts the patient, will in the course of time rub away or liquidate these nodules, and with this there is disappearance of the symptoms (Halliday, 1941: 666).

In the twentieth century, talk of chronic or muscular rheumatism gradually gave way to the ostensibly more precise diagnosis of fibrositis. The term was coined in 1904 by the Edinburgh doctor William Gowers, who sought to replace the vague humoralism of 'rheumatism' with a word that he felt captured more directly the essence of the affliction, namely, "an inflammation of the fibrous tissue of the muscles" (Gowers, 1904: 117-118). Following Gowers, Arthur Luff thus asseverated in 1913 that muscular rheumatism "is always a fibrositis" (Luff, 1913: 756). And fibrositis, Halliday explained,

> usually stands for the idea that subjective complaints of localized pain and stiffness can commonly be related to localized objective findings such as nodules, thickenings and indurations which result from inflammation of fibrous tissue and fascia (Halliday, 1941: 666).

This was the classical picture of fibrositis, built upon three pillars: subjective pain, objective nodules, and the theory of inflammation.

But the last pillar wobbled from the start. At the beginning of the century, Idler credited masseurs for drawing attention to the palpable patches of "inflammed infiltration" in muscular rheumatism, conceding that they did so "without adequate anatomical substantiation," but implying that such substantiation was imminent (Idler, 1900). This seemed a reasonable expectation. How else could one explain the pain? Yet the following decades produced no support. Instead, advances in investigative techniques made increasingly plain that, despite the pain and palpable nodules, there was no inflammation. And this is how things stand today, in 1996: biopsies scrutinized with electron microscopy have shown no sign of inflammatory or other microanatomical changes, and the subtlest biochemical analyses have revealed no metabolic peculiarities (Yunus, 1994: 812-813).[5] The century began with the expectation of anatomical substantiation; the century ends with the conclusion that there may be nothing, anatomically, physiologically, to substantiate.

But what of the nodules and indurations? Halliday observed,

> Enthusiasts for fibrositis have claimed that they are able to palpate nodules in a very large percentage of patients who are in common language said to be suffering from 'rheumatism' (non-arthritic), both by the laity and by the medical profession. To such enthusiasts, the problem of non-arthritic rheumatism is already solved.

5 K.G. Henriksson reads the recent research literature slightly differently. His review ("Aetiology and pathogenesis of chronic muscular pain," *Baillière's clinical rheumatology* 8 (1994): 703-719) sees it suggesting that chronic muscle pain sufferers may exhibit some, extremely subtle, distinctive anatomical and physiological characteristics—though their relevance to the pain and tenderness remains unclear. He too, however, rules out inflammatory infiltration.

While the theory of inflammation was always just a plausible hypothesis, the fibrous thickenings were a fact of experience. One could palpate them, diagnostically, and by rubbing them out one could cure the pain. For many these nodules were the essence of the affliction. "Unfortunately," Halliday continued, "many physicians, even after the most careful examination are able to detect nodules only in a very small proportion of such sufferers." The assertion that "this is because sufficient patience and practice have not been given to the examination," was, in Halliday's view, the opinion of "extremists ." He himself couldn't detect these nodules, though, he qualified, "sometimes, in the presence of an enthusiastic demonstrator, I am led to 'imagine' I can feel them" (Halliday, 1941: 666, 672).

Halliday's attitude pointed in the direction of things to come. As the nineteenth-century vogue of massage continued to recede, more and more doctors expressed uncertainty — first, whether they could really feel rheumatic nodules, and immediately after, whether there were really nodules there to be felt. Suspicion grew that these nodules were the artifact of the 'finger of faith', and fewer and fewer doctors even bothered to try their hand.

And so, deprived of its anchor in palpable objectivity, fibrositis floated free into the uncertainties of subjective pain. Halliday asked: "How do we differentiate between 'true fibrositis' and 'psychoneurotic rheumatism'?" But for E.F. Traut, writing in 1968, even this question seemed moot. The issue was more stark: "In discussing fibrositis, are we talking about something that does not exist?" (Traut, 1968: 531)[6]

We know this: it does not exist now. The diagnosis of fibrositis has been replaced by fibromyalgia. The change in endings mirrors the final abandonment of the inflammation theory, and the transition to an affliction defined by pure pain. In the guidelines for fibromyalgia that it established in 1990, the American College of Rheumatology cited only two criteria: pain and tender points (Wolfe et al., 1990). The latter referred to sites that radiate pain upon slight pressure; the former to pain even in the absence of pressure. A recent article elaborates:

> Fibromyalgia is a recognisable syndrome characterised by chronic, diffuse pain, an absence of inflammatory or structural musculoskeletal abnormalities and a constellation of symptoms that include fatigue, sleep disturbances, and mood disturbances. Physical examination and laboratory testing is unrevealing, except for the presence of pain on modest palpation of characteristic soft tissue locations, termed tender points (Goldenberg, 1995: 3).

What began in the nineteenth century as an ailment that was known and treated by the hand, has become, at the end of the twentieth century, a syndrome with no objective anchoring, a psychosomatic disorder associated with depression, insomnia, and chronic fatigue (Hudson et al., 1994).[7] Many now suggest that studying the patients' tenderness, that is, their psychological vulnerabilities, may be as important as studying tender points (Van Houdenhove et al, 1994: 473). Others question the wisdom of giving these vague aches an official name, fearing that

6 The problem of the reality of psychosomatic and psychiatric disorders is of course a prominent topic of current writing on the history of disease. For some lucid recent discussions, see Ian Hacking, *Rewriting the soul. Multiple personality and the sciences of memory* (Princeton: Princeton University Press, 1995), Chapter 2, "Is it real?," and Mark S. Micale, *Approaching hysteria* (Princeton: Princeton University Press, 1995), Chapter 2, "Theorizing disease historiography."

7 For some historical perspective on fatigue and fibrositis, see Edward Shorter, *From paralysis to fatigue. A history of psychosomatic illness in the modern era* (New York: Free Press, 1992), 307-314.

labelling legitimates patients' desires to think themselves sick, and contributes to the creation of a society of the 'worried sick' (Hadler, 1986).

Few katakori sufferers would recognize their discomforts in this picture. Fibromyalgia seems like an entirely different disorder — at once more serious, and more 'psychological'. While recognizing the relevance of social stresses and pressures on the incidence of katakori, most Japanese have no doubt that whatever its etiology, kori is a very 'real', physical affliction.

Key to this conviction, clearly, is the persistence of practices that give it palpable meaning, local habits of relating to the body by touch. Japan is still a country in which people — the middle-aged and elderly especially, but younger people as well — routinely call masseurs to their homes, a country where an invariable and indispensable part of the barber's routine is the massage of the neck and shoulders, and where, most commonly, family members massage each other. The last is what most struck an American doctor visiting in 1900:

> As every one knows, massage has been largely practiced in Japan almost from time immemorial. In a recent tour through that country one of the most interesting and curious sights that I witnessed was a little "tot" between five and seven years old, with the utmost seriousness and earnestness, and with a marked degree of skill, standing and massaging the age-stiffened trapezius and other muscles of the shoulders of an old grandfather or grandmother squatting before him (Woods, 1900: 877).

This custom survives to this day. Earlier this spring, a survey of parents in my son's third-grade class asked, 'Among the things that your child has done for you recently, what made you happiest?' The overwhelming majority of parents answered: massage my shoulders.

Conclusion

The character heki had yet another reading and sense. It was also read *kuse*, habit. Thus Gotō Konzan blamed stagnant accumulations for chronic migraines, and then explained, "The body becomes habituated *(kuse zuku).*" Likewise, lower back pain and chronic diarrhea, too, involved habituation (Gotō, 1846: 17b, 19b). In this way, the pathology of stagnation also mirrored a consciousness of time, a sense of how the past never just recedes or disappears, but instead forms residues, settles, accumulates, and endures, literally, as a felt hardness in a person. Unless, that is, one keeps moving ahead, tirelessly, without slacking.

The congelations that one can feel in the stomach, stresses Kagawa Shūan, didn't form overnight. They represent the accumulations of day after day, month after month, year after year. In the beginning, one can scarcely feel anything. But in time, this grows into a grain of rice, then a bead, then an egg, then a ball (Kagawa, 1982: 123-125). Nishikawa Joken makes a similar observation about the murder of one's lord or parents. Such horror doesn't just happen overnight, he says. It begins with the slightest of evil thoughts and accumulates over time, steadily piling up, expanding until it becomes huge (Nishikawa, 1975: 91).

This sense of the relentless accretion of subtle lapses explains, among other things, the extremism of Gotō Konzan's approach to moxibustion. Where traditional Chinese texts usually advised burning three or five or a dozen cones of moxa on a given spot, Konzan advocated burning thousands, even tens of thousands of cones. One couldn't, he argued, disperse stagnant

congelations with anything less. They were so inveterate, so hard, the deposit of months and years (Gotō, 1985: 83).

To what extent do we embody the past? And what is the extent of the past that we embody? Histories of Japanese medicine often suggest a decisive rupture, in the late nineteenth and early twentieth centuries, separating the modern from the traditional. And no one would deny the dramatic changes that transformed, say, the organization of medical training, and health care, and the beliefs of elite physicians. But the history of the experience of illness, and of everyday intuitions about how one gets sick and how one gets better is more tangled.

To be sure, people now complain of katakori where their plaint was once kenpeki, and the whole vocabulary of heki and chō has totally vanished. Yet the fact that people today still talk of — and suffer from — kori or congelation, suggests that at some deeper level, the Japanese experience of embodiment still retains some of the core features that crystallized in Edo times. This is perhaps the most intriguing lesson of our inquiry into katakori — the persistence of cultural memory in the body, the way in which, despite the passage of several hundred years, the past remains palpably present.

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肩こりの歴史的起源

栗山茂久

要旨：日本人が、いつ頃から、なぜ、肩こりに苦しむようになったか、ことにこの「凝り」感が歴史の中でいかに形成されたか。本論文の仮説では、肩こりは江戸時代に「疾癖」という訴えとして誕生して、すくなくとも三つの要素から構成された。すなわち、一、江戸時代の医学に病因観に多大な影響を及ぼした滞りの不安、二、経済社会の成立とともにおきた勤勉革命、三、腹診と按摩という揉むことを重視する医療の発展。さらに、西洋でマッサージが盛んになったころ誕生した fibrositis の概念の変遷と、揉まれることによって認知される「凝り」を比較し、最後に「肩こり」の歴史的研究から窺える身体感と時間の関係に言及して論を結んでいる。