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Hysteria and neurasthenia in pre-1914 British medical discourse and in histories of shell-shock

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Histories of shell-shock have argued that the diagnosis was subdivided into the categories hysteria and neurasthenia, and that the differential distribution and treatment of these diagnoses was shaped by class and gender expectations. These arguments depend on the presentation of hysteria and neurasthenia as opposed constructs in British medical discourse before 1914. An analysis of the framing of these diagnoses in British medical discourse c.1910–1914 demonstrates that hysteria and neurasthenia, although undergoing redefinition in these years, were closely connected through the designation of both as functional diseases, and the role attributed to heredity in each. Before the war these diagnoses were perceived as indicators of national decline. Continuity, as well as change, is evident in medical responses to shell-shock.

Keywords: *anxiety neurosis; degeneration; hysteria; neurasthenia; shell-shock*

Introduction

In recent years, shell-shock has been one of the hottest topics in the history of British psychiatry. Over the last two decades a number of excellent histories have appeared, variously situated as contributions to the history of civilian psychiatry and attitudes to mental health (Bogacz, 1989; Merskey, 1991; Stone, 1985); military psychiatry (Binnevald, 1997; Jones and Wessely, 2005; Shephard, 2002); the concept of trauma (Leys, 2000; Young, 1995); and, loosely defined, the challenge experiences of war posed to established notions

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of identity (Barham 2004; Bourke, 1996; Showalter, 1987). These histories have underscored the social, political and cultural importance of shell-shock, and have added immeasurably to our understanding of how the disorder was perceived, experienced and treated. In common with other areas of the history of psychiatry, however, one aspect of shell-shock remains relatively unexplored: 'its languages of diagnosis and prognosis, its classificatory schemes, its technological concepts, and their internal connexions and evolution' (Porter, 1991: 278).

This paper, although it deals only indirectly with World War I, is a contribution to filling this gap. It examines theories of hysteria and neurasthenia in pre-war British medical discourse, with a particular focus on the years 1910–14. Although hysteria and neurasthenia have generated a large secondary literature, relatively little has been written on British clinical constructions for the period covered here (reflecting a more widespread tendency within the history of psychiatry for the years between 1900 and the outbreak of war to be treated as a hangover of the Victorian era). The bibliography of nearly four hundred secondary works on hysteria provided by Mark Micale's magisterial study of the disorder lists only a handful of relevant items (Micale, 1995: 295–316). Most research on neurasthenia has focussed on North America or taken a pan-Western perspective (Drinka, 1984; Rabinbach, 1990: 146–78; Sicherman, 1977), although the relevant essays in a recent and excellent comparative collection suggest that the diagnosis evolved differently in the British context (Gijswijt-Hofstra and Porter, 2001). The discussion here has two aims: first, to draw out some salient features of the diagnoses of hysteria and neurasthenia in pre-1914 British medical psychology; second, to highlight chronological shifts in the understanding of these disorders with a view to evaluating the claim that shell-shock was a catalyst for the reorientation of approaches to mental health.

A nuanced consideration of the diagnoses of hysteria and neurasthenia in pre-war British medical discourse is crucial for understanding the intellectual underpinnings of the category of shell-shock. The one aspect on which most historians of this controversial topic are agreed is that prior to 1914 hysteria and neurasthenia were the two main nervous disorders recognized by British psychiatry, and that the diagnosis of shell-shock was comprised of these categories. A complex of related and influential arguments regarding the socio-cultural significance of shell-shock, reducible to three main strands, has been formed on the basis of this perceived division into hysteria and neurasthenia. The first of these is that, before the war, hysteria and neurasthenia were differentially distributed along class lines, and that this trend continued in war-time with officers diagnosed as neurasthenic and ranking men as hysterical (Leed, 1979: 163–4). The second is that these were also gendered diagnoses. The hysterical ranking soldier was seen in similar demeaning terms as hysterical females, while the neurasthenic officer was portrayed as closer to an acceptable male ideal (Showalter, 1987: 175). The third is that different treatments were

applied according to diagnostic label. Hysterical soldiers were punished by disciplinary therapies, but neurasthenic officers were sympathetically treated with 'talking cures' (Leed, 1979; Shephard, 1999: 35–6). These arguments accumulate force from the historiographical construction of hysteria and neurasthenia as separate and opposed categories, in which various dichotomies are attached to each diagnosis: body/mind, female/male, nature/culture, lower/upper class, ancient/modern disease. This construction is often presented as the established background against which shell-shock can be interpreted, rather than as an equally contestable rendering of evidence (Shephard, 2002: 8–10; Showalter; 1993: 321–7).

The above précis is unavoidably reductive. Not all historians agree with every aspect of this three-pronged analysis; recent scholarship has undermined each to some degree; and the latest histories do not accord hysteria and neurasthenia supreme prominence in their analyses. Nevertheless, because no revisionist account has directly tackled the use of the hysteria/neurasthenia divide in contemporary constructions of shell-shock, the sociocultural interpretations outlined above still cast a powerful shadow over recent histories. The language and intellectual content of diagnoses in pre-World War I British psychological medicine are peripheral to these works. This paper suggests some ways in which closer attention to this aspect of the history of shell-shock might alter the established historiographical narrative, and aims to contribute to the deepened understanding of wartime psychiatry which previous historians of shell-shock have provided.

Hysteria and neurasthenia were staple topics for discussion in the pre-war British medical press, and this material forms the bulk of evidence for the present study. Neurasthenia was commented on by specialists from every branch of the medical profession, including gynaecologists, neurologists, ophthalmologists, paediatricians, general practitioners and private consultants. As might be expected from such a motley crew, every shade of opinion on the definition, aetiology, symptomatology and treatment of the disorder can be found within the pages of these journals (Anon., 1913*a*; Anon., 1913*b*; Wilson, 1913: 1677; also, *Practitioner*, special issue on neurasthenia, 1911). The situation with regard to hysteria was similar, although with one crucial point of distinction. Although neurasthenia was admitted to be a relatively recent and foreign invention, commentators were quick to create a native body of opinion on the disorder. In contrast, although hysteria was discussed by an equally wide cross-section of the medical community, it was readily acknowledged that Britain had produced 'comparatively little of an authoritative character' on the disorder, and so most discussions centred on the welter of psychologically-oriented theories emanating from the Continent (Anon., 1911*a*: 951; Ormerod, 1911: 270). In articles, in published papers, in reports of papers received and discussed by regional medical societies, these theories were endlessly debated (Anon., 1911*b*; Anon., 1913*c*; Anon., 1913*d*; Brown, 1913*a*, 1913*b*; Fowler, 1911; Glynn, 1913; Hart, 1911; Wilson, 1911). Just before the war broke out, the *Lancet* ran yet another

exposition of these theorists over three issues (Ormerod, 1914). As will be seen presently, these discussions are essential to understanding the stance of British medical opinion towards psychological theories, given the frequent assumption of widespread hostility before the war forced a reconsideration of Freud.

Certain crucial aspects are, with regret, omitted in this paper: notably, class, gender, treatment methods, and the dynamic role of the patient in shaping diagnosis. (I have dealt with some of these aspects elsewhere: Loughran, 2006: 35–69 and 97–124.) As the aim here is to sketch out some broad areas of medical consensus on hysteria and neurasthenia, differences between various sections of the medical community have also largely been skated over. This is in many respects an old-fashioned top-down approach, and one which cannot hope to do justice to the full richness of pre-war British medical views of hysteria and neurasthenia. However, it may be justified with the view in mind of recreating, to some extent, the knowledge that the doctors who were to treat shell-shock from 1914 onwards brought to their clinical encounters. These doctors were also recruited from a remarkably wide cross-section of the medical community, many with no previous experience of treating nervous or psychological disorders (Loughran, 2006: 240–89). It is not unreasonable to assume that many of these doctors, grappling with such problems for the first time in their careers, were guided as much by general knowledge of similar disorders garnered from the pre-war medical press, or by wide and hastily-conducted research, as by the distinctive stance that neurology or psychiatry (for example) had taken towards these disorders.

There are three main parts to this paper. The first examines the status of hysteria and neurasthenia as functional disorders, arguing with reference to British expositions of Continental theories of hysteria that the shift from a predominantly somatic to a psychological paradigm was in evidence before World War I. The next section demonstrates that although an inherently ambiguous category, neurasthenia was conceived as in essence a condition of nervous exhaustion. This is in contrast to the portrayal of neurasthenia in most histories of shell-shock, which have conflated Pierre Janet's psychasthenia and a concept of anxiety neurosis derived from the later work of Freud and W. H. R. Rivers with the symptomatic content of neurasthenia. Finally, it is argued that hysteria and neurasthenia were conceptually linked at the aetiological level through the perceived importance of heredity. Through the notion of the 'neurotic temperament' the pathologies of individual and environment were linked to discourses of nation and race. Hysteria and neurasthenia were therefore highly charged, politicized categories on the eve of the war. These arguments suggest that the relationship between hysteria and neurasthenia, portrayed as opposed categories in most histories of shell-shock, must be rethought. Moreover, as both disorders were in a state of flux in the immediately pre-war years, with psychological and somatic elements of the diagnoses in continual interplay, extension and retreat, the extent to which the experience of shell-shock acted as a catalyst to modern modes of psychological understanding

must be measured with a renewed awareness that British psychological medicine was not statically and uncompromisingly organicist before 1914, but open (in often contradictory and always complex ways) to many different theories, ideas and influences.

Functional disease

In pre-war British psychological medicine, hysteria and neurasthenia shared one basic feature: both were classified as functional diseases. Functional disorder was, according to one definition, comprised of phenomena ‘which result from some disturbance or change in the functions of an organ without presenting any definite organic lesion by which the disease may be distinguished’ (Hack Tuke, 1892: 518). This classification provides the key to understanding the shifting relations of psyche and soma in conceptions of hysteria and neurasthenia before the war. The transposition of the concept of trauma from the physical to the psychological sphere during the late nineteenth century is now well established (Micale and Lerner, 2001). The same process, a related event, occurred to the concepts of hysteria and neurasthenia (Neve, 2001: 141). The category of functional disease facilitated this development. The concept originated as a convenient designation for disorders for which no organic cause could be found, and thus described effects without ascribing first causes. It was therefore a fundamentally ambiguous category (Bastian, 1893: 2). Although the dominant somatic paradigm of British psychiatry meant that initially the first point of reference within the concept of functional disease was the body, this ambiguity also provided a space within which psychological theories could develop (or be transplanted into) when the right set of historical conditions arose. It is therefore the necessary background against which the shifting roles attributed to psyche and soma in hysteria and neurasthenia should be discussed.

Today, the meaning of ‘functional’ is often loosely interpreted as equivalent to describing a disorder as ‘psychologically based’. But in the late nineteenth and early twentieth centuries, British psychiatry lacked a purely psychological paradigm, and so what remained when organic change had been excluded was not automatically referred to the mind. The concept of functional disease was predicated on the notion of an organic non-event. However, this non-event was also positive: functional disease was defined as such by the *presence* of an organic absence. The body was not merely the first, but the only point of reference within the definition of functional disease. One way this is shown is in the stated allegiance of British commentators to an as-yet undiscovered organic basis for hysteria, the archetypal functional disease. In the 1890s, it was still possible to suppose that when ‘examined by the light of improved knowledge and experience’, many of the symptoms of hysteria would be revealed as of organic origin (Buzzard, 1892: 1163). The optimism faded slightly in subsequent years, but it was still insisted that hysteria was ‘as real as smallpox or cancer, and that it has a physical basis’, and that psychological theories were only

a useful stop-gap measure for treating the disorder until its organic foundation could be discovered (Ormerod, 1914: 1169; Stewart, 1906: 307; Wilson, 1911: 336–7). In the event, when improved diagnostic techniques revealed that some of the symptoms traditionally associated with hysteria did have an organic basis, the result was the contraction of the disorder rather than the provision of a physical explanation for it (Micale, 1993: 504–10).

The list of disorders under the heading of functional disease in textbooks of nervous and mental diseases also demonstrates that this category was understood by reference to bodily rather than psychical processes. In one example, we find epilepsy, chorea, tetanus, aphasia, muscular spasm, writers' cramp, facial hemiatrophy, exophthalmic goitre and various kinds of paralysis (Nagel, 1905: 138–90; see also Potts, 1908: 385–437). Most of this list is utterly at odds with modern notions of functional disorder, but makes sense when placed against the background of the predominantly somatic paradigm of pre-war psychiatry. Functional disorder was a crucial way in which diseases that did not fit the somatic paradigm could be understood through reference to it. This is demonstrated in the work of Joseph Ormerod (1848–1925), a specialist in nervous disorders with a particular interest in hysteria. Ormerod frequently took pains to reiterate the physiological meaning of function in order to introduce and make plausible the notion of disruption of psychological function (Ormerod, 1911: 275; 1914: 1238–9). Psychological concepts became comprehensible only when filtered through the lens of physiological (and thus concrete, knowable and scientifically palatable) processes.

So far, this would seem to suggest more strongly than ever that British psychological medicine remained stubbornly, even dogmatically, wedded to somatic explanations. Yet the example of Ormerod's rhetorical strategy hints at an unexpected development: perversely, the very strength of the somatic paradigm enabled the infiltration of psychological ideas into mainstream British medical discourse. During this period, hysteria was mainly discussed in the British medical press in relation to the theories of Babinski, Janet and Freud. These theorists had 'to a great extent superseded the doctrines of Charcot, though [...] none of them has passed into the region of accepted fact' (Anon., 1910*a*). British commentators overwhelmingly (re)presented these theories via reference to the somatic paradigm, in the process normalizing them. This approach undoubtedly proceeded in part from an inability to comprehend psychological theorization. The nameless doctor who alluded to Babinski in the course of a discussion at the Liverpool Medical Institution but confessed himself unable to 'fully follow this distinguished French physician' probably articulated the secret sentiments of many (Anon., 1910*b*). However, precisely because they were unable to think far outside the somatic paradigm, for the most part the doctors discussed here greeted these theories with a surprising degree of openness.

Discussions of Freud demonstrate this trend. Older (but still frequently-cited) histories of shell-shock often argue that the British medical establishment

was almost uniformly hostile to Freud before World War I (Showalter, 1987: 189; Stone, 1985: 243). Yet when his theories were not presented in an evangelical fashion, many members of the medical community cocked an interested ear. In the pre-war medical press, Freud was most often viewed as just one of many thinkers who had contributed to the study of hysteria, and like these others, his theories did not have to be swallowed whole. For example, Ormerod thought the idea that the expression of repressed emotion could help to relieve symptoms was extremely useful, if somewhat overrated by Breuer and Freud. Although he could not stomach the inductive basis of Freud's theories – described as 'very unsubstantial, and literally such stuff as dreams are made of' – he was still able to appreciate some of the general insights it offered (Ormerod, 1911: 285–7).

This magpie approach was typical of the British commentators. They not only picked and chose those theoretical aspects which they perceived as useful, but re-inflected and tamed the whole as well. Paradoxically, this openness to new ideas was only possible because of their allegiance to the somatic paradigm. As long as it was accepted that hysteria had an organic basis which had not yet been discovered, psychological theories could be viewed simply as useful adjuncts to this supposed foundation. The outcomes of this process – perhaps described more accurately as welding than assimilation – can appear incongruous to the modern reader. Robert Cole (1866–1926), a specialist in mental diseases, incorporated new psychological theories into the account of hysteria in his well-received 1913 textbook of nervous and mental diseases. This referenced Babinski, Janet and Freud, and initially defined hysteria as 'a disorder of the subconscious mind; it is a peculiar mental state in which the psychological and physical symptoms are largely due to auto-suggestion'. Only a few pages later, however, he proposed some possible physiological explanations: perhaps hysteria was caused by an alteration in the state of nutrition of the cortex, or a secondary derangement of the lower nerve centres (Cole, 1913: 216–19).

This was not how Babinski, Janet or Freud intended their theories to be read. There is clear evidence of misunderstanding, such as when Cole referred to Janet's theory of 'neuronic dissociation' or attributed to Freud the view that the 'generative organs' always had 'direct aetiological influence' in hysteria (Cole, 1913: 217, 219). But it would be a mistake to view either these misapprehensions, or the plucking of certain features of Continental theories from their context, simply as misappropriations which distort their 'true' nature. They are evidence of a now-alien interpretative strategy available to contemporaries: not only because they did not perceive psychological and physiological categories of explanation as irreconcilable (and this is one of the respects in which they had an open-minded approach to the former, even if it was limited by final adherence to the latter), but because they sought in these theories practical solutions to the problems of diagnosis and treatment rather than intellectual satisfaction. Therefore it is possible that the frequent substitution of 'subconscious' for 'unconscious' in discussions of Freud (Anon., 1911*a*; Thomson, 1911: 77–9)

was not made only because the former concept was comprehended and the latter was not, but because these commentators afforded the difference little weight in comparison with those aspects of the theory they felt could be used. The consequence of such re-castings was the piecemeal incursion of psychological theories into the somatic framework of understanding. The groundwork had been laid for the acceptance of psychological paradigms before shell-shock burst onto the psychiatric scene.

Neurasthenia, nervous exhaustion, psychasthenia and anxiety neurosis

The description of a disorder typified by an underlying, if undiscovered, organic basis and accompanied by psychological elements fits neurasthenia as well as hysteria. Here the argument becomes slightly more complicated, however, both because of the fluctuating status of the disorder itself in the years before the war, and the way it has been described by historians of shell-shock. A wide-ranging and shifting set of symptoms were attached to the diagnosis of neurasthenia at different points and by different commentators. It is therefore impossible to pin down any one accepted definition of the disorder, but it is argued here that the dominant view among British commentators in this period was of a somatic condition of nervous exhaustion which constituted 'true' neurasthenia (Clarke, 1905: 191). Psychic elements could exist alongside this nervous weakness, but only as adjuncts to this somatic 'essence' of neurasthenia. In the years before the war the category was undergoing fundamental changes, as theorists including Janet and Freud sought to make it more manageable by redistributing some of its features among new diagnoses such as psychasthenia and anxiety neurosis (Wessely, 1990: 47). Historians of shell-shock have conflated the contents of these diagnoses with the older native conception of neurasthenia as nervous exhaustion, and this has contributed to the misleading representation of hysteria and neurasthenia as absolutely opposed categories. It appears instead that within British medical discourse, neurasthenia was seen as the nervous weakness which remained when psychic symptoms were parcelled out among other diagnoses, rather than these new diagnoses impacting on this core definition. Neurasthenia was still conceptualized primarily as a somatic entity.

This conception of neurasthenia is apparent in textbooks of nervous and mental diseases, which gave popular synonyms as 'nervous prostration', 'nervous debility' and 'nervous exhaustion'. The most prominent somatic symptoms were listed as nervous exhaustion and fatigue, particularly constant tiredness and general aches and pains which might affect any or several bodily functions (circulation, digestion, sexual activity). Attached to these were a set of 'psychic' symptoms which were perceived as further manifestations of this nervous weakness: inability to concentrate, particularly on mental labour, headache, insomnia, depression, excitability, irritability, introspection and excessive emotion (Nagel, 1905: 171–2; Potts, 1908: 405–7). This mixture of somatic

and mental manifestations contributed to ambiguity in views of neurasthenia. Some doctors stressed that neurasthenia shared similarities with certain stages of recognized and undisputed organic disorders, and warned other practitioners to be alert to the possibility of 'grave organic affection' lurking behind the nebulous set of neurasthenic symptoms (Mott, 1911; Russell, 1913: 1453). Few accounts of neurasthenia insisted on a solely somatic aetiology (Anon., 1911*c*), but even rarer were descriptions which retained the label while insisting that the 'malady is essentially mental; it is a psycho-neurosis' (Ferrier, 1911: 11). Most common was a compromise position, such as the view that there was an undetected organic lesion in some, but not all, cases of neurasthenia (Oldfield, 1913: 335), or that body and mind 'may alike be implicated and demand the same attention' (Anon., 1912). Philosophical pragmatism was therefore one way of negotiating the ambiguities posed by a concept as elastic as neurasthenia. Another was the attempt to delineate different types of neurasthenia according to whether symptoms were physical, psychical or a mixture of both (Russell, 1913: 1453).

The approach which eventually gained greatest currency was the removal of psychological symptoms from neurasthenia in order to create new diagnoses and to strip the old one down to its bare essentials. This process was underway some years before the war. In 1911 William Aldren Turner (1864–1945), a neurologist who was later to publish on shell-shock, stated that 'several pseudo-neurasthenic states', including manic-depressive psychosis, dementia praecox, psychasthenia and Freud's 'anxiety neurosis' had been eliminated from the diagnosis. This had left a pure core of nervous exhaustion or 'true neurasthenia', a primarily somatic category which incorporated a psychic dimension (Anon., 1911*b*). Although Aldren Turner spoke of 'the partial passing of neurasthenia' as established fact, other commentators were less confident that these redistributions had succeeded in making neurasthenia more comprehensible. H. Macnaughton-Jones, a distinguished obstetrician, argued that it was impossible to draw hard-and-fast lines between the modish categories of psychasthenia, phrenasthenia and neurasthenia. He suggested that because these clinical states 'all at times merge into another', it might be best for practical purposes 'to regard them as constituting a clinical group in which but shadowy borderlands exist between one member of it and another, and in which it is occasionally, indeed frequently, impossible for us to delimit by any boundary line the features peculiar to one or all of them' (Macnaughton-Jones, 1913).

In 1914 neurasthenia was therefore a confused and confusing diagnostic category. The little coherence it ever had as a clinical entity was being gradually undermined by the redistribution of its symptoms. Those who used the term could be fairly certain that it signified to their audience at the very least a condition of nervous weakness, but only context could determine which of the other manifold possible meanings an individual might also intend to convey. This ambiguity is rarely conveyed in historical accounts of neurasthenia as

a component of the shell-shock diagnosis. Historians of shell-shock almost invariably select anxiety as the dominant symptom of neurasthenia, and sometimes even use neurasthenia as a synonym of 'anxiety neurosis' (Barham, 2004: 76; Binnevald, 1997: 94; Bourke, 1996: 112; Leed, 1979: 163; Shephard, 1996: 435). The historical literature on shell-shock also frequently attributes to wartime doctors the view of hysteria as a primitive defence mechanism and neurasthenia/anxiety neurosis as a more sophisticated response to psychological trauma (Leese, 2002: 80, 95; Shephard, 1999: 36). The unintentional effect is to distort the concept of neurasthenia as it was employed in pre-war British medical discourse. The implication is that throughout the war, and before, neurasthenia both manifested and was understood primarily as a psychological disorder. The somatic aspect of the disorder which was dominant if not exclusively emphasized in most pre-war constructions is ignored.

This confusion stems from the conflation of three categories which were characterized as overlapping yet distinct before the war: nervous exhaustion, psychasthenia and anxiety neurosis. The conflation is understandable given the ambiguity of neurasthenia, but the historiography as a whole has tended to emphasize the attributes of psychasthenia and anxiety neurosis at the expense of nervous exhaustion. This has resulted in the misleading presentation of neurasthenia as a psychological construct within pre-war medical discourse. The discussion here suggests instead that the essence of neurasthenia was understood as somatic, and that this conception had gained further ground as a result of the removal of psychological symptoms to form separate diagnostic entities. In Britain, neurasthenia was not being redefined as a psychological disorder: rather, a process was occurring in which somatic elements were increasingly becoming the only essentials of its definition.

The term psychasthenia, formulated by Janet as a psychological disorder in which depression, phobias and obsessions existed with certain somatic symptoms (Janet, 1901: 519–21; see Shamdasani, 2001) was increasingly listed alongside hysteria and neurasthenia in pre-war discussions of functional disease. It was even occasionally presented as a synonym of neurasthenia (Ash, 1913: 123; Ormerod, 1911: 279). This does not mean, however, that British uses of the term signified acceptance of Janet's model of psychological functioning. As in British reformulations of European hysteria theories, psychasthenia was often reconfigured to accommodate a physical basis. In one account, psychasthenia was attributed to 'some physiological error in the mechanism controlling the emotions' (Thursfield, 1911: 118–19). Cole conceived of psychasthenia and neurasthenia as separate disorders which often co-existed in the same case, and awarded psychasthenia a physical aetiology, positing 'a weakened state of health in a predisposed individual' which had disturbed the action of the higher cortical neurons as the main cause (Cole, 1913: 225). Therefore although Janet's original concept of psychasthenia was a psychological disorder, uses of this term in pre-war British medical discourse cannot be automatically read as conveying an understanding of this disorder in the terms formulated by Janet.

Untangling how neurasthenia has come to be seen as virtually synonymous with anxiety neurosis is a more complicated matter. The idea of anxiety neurosis was first formulated by Freud in his 1895 paper, 'On the grounds for detaching a particular syndrome from neurasthenia under the description "anxiety neurosis"' (Freud, 1979*a*). Freud separated a cluster of symptoms described as 'neurotic disturbances' from the neurasthenia diagnosis, arguing that these differed in their 'aetiology and mechanism' (p. 35). These neurotic disturbances (including general irritability, anxiety attacks, night terrors, vertigo, agoraphobia and phobias relating to general physiological dangers, digestive disturbances and paraesthesias) were grouped around the chief symptom of anxiety (pp. 37–45). The symptoms left over, which comprised 'neurasthenia proper', were 'intracranial pressure, spinal irritation, and dyspepsia with flatulence and constipation' (p. 35). The aetiology of both 'genuine neurasthenia' and anxiety neurosis was sexual, but the first resulted from an inadequate release of sexual tension, such as masturbation or spontaneous emission, while the second was 'the product of all those factors which prevent the somatic sexual excitation from being worked over psychically' (p. 56). In his concluding comments, Freud also considered the relation of anxiety neurosis to hysteria. He stated that the two were extremely similar in terms of both symptomatology and aetiological mechanism, but that anxiety neurosis was 'the somatic counterpart to hysteria'. The displaced tension expressed in anxiety neurosis was 'somatic sexual excitation' and 'purely somatic', whereas that expressed in hysteria was 'psychical', 'provoked by conflict' (p. 63). In his paper, anxiety neurosis was conceived as a purely somatic category which was similar to the psychological category of hysteria in terms of symptomatic content and mode of operation of aetiological mechanism. This anxiety neurosis does not correspond to that invoked by historians of shell-shock, either of itself or in its relation to hysteria.

The term 'anxiety neurosis' was rarely used in the pre-1914 British medical literature on neurasthenia, either as a synonym for or as a component of the general diagnosis. Macnaughton-Jones' (1913) discussion of the redistribution of the symptoms of neurasthenia made no reference to anxiety neurosis. The term is not even found in the places where it might appear most likely to be used, such as an article by the neurologist Gordon Holmes (1876–1965) on sexual neurasthenia in men. Holmes referred briefly and disparagingly to Freud's work on hysteria, but showed no awareness of the concept of anxiety neurosis (Holmes, 1911: 50). A thorough search of the pre-war literature on which the present paper is based yields only four uses of the term (Anon., 1910*a*; Anon., 1911*b*; Anon., 1913*a*: 1470; Mott, 1914: 71). Perhaps most tellingly, it does not appear in the 1913 edition of Cole's textbook of mental diseases, although it is given as an alternative term for neurasthenia in the second edition of 1919, suggesting that this usage was a product of the war (Cole, 1919: 224). All evidence suggests that the term was not common in pre-war British medical discourse.

In fact, the three-pronged sociocultural argument regarding shell-shock outlined at the outset of this article has been influenced by a very particular concept of anxiety neurosis, which does not derive from Freud's 1895 paper. There are two related explanations for this historiographical confusion. The first is that in 1925 Freud fundamentally revised his concept of the anxiety neuroses, retaining the term and symptomatology but positing a different set of causal ideas (including the view of obsessional neurosis as a sophisticated psychological process compared with 'true conversion hysteria') (Freud, 1979*b*: 265–73; Micale, 1993: 520–2). The second is that the most well known of the shell-shock doctors, W. H. R. Rivers, used a distinctive concept of anxiety neurosis as a synonym for neurasthenia and postulated the relationship between hysteria and anxiety neurosis which historians of shell-shock have retrospectively applied to pre-war notions of the disorder. Rivers was aware that his concept of anxiety neurosis did not correspond to the then-current Freudian version, and his use of the term in this context did not go entirely unquestioned (Rivers, 1917: 19, 20). Although one of the most important theorists of shell-shock from 1917 onwards, Rivers was not typical either in his definition of neurasthenia/anxiety neurosis, or his views of the causative mechanisms of this disorder and hysteria.

The term anxiety neurosis was in fact infrequently used throughout the war, and when employed usually implied nothing more than a condition in which anxiety was prominent as cause or symptom, without the specific mechanisms invoked by Rivers or Freud. From a comprehensive analysis of writings on mental and nervous disorders of war from 1914 onwards, only three authors using the term (excluding Rivers) can be found before 1918 (Abrahams, 1915; Ballard, 1917*a*; Ballard, 1917*b*: 128; Mott, 1916: vi, xx). On the other hand, the use of neurasthenia to connote primarily nervous exhaustion, perhaps attended by a selection of 'psychic' symptoms, continued in a range of medical discussions on shell-shock during and after the war (Collie, 1916: 532; Craig, 1917: 254; Forster, 1918: 85; Hurst, 1944: 136–8; Marr, 1919: 46). Authors who defined neurasthenia in this way usually preferred to designate hysteria and psychasthenia as separate 'mental' conditions (Ballard, 1917*b*: 124; Hurst, 1917: 409–10; Marr, 1919: 125). As in pre-war British medical discourse, however, the capaciousness of the neurasthenia concept meant that its psychological aspects could be emphasized without occasioning a major re-definition or writing nervous exhaustion out of the picture (Burton-Fanning, 1917: 908; Fearnside, 1918: 45). The complex relations of hysteria and neurasthenia, their meanings in pre-1914 British medical discourse, and therefore the degree of change or continuity which their deployment in relation to shell-shock entailed, can only be understood through a precise and nuanced approach to the language of diagnosis. The reading employed here suggests that the tripartite social-cultural analysis of shell-shock has little relation to how hysteria and neurasthenia were conceived in pre-war British medical thought.

The neurotic temperament

An examination of aetiological theories of hysteria and neurasthenia further demonstrates that these disorders were not constructed as opposed or even entirely distinct categories within pre-war British medical discourse. They were connected by the crucial aetiological role attributed to heredity or inheritance. It was through this aspect, which emphasized a dialogue between the individual body and the environment conceived in various ways (the environment of the individual body, of the family and of the nation) that hysteria and neurasthenia took on a social and political dimension. In textbooks, the aetiological factors of these disorders were usually divided into a wide range of predisposing and exciting causes, with varying degrees of consensus on the specific causes. Virtually all, however, agreed on one general predisposing cause: a 'neuropathic tendency', 'inheritance' or 'taint'. This was usually defined as the existence of some neurosis or neurotic disease in the family (Clarke, 1905: 176; Nagel, 1905: 171; Potts, 1908: 414–15).

Hysteria and neurasthenia were therefore conceptually linked through the notion of faulty inheritance. The predisposing and exciting causes listed for both also had another common denominator: the concept of a weakened nervous system. This was either inborn (the result of heredity) or acquired (the result of an element in the environment, be it an undesirable mode of life or an accident such as shock or illness).

Nervous weakness was not only fundamental to the definition of neurasthenia, but was also perceived as a precondition for the development of hysteria and mental disorders such as hypochondria and melancholia (Potts, 1908: 411–12). This perception helps to explain neurasthenia's ambiguous status as a 'borderland' diagnosis. Because nervous weakness was seen as a stepping stone to disorders with a more pronounced 'psychic' element, it was impossible to demarcate where this element began and ended in neurasthenia. Although understood as primarily a somatic disorder, neurasthenia therefore always potentially contained this psychic element. The role of nervous weakness as the defining factor of neurasthenia and as an aetiological factor in hysteria also underlines that these were linked rather than opposed categories. This explains not only the occasional conflation of hysteria with neurasthenia despite the efforts of most authorities to keep them separate, but also the existence of otherwise confusing designations such as 'hystero-neurasthenia' (Anon., 1910*b*; Cole, 1913: 94).

The fact that heredity was conceived as the most important factor in the aetiologies of both diagnoses also acted to neutralize the perceived importance of exciting causes, and thereby to locate the cause of the disorder in the individual rather than the social environment. Although it was stated that a specific, external stimulus was always necessary for the *actual* development of hysteria or neurasthenia, the emphasis on heredity as a predisposing cause meant that once this development had occurred, the disorder was usually

seen as a pre-existing potential of the individual which had been latent until the right circumstances for its expression arose. The apparent and immediate cause was always at most only 'a coefficient, and often merely serves as the spark which falls into the explosive matter' (Mott, 1907). In practice, once the disorder had been diagnosed the specific stimulus was constructed as only of secondary importance. This did not mean that the social environment was insignificant, but that its importance was conceived mainly in terms of its possible modification to prevent the appearance of outward manifestations of nervous disorder, rather than in terms of its ability to effect a permanent change in the nervous individual (see for example Riviere, 1911).

Biological determinism became more entrenched in the years immediately before the war, as can be seen in changing uses of a recurrent motif in discussions of nervous disorders: analogies to plant life. In 1892 one contributor to Hack Tuke's *Dictionary* described neurasthenia as 'to a certain degree the starting-point of all the more severe nervous disorders, and the soil from which they grow' (Arndt, 1892: 840, 842); another, the obstetrician and gynaecologist William Playfair (1896–1903) argued that the 'rank weeds of neurotic disease will only grow and flourish in suitable soil – that is, in a state of depressed vitality; improve the soil, and the unhealthy growth will disappear' (Playfair, 1892: 853). The outlook here was essentially positive: although nervous exhaustion was the 'bad soil' which fostered the growth of neurotic disorders, more serious disorders could be prevented if the right measures were taken. Nervous exhaustion was portrayed simply as an illness which affected the individual, not a pathology which defined her. Only a few years later the metaphor was being used quite differently: to describe how 'the seeds' of neuroses were 'sown by stupid or ignorant parents or nurses through want of recognition of the signs of the nervous predisposition and temperament of the child' (Clarke, 1905: 7; Macnaughton-Jones, 1911: 69). The ultimate cause of the neurosis was the child's 'nervous predisposition and temperament'; the social environment was implicated only as a factor which allowed and encouraged the disorder to develop. This was an illness which, like original sin, was embodied rather than contracted, and the aim was not to cure but to prevent its worst potentialities from manifesting.

The key term here is 'temperament', in pre-war British medical discourse often conceived as a biological destiny rather than a mere personality trait. Robert Jones (1857–1943), superintendent of Claybury Asylum, stated that in the individual temperament was a tendency determined by nation and race, and which therefore differed according to evolutionary development (Jones, 1911: 1–2). His colleague, the neuropathologist Frederick Mott (1853–1926), put forward a similar definition of the 'neuropathic temperament' as an inborn tendency determined by biological inheritance (Mott, 1914: 68–71). This concept of the neurotic temperament was fundamental to medical accounts of hysteria and neurasthenia. In discussions of neurasthenia, the notion of

‘hereditary neuropathic taint’ in conjunction with ‘nationality and temperament’ was presented as crucial to understanding and treating the disorder (Russell, 1913). In one account, it was even suggested that doctors ‘had frequently to deal with a neurasthenic temperament – not really a disease’ (Anon., 1913*a*: 1469). Hysteria and neurasthenia were such large and ill-defined categories that the concept of a neurotic temperament was the glue which held each together as a discrete clinical entity in the absence of an identifiable pathology. The conceptualization of the neurotic temperament as a biologically determined quality also meant that the actual appearance of hysteria or neurasthenia was merely the final stage of a preordained process, the disease itself simply confirmation of a pathological identity. The neurasthenic or hysteric was not only pathological, but her whole being provided the pathology, literally embodied it at a level beyond the body, so deep that no autopsy or microscope would ever uncover it. At the core of these amorphous clinical entities, what was left when all the extraneous symptoms and abstruse jargon were removed, was the neurotic temperament.

Hysteria and neurasthenia were both viewed as evidence of the biologically determined neurotic or neuropathic temperament. The significance of this perception in the present context is two-fold. First of all, it further highlights the close conceptual relationship between hysteria and neurasthenia, and particularly an aspect which is often glossed by historians of shell-shock who wish to emphasize the construction of these disorders as opposed categories. In these histories, neurasthenia is frequently presented as a fashionable ‘disease of civilisation’, a focus which has heightened the contrast with the ancient disease of hysteria (Barham, 2004: 76–8; Leed, 1979: 63–4; Showalter, 1987: 174–6). The construction of neurasthenia as a malady fostered by the conditions of modern life was undoubtedly present in the pre-war literature (Clarke, 1911; Cobb, 1913: 745), but commentators were equally likely to refer more generally to the increase of all nervous disorders as a concomitant of the ‘rise in the general level of culture and civilisation in a race’ (Anon., 1911*d*). In the immediately pre-war years the view that nervous disorders were more prominent in civilized societies increasingly dovetailed with theories of degeneration (Fleming, 1911: 32–3), a development which appears to have been common in Britain and Europe, but not in the North American context (Drinka, 1984: 213–14; Micale, 1995: 205–20). The rise of eugenics, particularly from the turn of century, meant that any putative claim neurasthenia might have had as a symbol of status was outweighed by fears that it signalled the beginning of biological and therefore social, political and imperial decline.

This leads onto the second reason why it is important that hysteria and neurasthenia were seen as biologically determined: both disorders were increasingly conceptualized as social dangers. Committed eugenicists argued that nervous and mental disorders were ‘certainly on the increase’ and that ‘incipient disease of mind’ would ‘lead to even more disastrous results

than [...] disease of body' (Tredgold, 1911: 95). Mott framed these fears of national degeneration explicitly in relation to neurasthenia. He reasoned that if neurasthenia was both 'a special outcome of modern civilization' and 'the starting-point of an unstable nervous condition in a stock' which would intensify under the continued influence of an unfavourable environment, then modern Britain was in trouble (Mott, 1913: 26–8). The fear of latent nervous and mental instability was apparent even in accounts which attempted to strike a more optimistic note. Sir George Savage (1841–1921), a lion of the pre-war psychiatric establishment, warned against believing too much in 'the tyranny of the organism', arguing that the right conditions were necessary for the development of insanity. In order to make this point he compared heredity to 'the mycelium of the mushroom', which 'spreads far and wide and is not recognised till suitable conditions lead to what we call the mushroom which comes to the surface'. His audience probably took little comfort from his conclusion that, similarly, 'the neurotic inheritance spreads far and wide and is deeply seated, but the occasion for its development may be wanting' – after all, if this were the case, what would happen in a national crisis? (Savage, 1912: 1136).

Hysteria and neurasthenia were therefore framed as indicators of national and political health. An anonymous 1910 comment piece in the *Lancet* took issue with the French neurologist Jules Déjerine's contention that emotional shock was the main aetiological factor in the development of hysteria. The author argued that, as individuals and in the aggregate, the Latin races were less emotionally stable than the Teutonic, linking the prevalence of both hysteria and social upheavals in France to this fact. It was well known that the Parisian mob became 'inflamed by any passing wind of emotion', while such events were uncommon in England. These differences could only be explained as the result of 'national and racial differences'. As a nation, the English were 'less emotional, less exuberant, less gesticulative' – in short, less hysterical (Anon., 1910c). The physician and neurologist Samuel Wilson (1874–1937) put forward a similar argument, pointing to the moment in the 1880s when 'the telegraphic announcement of an insignificant reverse at Langson provoked a fury in Paris and France, and brought about the instantaneous overthrow of the Government' when 'a much more serious reverse undergone by our English expedition to Khartoum produced only a slight emotion, and no ministry was overturned' (Wilson, 1911: 322). Here, hysteria moved from individual to social and political pathology, and was constructed as a fundamentally un-English disorder. It is not surprising that hysteria was deemed to be more prevalent among Jews as well as the Latin races; the former were also seen as more liable to neurasthenia (Clarke, 1905: 4–5, 175; Oldfield, 1913: 335; Stewart, 1906: 308). By association, English neurotics were not part of the nation, but aligned with the threatening forces clustered on its borders, awaiting their chance to attack or, worse, silently infiltrate the body politic.

It is therefore no coincidence that the dialogue between medicine and politics on the eve of the war featured hysteria and neurasthenia, both as actual diagnosis

and as linguistic trope. Historians usually locate three main sources of disruption to British political life in 1914: the threat posed to industrial productivity by trade union activity, the militant suffrage campaign, and the crisis around Home Rule for Ireland (Hynes, 1991: 6–7; Read, 1994: 483–97). As regards the first of these, the relationship between medicine, the state and the labour force was still being worked out in the wake of the Workmen's Compensation Acts of 1897, 1900 and 1906. One of the most vexed aspects of these debates was the issue of compensation for traumatic neurosis, in which hysteria and neurasthenia were clearly implicated (Grant, 1914; Palmer, 1911; Thorburn, 1913). The militant suffragettes, meanwhile, were stigmatized as hysterical for their 'unwomanly' violence to private property, and by extension the state (Wright, 1913: 166–88). Although the Celtic races were seen as more liable to hysteria and neurasthenia (Clarke, 1905: 4–5, 175), such labels were not applied to figures in the debates on the Irish Question. However, when seeking to explain the mechanism of hysterical dissociation in early 1914, Ormerod plucked a prescient metaphor from political life: in the hysterical mind, he wrote, the 'central government is weak, and there results a turbulent home rule all round' (Ormerod, 1914: 1236).

Conclusion

It has been argued here that hysteria and neurasthenia were not fundamentally opposed categories in pre-war British medical discourse but, rather, linked through their definition as functional diseases and the crucial role attributed to hereditary predisposition in the aetiologies of both. The conceptual closeness of hysteria and neurasthenia undermines the three-pronged sociocultural interpretation of shell-shock outlined earlier. To a certain extent, the demolition of arguments based on the hysteria/neurasthenia divide is little more than the completion of a clean-up operation begun by previous historians of shell-shock, attacking the problem from a different angle. Powerful criticisms of arguments regarding gendered perceptions of shell-shock and differential treatment according to class have already been made by Laurinda Stryker (2003) and Peter Leese (2002: 110–16). The main difference is that here the critique has been based on an analysis of diagnostic categories, and therefore strikes at all three arguments simultaneously.

Demolition, however, is secondary to the main purpose of this paper. In focusing on the clinical categories of hysteria and neurasthenia in the 'forgotten years' of 1900–14, my aim has been to question certain aspects of the conventional historiographical argument that shell-shock forced a transition from physical to psychological understanding. That there was some shift in this direction seems unmistakable: in the post-war years hundreds of doctors returned to their day jobs with vastly increased experience of dealing with psychological disorders, thousands of shell-shocked veterans sought psychiatric

treatment and pensions throughout the 1920s, and in 1930 the Mental Health Act partially dismantled the asylum system and created out-patient clinics. Yet the other side of the chasm which is 1914–18 demands equal attention if we are to judge to what extent and in what ways the war itself was a force for change. There was not one giant leap from Victoria to Freud via World War I. British psychological medicine did not stand still between 1901 and 1914.

This paper has pinpointed some of the areas in which small steps were being taken before that cataclysm. Through the category of functional disorders, psychological concepts were infiltrating the dominant somatic paradigm, a development which was paradoxically enabled by the very inflexibility of that world-view. British doctors were not uniformly deaf or hostile to the clamour of Continental voices entreating a psychological view of mind. Their eclectic interpretations of these theories suggests that sometimes they might have been served well by an ear-trumpet, if not a translator, but nevertheless the pidgin versions of Freud, Janet, Babinski and others which were disseminated in the medical press meant that no well-read doctor could claim complete ignorance of these theorists. The shift from a somatic to a psychological paradigm was in progress before the war, and it might be more fruitful to look for evidence of continuity and natural growth in this process over 1914–18 than to assume radical and abrupt change.

The gradual assimilation of psychological theories proceeded simultaneously, although not exactly hand-in-hand, with the increasing entrenchment of biological determinism, signalled perhaps above all by the popularity of moderate eugenic ideas. The biological dimension of hysteria and neurasthenia meant that both were linked to prevalent socio-political concerns and were thus highly charged categories on the eve of the war. Before 1914, medical discourse portrayed neurotic Britons as not just ill or bad, but unpatriotic. They were enemy aliens at the most basic biological level, latent lesions on the body of the nation which might erupt and threaten the health of the whole at the first serious crisis. There was an enormous difference between representations of the shrieking hysteric or lurking neurasthenic and the figure of the shattered soldier; but although shell-shock pushed mental health issues onto the mainstream medical agenda with unprecedented force, the signs are that this was a move which some prominent medical spokesmen had been enjoining before the war, albeit for different reasons. In a ground-breaking, and still indispensable, essay written more than twenty years ago, Martin Stone argued that shell-shock redefined 'the boundary of the pathological [...] at all its constitutive levels' (Stone, 1985: 266). This conclusion has rarely been disputed, but it may be premature: as yet, we do not know nearly enough about how this boundary was delineated in the crucial years immediately before 1914 to judge. This paper suggests that a detailed mapping of the pathological in the opening decades of the twentieth century may yet surprise us by revealing continuities which survived the several ruptures of the war.

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