

'Paralysed with fears and worries'

Citation for published version (APA):

Oosterhuis, H., & Slijkhuis, J. (2013). 'Paralysed with fears and worries': Neurasthenia as a gender specific disease of civilisation. *History of Psychiatry*, 24(1), 79-93.
<https://doi.org/10.1177/0957154X12450140>

Document status and date:

Published: 01/03/2013

DOI:

[10.1177/0957154X12450140](https://doi.org/10.1177/0957154X12450140)

Document Version:

Publisher's PDF, also known as Version of record

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History of Psychiatry

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History of Psychiatry 2013 24: 79

DOI: 10.1177/0957154X12450140

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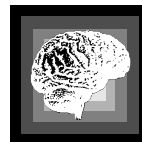
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History of Psychiatry
24(1) 79–93

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DOI: 10.1177/0957154X12450140

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Abstract

Around 1900 neurasthenia received much attention in both the medical world and society at large. Based on professional publications by Dutch psychiatrists and neurologists and on patient records from the Rijngeest sanatorium near Leiden in the Netherlands, this article addresses the meanings and interpretations of this nervous disorder as put forward by doctors and patients. We argue that their understanding of this disorder was determined not only by medical views, but also by social-cultural factors and prevailing gender norms.

Keywords

Bourgeois morality, gender, Netherlands, neurasthenia, psychiatry, sexuality

Introduction

At the end of the nineteenth century, the field of psychiatry began to see significant expansion in the Netherlands. As a medical specialty, psychiatry developed in asylums for the insane, but from the 1880s psychiatrists and neurologists also started to look after ‘nervous sufferers’, a diverse group of patients who struggled with mental problems but did not belong in a mental asylum. They included people who suffered from a variety of neurotic disorders, psychosomatic complaints and neurological disorders. This wide array of mental and physical symptoms offered physicians who specialized in psychiatry and neurology the opportunity to extend their professional area beyond asylums and to open up new markets. Special facilities were set up for the treatment of this new category of patients, such as convalescent homes, health resorts and sanatoria. In addition, the rising number of neurologists in private practice offered to help these patients. This new demand for

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medical expertise also gave psychiatrists new options for enhancing their status. The country's mental asylums had a bad image because they were largely populated by lower-class patients, who were admitted on the basis of legal certification and the Poor Law. Sanatoria and health resorts, on the other hand, catered for patients from the middle and upper echelons of society who were seeking medical help of their own accord. Moreover, physicians assumed that it was possible to cure many of them, which was not true for the large number of chronically insane who populated the mental asylums.

In particular, the nervous disorder called 'neurasthenia' (literally: nerve weakness) received ample medical and public attention around 1900. This article is about the various meanings that Dutch doctors and patients attached to this disease. Without denying the physical and mental realities of neurasthenia, we claim that these meanings were largely of a social-cultural nature and that they were frequently framed in gender-specific terms (Rosenberg and Golden, 1992). We rely on two types of sources: medical discourses about neurasthenia and patient records. First, we briefly address the medical view prevailing at that time of the nature, causes and treatment of neurasthenia. Next, a consideration of the records for neurasthenia patients hospitalized at Rhijngeest sanatorium near Leiden between 1903 and 1920 allows us to describe how they themselves experienced their various complaints and how doctors interpreted and treated them. In our conclusion we explain how those involved understood the disease's social-cultural meanings, including its inter-related gender-specific significance.

Neurasthenia as a 'disease of modernity'

As has been true of mental suffering in general, neurasthenia proved hard to define and delineate. Often, neurasthenia served as a container concept for a range of problems that failed to fit the existing psychiatric categories (Gijswijt-Hofstra and Porter, 2001). Today, neurasthenia is no longer common as a medical category, but the complaints and symptoms associated with it still survive in other names and categories in psychiatric diagnostics. Since World War I, the concept has gradually vanished from medical discourse, to be replaced by such interrelated clinical pictures as 'depression' and '(psycho)neurosis' (Gijswijt-Hofstra, 2001a: 1; Hutschemaekers, 1990, 1993: 88). Moreover, what used to be called neurasthenia also comprised symptoms that today we associate with chronic fatigue syndrome, burn-out and repetitive strain injury (RSI). These contemporary clinical pictures share with neurasthenia not only the absence of provable physical causes and the notion that therefore they are hard to explain medically, but also the view that they pertain to passing disorders that epitomize particular problems of modern society (Hermans and Schmidt, 1996; Showalter, 1997; Slijkhuis, 1998, 2001). At the end of the nineteenth century, neurasthenia was generally considered a 'disease of modernity', one that was at first attributed mainly to members of the bourgeoisie and intelligentsia, but later to all sections of the population.

There are no reliable data on the frequency of neurasthenia, partly because of the absence of a clearly delineated diagnosis. It is likely that the observed increase around 1900 was at least in part due to the greater medical and social attention to this disorder (Gijswijt-Hofstra, 2001b: 282; Hutschemaekers, 1990: 237). Although as a term neurasthenia had probably been around for some time, in the final two decades of the nineteenth century it gained broader familiarity as a clinical picture through some publications by the US neurologist George M. Beard¹ (1880, 1881). In these works, Beard suggested that a host of physical and mental complaints might be an indication of neurasthenia, including anxiety, desperation, insomnia, lack of concentration, sustained lassitude, palpitations, migraine, digestive problems and impotence. In his view, these resulted from nervous exhaustion, which in turn was caused by excessive burdening of the brain or the gastro-intestinal

and reproductive organs. This strain could be accounted for by the pressures of modern society: hectic urban life, fast means of transportation and communication, increased brainwork, women's growing intellectual activity, and the heightened pace of work. The therapeutic repertoire recommended by Beard consisted of electrotherapy, seclusion and (bed) rest, a nutritious diet, massage, psychotherapy, and a stay in a sanatorium or health resort.

From the early 1880s, Beard's views began to spread in Europe.² In the Netherlands the new clinical picture became better known, partly through the dissemination of various non-specialist publications – medical handbooks for the layman, self-help books and moral-didactic treatises on nervous disorders – many of which were translated from German (e.g. Donkersloot, 1881; Dornblüth, 1903; Hulst, 1884; Juda, 1905; Krafft-Ebing, 1903; Mantegazza and Donkersloot, 1888; Möbius and Kuile ter, 1884; Schilling, 1900; Schneckenberg, 1890; Soesman, 1908; Voorhoeve, 1905; Zbinden, 1907). The notion that these disorders increasingly gained ground was part of the criticism advanced, in particular, by representatives of the conservative liberal bourgeoisie who voiced their fear of the effects of material progress and social and political democratization. In their view, nervous disorders represented the reverse of major bourgeois-liberal virtues such as self-control, will-power, work ethic, independence and sense of duty, and such impairments threatened to undermine the upper and middle classes as well as the nation at large. In countries such as Germany and France this pessimism, fostered by the theory of degeneration, won even greater currency, and in the Netherlands there were also fears of national decline and calls for regeneration (Gilman and Chamberlain, 1985; Nye, 1984; Nys, De Smaele, Tollebeek and Wils, 2002; Pick, 1989; Radkau, 1998; Velde te, 1989, 1992: 56–62, 78–82; Vijselaar, 2001). On the other hand, several critical groups and proponents of decadence in the *fin de siècle* era, notably in literature and the fine arts, capitalized on nervousness for satirizing and ridiculing bourgeois morality. Instead of the bourgeois-liberal axioms of community spirit and sense of duty, critical intellectuals and artists treasured the value of individual emotional expression (Fontijn, 1983; Kemperink, 1988, 1993, 1995).

From 1884, Dutch professional medical publications started to pay attention to nervous disorders in general and neurasthenia in particular (e.g. Deventer van, 1896, 1899; Erp Taalman Kip van, 1904; Huet, 1886; Jelgersma, 1897, 1898, 1907, 1911, 1912; Renterghem van and Eeden van, 1889, 1894; Scheffer, 1906; Tellegen, 1884; Wijsman, 1891). In this respect, the work of Gerbrandus Jelgersma, who from 1894 to 1899 was medical director of a sanatorium in Arnhem and from 1899 Professor of Psychiatry at Leiden University, set the tone. His textbook on functional neuroses (*Leerboek der functioneele neurosen*, 1897) secured his authority in the field of nervous disorders. Like other physicians, Jelgersma classified neurasthenia as a so-called functional neurosis, meaning a nervous disorder without demonstrable physical disorders. A wide variety of complaints, in his view, could point to neurasthenia: persistent fatigue; gastro-intestinal complaints; muscular aches and headaches; tics and tremors; sexual problems such as a too strong or too weak sex urge, nocturnal emissions and masturbation; intellectual overexertion and lack of concentration; lack of self-control, will-power and indecision; unfounded anxieties, obsessions and phobias such as agoraphobia; irritability, grief, insomnia (or, conversely, narcolepsy) and sleepwalking; and persistent muscular aches or paroxysms (Jelgersma, 1897: 216). Similarly, the causes of neurasthenia were quite divergent according to Jelgersma: its emergence could be caused by constitutional factors such as a weakened nervous system, mainly as a result of hereditary degeneration, and also by conditions related to social position and harmful influences such as grief and exhaustion. The disorder was prevalent in particular among men aged between 20 and 50, with a family and a job that set high standards in terms of their responsibility and intellectual powers.³ Insofar as women suffered from neurasthenia, this was due to their 'natural' physical constitution and the interrelated

gynaecological problems, their especially sensitive nervous system, as well as overburdening of their intellectual powers; those in risk groups included female teachers and students, as well as telegraph operators (Jelgersma, 1897: 18–29).

Generally, physicians gave more weight to physical causes in women than in men; for men, the emphasis was on their social rank and situation. This difference should perhaps be linked to the prevailing views of the medical profession, which at the time consisted almost exclusively of men. The social position and working conditions of the men who suffered from neurasthenia showed many similarities with those of physicians themselves, who could perhaps empathize with the feelings of fatigue that troubled neurasthenic middle-class men; therefore doctors attributed such complaints rather to external social pressures, while in the case of women the medical gaze was geared more to their bodily complaints and their individual character (Hutschemaekers, 1993: 87, 92).⁴ But whether male or female patients were involved, in general Dutch psychiatrists pointed to broad social developments as the underlying cause of the strong increase they observed in the incidence of neurasthenia. No doubt, it related to modern life as marked by rush and speed, an excess of sensory stimuli, high standards with regard to mental competence, exaggerated ambitions, and increasing competition and covetousness. Given their emotional life and nervous system, people were incapable of handling all the rapid scientific and technological developments. The discrepancy between biological evolution and swift social changes would potentially be detrimental, in particular for people with modern professions that required much intellectual power and concentration, such as civil servants, teachers, businessmen, artists and students (Jelgersma, 1897: 3, 18–30; Jelgersma, 1907; Scheffer, 1905; Tellegen, 1884: 25, 35).

Jelgersma and other physicians stressed that in medical practice, as well as socially, there was a major distinction between insanity (psychotic disorders) and nervous disorders like neurasthenia (Jelgersma, 1897: 175–6; see also: Spaink, 1895; Stephan, 1896: 13, 40; Wijsman, 1891, 1899). Nervous sufferers displayed less serious symptoms and posed no danger to others or themselves and, unlike most of the insane, they were aware of their ailments, which the doctor could also discuss with them. The patients' insight into their illness and the subjective character of their complaints counted as the crucial distinctive features of neurasthenia, and these individuals did not belong in mental asylums. Admission to a mental asylum required judicial certification of insanity in order to protect the patient against himself and/or society against his disturbing and dangerous conduct. Also, asylums were partly populated by insane individuals without means, whose hospitalization was paid for by the municipal poor relief. These stigmatizing legal and financial conditions did not apply to care and treatment of those who suffered from nervous problems. For them, other medical services were needed, with physicians who had not only psychiatric and neurological knowledge at their disposal but also tact and the power to empathize and who could provide, aside from somatic treatments, a variety of mental treatments.

From the mid-1880s, sufferers from neurasthenia who wanted to seek treatment had several options. Depending on the nature and seriousness of their complaints, as well as their social position and financial means, they could go see a neurologist in private practice. They might also go to a convalescent home, a rest home, a health resort, a medical sanatorium or a bathing establishment, and, after the turn of the century, to a university psychiatric-neurological clinic or a general hospital or polyclinic which employed neurologists (Andel van, 1901; Huddleston Slater, 1935; Kerkhoven and Vijselaar, 1993; Oosterhuis and Gijswijt-Hofstra, 2008: 1417–21 and Table 11; Vijselaar, 2001: 246, 250). These facilities would largely provide somatic treatments, such as electrotherapy, various water cures, massages, gymnastics, rest and diet cures, medication and also all sorts of 'mental' therapies: conversations in which patients relieved their feelings and the doctor offered insight and encouragement. These mainly centred on moral influencing to strengthen

self-control and will-power and to promote a regular and disciplined lifestyle. This moral-didactic approach was in line with the preventive approach advocated by some physicians. For example, F.J. Soesman, a neurologist from The Hague, in his 1908 book, *Hygiëne van den Geest: Tucht als Middel tegen Zenuwzwakte* (Mental Hygiene: Discipline as Means against Nervous Weakness), argued for a 'rational mental hygiene' as a way to prevent nervous disorders. He thought that such disorders were a sign of a lack of self-control, will-power and a sense of realism; a balanced mental health depended on self-knowledge, meaning insight into one's capabilities and a realistic fine-tuning of one's personal ambitions with the demands of modern society, as well as on order and discipline (Soesman, 1908: 46–57).

Neurasthenia at Rhijngeest

One of the larger institutions for nervous sufferers in the Netherlands was Rhijngeest in the village of Oegstgeest near Leiden. This sanatorium, which was located very close to Endegeest, a mental asylum, opened its doors in 1903. Jelgersma (1897: 188–9) welcomed the establishment of Rhijngeest because for a long time he had wanted to see sanatorium care available to 'those of lesser means', such as teachers, civil servants and artists. Initially this facility offered room to 74 patients in second-class and 9 in first-class wards (Verslag ..., 1905). The sanatorium was a municipal facility of Leiden, but from 1908 it also maintained close ties with the state university in the same town, where Jelgersma was a professor. Twenty state-funded beds were added in second-class wards, which became available for training in psychiatry and neurology; in the Rhijngeest examination room, Professor Jelgersma would examine state-funded patients in the presence of his students once a week (Jelgersma, 1897: 3–4; Rooijmans, 1998: 21, 34; see also Verslag ..., 1908). These 'state beds' made it possible to admit patients who could otherwise not afford treatment, while all the other beds were only available to those with sufficient means to pay for their hospitalization. Apart from patients who suffered from neurasthenia and other neurotic disorders such as hysteria and 'psychasthenia', the new facility also admitted those with organic neurological disorders (such as multiple sclerosis, general paralysis and epilepsy) and mild psychoses (Verslag ... 1905).⁵

The public information on Rhijngeest carefully avoided any association with a mental asylum. For example, one prospectus noted that the sanatorium was meant for 'sufferers from organic and functional nervous diseases' and that 'the insane' were not eligible for admission. Further, it was indicated that the sanatorium, situated on a 'beautiful estate', was equipped with all the modern amenities such as electricity and central heating and that patients could find rest and relaxation. Various medical treatments were offered: 'lifestyle and dietary arrangements, effective combinations of rest and physical activity, psychotherapy, application of baths, wrappings and rubbings, electric treatment, medical gymnastics, rest cures, etc.' The fact that the Endegeest mental asylum was located in the next street was not mentioned ('Rhijngeest': Sanatorium ...; see also Scheffer, 1905). Nevertheless, psychotic patients were sometimes admitted to Rhijngeest – but only if they displayed calm behaviour. The sanatorium's annual reports reveal that patients' behaviour, rather than their diagnosis, was most important as an admission criterion. The advantage of care in a sanatorium, unlike that in a mental asylum, was that the former did not come with the stigma of certified admission – which the 'better' classes, in particular, tried to avoid as much as possible (Verslag ... 1908; see also Jelgersma, 1897: 2).

Based on statistical information from the Rhijngeest annual reports and a number of selected records for patients admitted to this sanatorium's first- and second-class wards between 1903 and 1920, we can learn more about those who suffered from neurasthenia. The annual reports of

Rhijnegeest provide factual information on admissions and discharges per nursing class and gender, with data on their age, civil status, profession (or, in the case of married women, the number of children), education, religious affiliation, social position, causes and duration of illness and the medical results.

The annual reports reveal that from 1905 to 1908 the neurasthenia patients made up more than half the total number of neurotic patients. From 1908, when the diagnosis 'psychasthenia' grew common, the number of neurasthenia patients dropped considerably. In the next six years the proportion fluctuated between 10 and 30 per cent, peaking in 1915 at nearly 70 per cent, to be followed by a sharp decline again. We have no explanation for the strong fluctuations, but the sharp drop after 1915 is probably related to changing diagnostics and the gradual fading of neurasthenia as a diagnosis in psychiatry in general.

Strikingly, women made up the majority of neurasthenia patients (with an average of 58 per cent), which conflicts with the general presumption among physicians that men in particular suffered from neurasthenia (Gijswijt-Hofstra, 2001a: 23–4; 2001b: 299–300; 2008: 78). On average two out of three patients in the sanatorium were Protestant, 40 per cent were recorded as married and 40 per cent unmarried; for the others in our sample no civil status is mentioned. Most were aged between 30 and 50. Half of them had had primary school education and slightly fewer had been to secondary school; a small proportion had gone on to higher education. Compared with the Dutch population as a whole, the working classes were under-represented while the middle classes were over-represented. Those who suffered from neurasthenia included physicians, teachers, merchants, manufacturers, shopkeepers, civil servants, students, domestic servants and workers in light manual jobs; but there were also a large number of married housewives. Apart from this category, quite a few unmarried women who worked as teachers, nurses or servants were admitted as well.

The annual reports also contain information on the causes of the patients' illnesses. Their nervous problems were caused in particular by mental factors such as persistent depression, worries and exhaustion, and also by the occurrence of neuroses and psychoses among parents or ancestors, in particular 'edgy' mothers and 'hot-tempered' or alcoholic fathers. Furthermore, various physical causes are mentioned in the reports: ageing, accidents, chronic illness, syphilis infection, and alcohol and morphine addiction. The annual reports offer fewer data on treatment. The information about how patients spent their day at Rhijnegeest suggests that the treatment was in some respects akin to the moral treatment as developed earlier in mental asylums. In 1903, Rhijnegeest's medical director, Jan C.Th. Scheffer, wrote that nervous sufferers needed rest but should also be encouraged to do activities: women sewed and men worked in the garden or did carpentry. For relaxation and entertainment there were books, magazines, a gramophone and billiards available, while communal activities such as celebrations and musical performances were organized as well (Verslag ... 1903, 1910).

The moral treatment at Rhijnegeest, however, comprised more than just work, games, rest and order. According to the physicians, neurotic patients also benefited from what they called 'mental pedagogy' or 'moral philosophy': through conversations and 'suggestion' the staff tried to motivate sufferers to changing their attitude and behaviour (Verslag ... 1910: 33). The annual reports indicate that the majority of the patients left the sanatorium within six months; over half of those discharged had 'recovered' or at least 'improved' to a smaller or greater degree. From 1910 the treatment was sometimes continued outside the sanatorium in the form of 'polyclinical aftercare'. Female patients in particular, according to J. van der Kolk, who in 1906 succeeded Scheffer as medical director, would not be able to cope with the abrupt transition to normal life and for them follow-up consultations with their attending doctor were indispensable (Verslag ... 1910: 33).

Neurasthenia in the Rhijngeest patient records

The annual reports provide no information about the practical implications of neurasthenia as a diagnosis, or about the actual complaints involved and how these were experienced and expressed. However, patient records⁶ do throw more light on these issues, although it should be noted that the amount of information varies greatly, depending on the duration of the care provided and the intensity of the treatment. Of course, the content of these records is strongly coloured by the medical viewpoint of the physicians involved, as described in the first part of this article. We inspected 15 archive boxes at random, each holding some 50 records, and we selected the patients diagnosed with neurasthenia. Often this diagnosis consists of a combination of neurasthenia and an adjective – such as ‘sexual’ or ‘hereditary neurasthenia’ – or another diagnostic category, such as ‘neurasthenia with hypochondria symptoms’ or ‘depression’. Each patient record has space for a description of the patient and his or her life story, the diagnosis, a description of the patient’s attitude and conduct on admission, the anamnesis and the *status praesens*. In addition, the results of the physical examination could be entered, including data on aberrations in build, skull size, tendon reflexes, skin colour, genitalia, stool and breathing.

Based on the records’ completeness, i.e. the various sections were fully filled in, we selected 30 records for closer analysis. Most are hand-written by Abraham Hermanus Oort, who served as first physician at Rhijngeest from 1903 to 1934, and by H.W. Borgerhoff Mulder, who worked there from 1908 until the mid-1940s (Rooijmans, 1998: 21–4). Given our concern with the meaning and interpretation of neurasthenia, we paid attention not only to how doctors approached and treated patients, but also and in particular to how these patients articulated and experienced their complaints. Notably, the forms with doctors’ notes about the course of the illness provide information about what patients thought and felt. Where the doctor recorded a patient’s remarks, this was typically done in a summarized or paraphrased fashion, apart from an occasional quotation. So although the records do not feature the patient’s words directly in most cases, and their problems were interpreted by the physician in quite specific and selective ways, the records clearly reveal that patients had their own views of their problems which they also discussed with the doctor.

The records show that in addition to psychosomatic ailments, neurasthenics also struggled with everyday problems such as worries of a relational, sexual or financial nature, or concerns about their health, their work or their children. Complaints of male neurasthenia patients were often linked to problems at work or to money or to study-related difficulties. For example, a 37-year-old police inspector attributed his apathy, tiredness, the paralyses in his arms and legs and his inclination to burst out crying to ‘fuss at the office associated with his responsibilities [and his] bothersome chief [...] He fears being reprimanded by his superior’.⁷ The physician he had consulted prior to his admission to Rhijngeest wrote in a letter to Oort that the inspector’s fears were unfounded, pointing out that the man was in fact well regarded by his superiors.

A 21-year-old student from a ‘healthy family’ admitted for two months to the sanatorium’s second-class ward, felt his ailments – ‘being too despondent, head pressure, headaches, and sensitivity to noise and light’ – to be an effect of his arduous study. After discontinuing it, his complaints decreased.⁸ Another student also felt that his ‘mental incapacity’ was caused by overburdening: he claimed to be ‘chronically overworked’ and that he could ‘not understand or recall anything anymore’. A six-week admission to a sanatorium in Arnhem, where he was encouraged to take part in sport and to go out had failed to benefit him; after a stay of two years in the first-class ward at Rhijngeest, where the student underwent treatment with ‘mental’ therapy and electric massage of the stomach, he was discharged in a slightly improved condition.⁹

Monetary worries might also lead to neurasthenic complaints. In 1912 a 56-year-old widower, director of a telegraph company, was admitted to Rhijngeest. According to his family doctor, who referred him to Rhijngeest, the man had suffered from neurasthenia for years and it had grown worse after the death of his wife. The patient worried 'about finances' and indicated that the pains in his back and sides, as well as his dejected mood, were due to his 'too large [extravagant] living' and 'hyperactivity'.¹⁰ Another widower, a shopkeeper aged 57, came with a similar story about too large and 'irresponsible' financial expenses. In the short autobiography that he wrote for his admission to Rhijngeest, one reads that he was 'born in a bourgeois family [...] we received an education in proportion to our standing [...] our lifestyle was fine, but simple'. He felt that his expenditure was at odds with the Protestant morality with which he was raised. His problems had started immediately after his marriage. His wife, although 'well educated', had 'had a bad example in terms of financial management [...], which is why there had occasionally been disagreements on finances; but since my character is weak [...] I would lose out to my wife all the time.' 'Paralysed with financial fears and worries,' the man filed for bankruptcy, even though there was no need for it. After the death of his wife, things continued to go downhill: 'now and then I noted that people thought I was crazy, and that others tried to take advantage of me [...]. I then began to fear becoming insane.'¹¹

Oort described this patient as 'a very easily moved man, friendly to all, soft and calm, with insight into his condition'. The extensive notes in the record show that Oort had many conversations with him. 'Each talk about his condition causes him to cry [...].' The patient, according to Oort, tended strongly towards 'notions of sin'. He would call himself 'moonwise and haughty' and blamed his troubles on his personality, labelling himself a 'worthless dead loss': 'if it had not been my nature to be austere and take everything seriously, perhaps I'd managed to cope.' He not only reproached himself for his weak character and bad financial management, but he also felt he had led a 'bad' life, also fearing he had contracted syphilis. In his view it was his fault that his children displayed 'odd deficiencies' and 'live [in a] morally reprehensible [way], work too hard and go around Amsterdam like ghosts'. Despite the talking, electrotherapy and the administering of opium, his condition continued to decline. Over the next nine years he was admitted to Rhijngeest five times, before ending up in a mental asylum.¹²

Feelings of guilt and self-reproach also constitute the basic theme in the record of a 57-year-old Protestant state official admitted in 1919 to the second-class ward and diagnosed as having a 'depressed condition with neurasthenia as a result of disheartening emotions'. In his view, his mental suffering followed from his financial troubles, the effects of the war, fear of catching Spanish flu, fear of sexual stimuli and, in particular, worries about his youngest son who suffered from dementia praecox (schizophrenia). His complaints consisted of bacteriophobia, endless fretting, and over-sensitivity for sounds and insomnia, for which he had been prescribed sedatives. The patient was troubled by feelings of guilt. As a father he had failed: his son had become mentally ill 'because he raised him too weakly'. The physician at Rhijngeest failed to change his way of thinking. Further, the man reproached himself for a lack of will, which is why he could not control his sexual urges and indulged in 'onanism' time and again, causing him to feel 'doubly inferior'. In the course of his nine-month stay at Rhijngeest, he produced new self-accusations all the time, centring on his sense of failure, his 'neglect of his duty' and his assumed lack of will and responsibility.¹³

Many male neurasthenia sufferers, and also their doctors, pointed to sexual urges, notably masturbation and extramarital relations, as one of the causes of their complaints. In the life of a 40-year-old musician, admitted to the second-class ward for his dizziness and palpitations ('the notes started dancing before his eyes'), sexual excesses played a key role. As one physician stressed:

'patient has indulged in onanism as of age 12, in recent times the patient does it less often because he went to see women'. The latter was a reason for the doctor enquiring after possible infection with syphilis or gonorrhoea.¹⁴

A 34-year-old baker, a patient in the second-class ward, reproached himself for having an extra-marital relationship whereby he had contracted gonorrhoea. On account of this 'slip' he felt both physically and mentally exhausted and he slept poorly. His worries did not pertain to his physical health, for his gonorrhoea was cured 'swiftly and well', but the problem was 'that he had been indecent', that he was 'no longer the same person anymore' and that 'his former zest' had not returned. He was consumed with remorse: 'not a single hour it was out of his mind and had he no wife and children, he would not want to live another day'.¹⁵

Other men related their neurasthenic complaints to their nocturnal emissions. One 'neurasthenic with hypochondria complaints' attributed his disorder to 'nocturnal emissions he wanted to prevent by squeezing the [...] penis] when ejaculating. The patient did this once [...], but afterward his groin and scrotum ached, causing him to think he discovered all sorts of aberrations there, resulting from his action [...]' Oort added to the diagnosis 'with hypochondria complaints', because the patient invented his ailments: 'he wants to be operated on his alleged suffering', while his complaints were of a 'psychogenic' nature.¹⁶ Another patient, a 22-year-old unmarried cabinetmaker, who voiced similar complaints – he was dispirited, listless, and sleepless and struggled with masturbation and nocturnal emissions – suffered from 'sexual neurasthenia', the doctor noted. The man received treatment with medication (bromide and opium) and electricity.¹⁷

A 24-year-old unmarried grocer, who said he did not masturbate but did suffer from unwanted ejaculations, could not control 'these phenomena', as his record puts it. '[S]ometimes there was a reason: contact with a woman, erotic fantasies, the rubbing of his clothes [...]. He did not trigger it deliberately.' The young man was very worried and fearful because he had heard there was a link between nocturnal emissions and insanity. It seems the doctor refuted this, but he did tell the patient that the nocturnal emissions and his lumbar and abdominal pains were interrelated. Treatment consisted of medications, lukewarm baths and daily electrotherapy, whereby one electrode was attached in the lumbar area and the other in the abdominal area. After five months the recovered grocer was discharged.¹⁸

Other neurasthenia patients also expressed great fear of their potential suffering from insanity. The record for a 26-year-old machine manufacturer with complaints about persistent palpitations – a man diagnosed with 'hereditary neurasthenia' because of his alcoholic father and nervous mother – contains the following observations:

He himself links them [the palpitations] to onanism, which he does not seem to have practised too often and more recently not at all anymore. In the last months his condition grew worse still [...] with obsessive fears that he would do 'something' to his relatives, having a sense of no longer being alive, as if having no family anymore, as if surrounded by a void, as if he was walking on down [...] and having fears of becoming insane.¹⁹

Sometimes relatives also voiced the fear that a neurasthenic patient was perhaps insane. As one cousin of an unmarried 51-year-old woman, who came to Rhijngeest after a suicide attempt, wrote: 'In my view she is no mental institution patient, even if she is often hot-tempered and then acting crudely and coarsely. If admission [to a mental asylum] might provide relief to others, it would do her no good. It seems to me that this cannot be the solution.'²⁰ Likewise, other records contain letters from relatives, family doctors or other physicians to the medical staff of Rhijngeest in which they stress that the patient to be admitted was not insane: 'the man is certainly not insane, will not

commit suicide'; 'he is *not* insane, yet suffers from melancholia'; 'he does not have a contagious disease, nor is he insane.'²¹

While worries of married men with a family often centred on financial troubles, many married women without a profession referred to worries about their husbands and children as the cause of their neurasthenia. For example, a 74-year-old 'morally and intellectually high-minded woman with 13 children', admitted to Rhijngeest's first-class ward in 1905, said that she was 'exhausted' and unable to work or sleep. She feared becoming insane. Her 'suffering from nerves' had, in her view, emerged after having nursed and looked after her husband who had died five months earlier.²² A 47-year-old woman 'from the lower middle class' was afraid that she would not recover and that something would happen to her children. She said that her alcoholic husband was irascible and edgy. The sanatorium offered her a comforting ambience, far removed from the troubles at home.²³

In many records of young unmarried women, sexual experiences play a major role. For example, in 1903 an adolescent woman, admitted to the first-class ward, was diagnosed with 'hereditary neurasthenia (inclination to paranoia) and some hysteric traits'. In the subsequent 12 years, three more admissions would follow. She not only slept badly, dreamed a lot and was nervous, but she also complained all the time about the compulsive movements she would have to perform and she displayed a tendency to 'say ugly stupid things'. As she claimed, her obsessions had surfaced after she had been 'touched indecently' when she was 11 years old, which had made her a very frightened person. Her condition improved somewhat until, when at home again, she happened to find her parents having sexual intercourse: 'afterwards [she] developed an irresistible urge to utter dirty words, never did it but lived in great fear that she would do so anytime'. This fear got worse after she once slept in a room in which a man, unknown to her, was also asleep, the two separated merely by a screen. Over the years Oort treated this patient in all sorts of ways: electrotherapy, exercises to raise control of her muscles, warm baths before sleeping, 'copying work', talking about her deceased mother and 'soothing hypnosis'. In the period before her last admission to Rhijngeest, when living and working in Amsterdam, she was being treated by a neurologist in private practice. He characterized her as 'an unhappy soul, as so many who found themselves on the borderline' and he added that life in Amsterdam, which was 'expensive, noisy and lonely', was not suitable for her.²⁴

An unmarried 25-year-old woman's mental suffering was also attributed to sexual harassment and her fear of it. She felt that 'what happened to her in the past has ruined her whole life'. When staying with a friend, the friend's husband had tried to harass her sexually. The notes made by Dr Borgerhoff Mulder after talking to her show that she was sad and anxious because she believed that everybody felt 'she is bad [...] [that] one accuses her of indecency in relation to what happened earlier [...] believes that she can never stay with a family [as household servant] because of her past.' '[I] mistrust everything, it's horrible!', the woman told Borgerhoff Mulder, adding that 'self-reproach is what her illness comes down to'. The doctor noted that she cherished 'all sorts of small romantic ambitions from her youth', was sensitive to 'male company', 'masturbated as of age nine' and 'suffers from onanism'.²⁵

Strikingly, another unmarried female patient with a similar story – nervous complaints in response to an 'unpleasant adventure' – was referred to as a neurasthenic but also as a hysteric. She too said that she slept badly, was anxious and had to think back to the 'emotion experienced' regularly. The difference from the story of the previous patient was that, in the doctor's opinion, the event had not 'really' taken place: 'this girl fancies herself the object of attacks on her chastity and aggrandises the interrelated associations'.²⁶ Whether it truly happened or not, female neurasthenia patients felt guilty, ashamed and frightened as a result of events that were designated as sexual by both themselves and the doctor.

In contrast to many male patients, women did not raise the issue of masturbation themselves. While men would mention masturbation as a cause of neurasthenia, in the case of women it was the physician who mentioned self-gratification as an aspect of the clinical picture. Another difference is that with men the risk of uncontrolled sexuality came from within, but women were threatened from outside. This difference was in line with the prevailing bourgeois morality which assumed that sexual urges with men were innate and could normally be controlled by will-power, while honourable women would not possess an autonomous sexuality and would also have a natural dislike of it. With women, sexual experiences, especially before marriage, were at odds with the bourgeois ideal of woman as essentially an asexual being.

Conclusion

The Rhijngeest patient records that we studied show many examples of the individual perspective of the neurasthenia patients on their complaints and problems – even if represented only by the physician. Patients expressed what they experienced as troublesome, reflected on their disorder and asked for the physician's help. Although the patients in our sample also displayed physical disorders, the records reveal neurasthenia above all to be a psychological problem. This corresponded with the psychiatric presumption that neurasthenia was a functional neurosis, a nervous disorder without provable somatic disorders, whereby the fact of patients' insight into their own condition served as basic criterion for distinguishing neurasthenia from insanity. Physicians viewed a patient's individual story not merely as a symptom of the mental disorder, but took its content seriously, while they considered the patient's insight into their illness as a key to its cure. This is also shown by the evidence that conversations between doctor and patient were a prominent element of the treatment. Apart from therapeutic conversations, the treatments applied to neurasthenic patients did not differ from therapies used on other patients at Rhijngeest. Complaints such as headaches, anxiety and sleeping problems were treated with medication, gastro-intestinal problems with a diet, and muscular and joint aches with electrotherapy and other 'physical' therapies, such as warm and cold baths. All these various treatments were mainly geared to restoring the patient's mental and physical balance. As our discussion demonstrates, the psychiatric interpretation of neurasthenia in the patient records was in line with the views advanced by physicians in their professional publications, in which loss of self-control was seen as centre-stage – a factor that was also influenced by social pressures.

Our investigation also establishes that neurasthenia as a diagnosis was important to patients and their relatives. In particular, their fear of becoming insane or being labelled as such and soon end up in Endegeest, the nearby mental asylum, played a role. As a diagnosis, neurasthenia could help patients to avoid loss of face and being stigmatized. Importantly, too, neurasthenia's prognosis was generally more hopeful than that of many psychoses. The fact that the physicians at Rhijngeest were quite aware of the sensitivity of this distinction shows from notes such as 'nervous, but intellectually in order' or 'nervous, but otherwise healthy'.²⁷

Furthermore, our argument shows that causes of neurasthenia as presented by patients and adopted by the attending physician were often related to feelings of guilt and self-reproach regarding a lack of self-control, of a sense of responsibility or a sense of duty in the domains of work, study, family and sexuality. The fear of failure and loss of self-motivation expressed itself in the pervasive anxiety, in both patients and their relatives, of becoming 'truly' insane. That the neurasthenia sufferers experienced and articulated their disorder as a (threatening) lack of self-control and common sense seems related to the bourgeois morality at the time, whereby the (feared) loss of control took on different forms with women and men. While contemporary psychiatric

publications on neurasthenia did not foreground sexuality, the records suggest that at Rhijngeest sexual problems were given much attention by patients and doctors alike. In this way, the meaning of neurasthenia differed for men and women. With men it involved the struggle with their hard-to-control sexual urges, which they expressed in masturbation, nocturnal emissions, extramarital relations or visits to prostitutes, and also the fear of the possible negative consequences (venereal diseases and insanity), while with women the fearful recollection of shameful incidents was prominent. Our finding that sexual problems played a major role among both genders is in fact at odds with earlier studies on neurasthenia which argue that physicians put emphasis on individual and physical causes in the case of female patients and on social pressures in the case of male patients.

More generally, the Rhijngeest patients' complaints, it seems, were the result of inner conflicts between themselves and the prevailing bourgeois and religious morality to which they subscribed. Their discontent was closely tied to their inability to meet the core values of that morality: self-control, self-discipline, will-power, sense of duty, character, family ethos and reproductive sexuality. The fear of the loss of these values in personal life formed a crucial element in the understanding of neurasthenia by both physicians and patients. The same values were also reflected in the central objective of treatment: restoring the patients' balance, self-control and will-power or, in short, their moral regeneration. Neurasthenia was the medical label that physicians attached to troubles actually experienced by individuals, in particular regarding the tension between inner insecurities and social norms. In this sense, psychiatry met a particular need for help and intervention that circulated in Dutch society at the time.

Notes

- 1 On Beard, see Gosling, 1987.
- 2 For international comparisons, see Gijswijt-Hofstra and Porter, 2001; see also: Oppenheim, 1991; Radkau, 1998; Shorter, 1992.
- 3 The physicians Albert Willem van Renterghem and Frederik van Eeden, who specialized in nervous disorders and treated some 260 neurasthenia patients in their Amsterdam private practice between 1887 and 1897, claimed that three-quarters of them were men; Renterghem van, 1898; Renterghem van and Eeden van, 1889, 1894.
- 4 Micalé (1995) also identified such gender-based distinction regarding patients with hysteria.
- 5 Although it appears that psychasthenia was another diagnostic term for neurasthenia as a clinical picture, in the case of psychasthenia the emphasis was more exclusively on the mental symptoms while the nervous disorders were relegated to the background. The term 'psychasthenia' was later replaced by the currently more common term 'psychoneurosis.'
- 6 The alphabetically arranged patient records of Rhijngeest are stored in the Municipal Archive Leiden and the Leiden University Medical Center. In our references to these records below, we indicate the record number and the year in which the patient was admitted.
- 7 Patient Record 121 (1903).
- 8 Patient Record 453 (1906).
- 9 Patient Record 181 (1904).
- 10 Patient Record 1687 (1912).
- 11 Patient Record 1295 (1903).
- 12 Patient Record 1295 (1903).
- 13 Patient Record 3127 (1919).
- 14 Patient Record 493 (1906).
- 15 Patient Record 123 (1903).
- 16 Patient Record 4500 (1907).
- 17 Patient Record 56 (1903).
- 18 Patient Record 314 (1905).

- 19 Patient Record 570 (1907).
- 20 Patient Record 610 (1907).
- 21 Patient Record 1295 (1903); Patient Record 197 (1904); Patient Record 121 (1903).
- 22 Patient Record 3331 (1905).
- 23 Patient Record 2696 (1917). Gijswijt-Hofstra (2008) observes that women with children in particular seemed to benefit from their admission to Rhijngeest.
- 24 Patient Record 2329 (1903).
- 25 Patient Record 1970 (1912).
- 26 Patient Record 2497 (1917).
- 27 Patient Record 3126 (1919); Patient Record 1295 (1903).

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