

Cadaver Brains and Excesses in Baccho and Venere: Dementia Paralytica in Dutch Psychiatry (1870–1920)

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ABSTRACT: This article explores the approach of dementia paralytica by psychiatrists in the Netherlands between 1870 and 1920 against the background of international developments. The psychiatric interpretation of this mental and neurological disorder varied depending on the institutional and social context in which it was examined, treated, and discussed by physicians. Psychiatric diagnoses and understandings of this disease had in part a social–cultural basis and can be best explained against the backdrop of the establishment of psychiatry as a medical specialty and the specific efforts of Dutch psychiatrists to expand their professional domain. After addressing dementia paralytica as a disease and why it drew so much attention in the late nineteenth and early twentieth century, this essay discusses how psychiatrists understood dementia paralytica in asylum practice in terms of diagnosis, care, and treatment. Next we consider their pathological–anatomical study of the physical causes of the disease and the public debate on its prevalence and causes. **KEYWORDS:** psychiatry, neurology, professionalization, patient records, dementia paralytica, paralysis, syphilis, brain anatomy, moral purity, The Netherlands.

THE clinical presentations associated with insanity in Dutch asylums of the late nineteenth and early twentieth century differed substantially from those of patients in today's psychiatric hospitals. Compared to our current understanding of psychiatric

JOURNAL OF THE HISTORY OF MEDICINE AND ALLIED SCIENCES, Volume 69, Number 3

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Advance Access publication on October 10, 2012

doi:10.1093/jhmas/jrs062

disease, the concept of insanity prevalent around 1900 covered a broader range of disorders. While today most patients suffer from psychotic and mood disorders, a century ago such patients did not exceed 60 percent of those admitted. The others suffered from feeble-mindedness (20 percent), senile dementia (10 percent), and neurological disorders, possibly in combination with mental disorders (more than 8 percent).¹ Nearly 40 percent of the insane were chronic sufferers and not amenable to treatment. Asylums largely served as nursing institutions; the share of patients annually dismissed as “recovered” or “improved” was no more than one-third of the number of insane annually admitted.² This article concentrates on one of these chronic disorders, dementia paralytica. Specifically, we consider how Dutch psychiatrists approached it in the years between 1870 and 1920 against the backdrop of the establishment of psychiatry as a medical specialty and their effort to widen their professional domain.

In the period under study, however, the emerging field of psychiatry was varied in shape and there were differences and even inconsistencies between the clinical practices, scientific aspirations, and social ambitions of psychiatrists. This becomes clear in particular in their involvement with dementia paralytica. Relying on patient records and medical publications as our main sources, our study reveals that the psychiatric interpretation of this disorder would vary depending on the institutional and social context in which physicians studied, treated, or discussed it. Although one should not downplay the significance of the physical and mental realities of dementia paralytica, it can be argued that the interpretations put forward by doctors in their diagnoses and explanations were framed in various institutional and social contexts and, in part, had a social-cultural basis.³ The first section of the article provides basic information about the development of psychiatry in the Netherlands in the second half of the nineteenth century

1. E. Borgesius and W. Brunenberg, *Behoeftte aan asiel? Woon- en zorgbehoeften van ‘achterblijvers’ in de psychiatrie* (Utrecht: Trimbos-instituut, 1999), 15–16; J. H. Schuurmans Stekhoven, *Ontwikkeling van het krankzinnigenwezen in Nederland 1813–1914* (The Hague: Algemeene Landsdrukkerij, 1922), Table VIII; H. Oosterhuis and M. Gijswijt-Hofstra, *Venueard van geest en ander ongerief: Psychiatrie en geestelijke gezondheidszorg in Nederland (1870–2005)*, 3 vols. (Houten: Nederlands Tijdschrift voor Geneeskunde, Bohn Stafleu Van Loghum, 2008), 113–15.

2. D. Schermers, “De toeneming van het aantal krankzinnigen in ons land,” *Nederlandsch Tijdschrift voor Geneeskunde*, 1913, 57, 589–601, 594.

3. Compare to Charles Rosenberg and Janet Golden, eds., *Framing Disease: Studies in Cultural History* (New Brunswick, N.J.: Rutgers University Press, 1992).

and about dementia paralytica, a rare disease today. Next the paper discusses how doctors understood this illness: (1) in asylum practice, as geared to diagnosis, care, and treatment; (2) in their laboratories as geared to pathological–anatomic research after the physical causes of this disease; and (3) in debates on its prevalence and social–cultural causes. The conclusion relates our findings about the Netherlands to the British and American historiography about dementia paralytica.

THE RISE OF PSYCHIATRY IN THE NETHERLANDS

Even though institutional care of the insane has been around for centuries, psychiatry as a medical field developed only in the nineteenth century. In the Netherlands, the founding in 1871 of the Dutch Psychiatric Association and the publication of the first psychiatric journal in 1876 by asylum doctors marked the beginning of psychiatry's formal development as medical specialty, which as of 1896 would be combined with neurology. The Association's leading members were positivist, liberal-minded doctors who considered medical science a crucial basis for social advancement. In their view, they were the ones most qualified to be in charge of the care of the insane and this care was supposed to have a medical basis.

Dutch asylum doctors, however, lagged behind their British, French, German, and American colleagues, who had established professional organizations and journals in the 1840s and 1850s and who had, at the same time, gained authority in the newly built asylums by applying a new treatment called moral therapy, which relied on kindness and a well-regulated pleasant environment to heal the damaged mind.⁴ As opposed to the surrounding countries, until the middle of the 1880s hardly any new asylums were built in the Netherlands. The trend-setting provincial asylum Meerenberg (1849) in the dunes near

4. Andrew Scull, "From Madness to Mental Illness: Medical Men as Moral Entrepreneurs," *Eur. J. Sociol.*, 1975, 16, 219–61; Andrew Scull, "Mad-Doctors and Magistrates: English Psychiatry's Struggle for Professional Autonomy in the Nineteenth Century," *Eur. J. Sociol.*, 1976, 17, 279–305; Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (London: St. Martin's Press, 1979), 183–85; J. M. W. Binneveld, *Filantropie, repressie en medische zorg. Geschiedenis van de inrichtingspsychiatrie* (Deventer: Van Loghum Slaterus, 1985), 32–34; Jan E. Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Cambridge: Cambridge University Press, 1987), 64–117; Eric J. Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca, London: Cornell University Press, 2003), 16–50; Gerald N. Grob, *The Mad among Us: A History of the Care of America's Mentally Ill* (Cambridge, MA, and London: Harvard University Press, 1994), 55–77.

Haarlem was the exception that proved the rule. Most of the others were older, renovated institutions in towns and until the 1870s physicians usually played a minor role in the running of these mental asylums. In their view, the patched up and overcrowded municipal asylums did not meet the requirements for applying moral therapy and neither did these institutions offer sufficient provisions for segregating different groups of patients and for agricultural work and gardening, which were considered curative for the insane. Municipal and religious authorities, non-medical administrators, and charity institutions disputed the authority and expertise of asylum doctors. The medical control over the admission of new patients was restricted by the first and second Dutch insanity law (1841 and 1884) which stipulated that hospitalization in a mental asylum should be certified by a court of law.⁵

In the 1880s and 1890s, however, psychiatrists succeeded in establishing more control over the operation of Dutch asylums. From the mid-1880s onwards, the central government and provincial and local authorities as well as voluntary and denominational organizations provided more money for the care of the insane. A substantial number of new asylums was built, all situated in the countryside and providing more room for medical provisions such as separated wards for different groups of patients, treatment facilities, and pathological–anatomical laboratories. By introducing a training program for psychiatric nurses, new treatments such as bed care, prolonged baths, and occupational therapy as well as restrictions on the use of mechanical restraints, asylum doctors came nearer to realizing what they considered as proper medical care of the insane. From around 1900, they also cleared the way for admitting patients to asylums and psychiatric clinics without legal certification.⁶

In the first half of the nineteenth century, reform-minded physicians, philanthropists, and some civil servants were influenced by French and British reforms in the care of the insane.⁷ From the

5. Binneveld, *Filantropie*; Oosterhuis and Gijswijt-Hofstra, *Venward van geest*, 43–55; H. Oosterhuis and J. Slijkhuis, *Verziekte zenuwen en zeden: De opkomst van de psychiatrie in Nederland (1870–1920)* (Rotterdam: Erasmus Publishing), 37–56.

6. M. F. Gijswijt-Hofstra, 'Within and Outside the Walls of the Asylum: Caring for the Dutch Mentally Ill, 1884–2000,' in M. Gijswijt-Hofstra, H. Oosterhuis, J. Vijselaar, and H. Freeman, eds., *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century* (Amsterdam: Amsterdam University Press), 35–72; Oosterhuis and Gijswijt-Hofstra, *Venward van geest*, 70–185; Oosterhuis and Slijkhuis, *Verziekte zenuwen en zeden*, 83–112.

7. See Joost Vijselaar and Timo Bolt, *J. L.C. . Schroeder van der Kolk en het ontstaan van de psychiatrie in Nederland* (Amsterdam: Boom, 2012).

1860s onwards, however, German psychiatry, emphasizing a biomedical approach, set the tone among prominent Dutch psychiatrists, the more so in the 1890s when the first chairs and clinics for psychiatry and neurology were set up at Dutch universities and psychiatric education and scientific research were institutionalized at medical faculties. They believed that psychiatry had to associate itself with modern medicine, neurology in particular, and that research in laboratories would result in natural scientific explanations of insanity. Leading professors and asylum doctors dissected and prepared the brains of their deceased patients and gazed through their microscopes in search of the somatic causes of mental diseases. However, the results of anatomical brain research proved disappointing, and from the late 1890s on academically employed psychiatrists, while dissociating themselves from the neurological reductionism of the biomedical approach, began to explore other ways to establish their field as a clinical science. One of these ways was the adoption of the clinical methods and disease classification of the German psychiatrist Emil Kraepelin. He advocated systematic observation of large numbers of patients, meticulous recording of clinical pictures, statistical processing of mental symptoms, and experimental psychological research in support of diagnostics.⁸

Between 1870 and 1920, the number of Dutch physicians working in the field of psychiatry and neurology increased more than tenfold from around twenty to almost 220.⁹ Well into the twentieth century, the core activity of psychiatrists was to provide care to the mentally ill in psychiatric institutions, but already by the end of the nineteenth century they began to unfold professional activities outside asylums as well. Apart from universities, they also worked in sanatoria and clinics for nervous patients, in general hospitals, and in private practice. At the same time they sought to expand their professional domain by advocating a larger role of psychiatry in the legal system and by promoting hygienist measures in society aimed at preventing mental and nervous disorders. Just like psychiatrists in some other European countries, in particular in France and Germany, some of them

8. Oosterhuis and Gijswijt-Hofstra, *Verward van geest*, 186–207; Oosterhuis and Slijkhuis, *Verzichte zenuwen en zeden*, 131–57; see also H. de Waardt, *Mending Minds: A Cultural History of Dutch Academic Psychiatry* (Rotterdam: Erasmus Publishing, 2005).

9. Oosterhuis and Gijswijt-Hofstra, *Verward van geest*, 64–70; Oosterhuis and Slijkhuis, *Verzichte zenuwen en zeden*, 72–75.

presented themselves as experts in the field of mental hygiene in society at large and as guardians of social order or popular educators.¹⁰

DEMENTIA PARALYTICA: A DISTINCTIVE DISEASE OF THE
NINETEENTH CENTURY

Dementia paralytica expressed itself not only in physical symptoms, such as paralyzes, epileptic attacks, and motor, speech, and hearing impediments, but also in various mental and behavioral disorders: dementia, depression, mania, hallucinations, megalomania, and the loss of memory, self-control, and self-consciousness.¹¹ Since the early twentieth century, physicians have identified these symptoms as stemming from neurosyphilis, the infection of the brain by the syphilis spirochete. Dementia paralytica, first described as a disease by the French physician Antoine Laurent Bayle in 1822, was also called general and progressive paralysis (of the insane), paralysis cerebri and mentis, insania paralytica, paralytic dementia and paresis, or, in popular parlance, “softening of the brain.”¹² By the twentieth century, the terms parasyphilis and neurosyphilis were used as umbrella-terms for all the mental and neurological disorders caused by syphilis.¹³

Together with tabes dorsalis (syphilitic damage to the spinal cord sometimes called “spinal consumption”) dementia paralytica marked the last stage of syphilis, which could surface after five to twenty years after infection among 5–10 percent of untreated syphilis sufferers. Although physicians in the nineteenth century suspected a connection with syphilis, there was no clear understanding of the

10. Oosterhuis and Gijswijt-Hofstra, *Verward van geest*, 207–38; Oosterhuis and Slijkhuis, *Verzichte zenuwen en zeden*, 187–239; R. Castel, *L'ordre psychiatrique. L'âge d'or de l'aliénisme* (Parijs: Minuit, 1976); D. Blasius, *Umgang mit Unheilbarem. Studien zur Sozialgeschichte der Psychiatrie* (Bonn: Psychiatrie Verlag, 1986); D. Blasius, ‘Einfache Seelenstörung’. *Geschichte der deutschen Psychiatrie 1800–1945* (Frankfurt am Main: Fischer, 1994); Robert A. Nye, *Crime, Madness, and Politics in Modern France. The Medical Concept of National Decline* (Princeton, N.J.: Princeton University Press, 1984); Goldstein, *Console and Classify*; Ian Dowbiggin, *Inheriting Madness. Professionalization and Psychiatric Knowledge in Nineteenth Century France* (Berkeley: University of California Press, 1991); Andrew Scull, “Psychiatry and Social Control in the Nineteenth and Twentieth Centuries,” *Hist. Psychiatry*, 1991, 2, 149–69; Harry Oosterhuis, *Stepchildren of Nature. Krafft-Ebing, Psychiatry, and the Making of Sexual Identity* (Chicago, London: The University of Chicago Press, 2000), 85–86, 95–96, 100–12.

11. H. van den Berg and B. Meijer, *Zakwoordenboek van de psychiatrie* (Amsterdam: Elsevier, Arnhem: Koninklijke PBNA, 1994), 63.

12. E. M. Brown, “French Psychiatry’s Initial Reception of Bayle’s Discovery of General Paresis of the Insane,” *Bull. Hist. Med.*, 1994, 68, 235–53.

13. E. M. Brown, “Why Wagner-Jauregg Won the Nobel Prize for Discovering Malaria Therapy for General Paresis of the Insane,” *Hist. Psychiatry*, 2000, 9, 371–82.

relationship until the First World War. After the Germans Fritz Schaudin and Paul Hoffmann had demonstrated that syphilis was caused by a bacterial microorganism, the *Treponema pallidum*, in 1905, the German physician August von Wassermann developed a test to reveal the presence of antibodies for syphilis in the blood. In 1913, with the discovery by Hideyo Noguchi and co-workers at the Rockefeller Institute of New York of the syphilis microbe in the brain of paralytics, it became clear that dementia paralytica constituted the tertiary stage of syphilis. Psychiatrists accordingly began to employ the Wassermann test for diagnosing it.¹⁴ While during the 1910s physicians began treating syphilis patients with salvarsan and neosalvarsan, these drugs had little effect on the neurological damage apparent in tertiary syphilis. Many patients died physically and mentally devastated, often within five years after the first symptoms. In 1917, the Austrian psychiatrist Julius Wagner-Jauregg discovered that the disease's progress could be halted through high fever induced by artificial infection with malaria. This therapy, whereby the malaria in turn was treated by quinine, was applied until the introduction of penicillin in the mid-1940s as medication for syphilis and dementia paralytica.¹⁵

Paralysis received much attention in psychiatry of the late nineteenth and early twentieth century. In medical–historical works we find three explanations for this. First, from the 1880s, physicians observed a strong rise of the number of paralytic cases. Some historians corroborate this medical perception, indicating that the prevalence of paralysis had indeed increased because of a syphilis epidemic in Europe and North America and the emergence and gradual spread of a virulent neurotropic mutation of the syphilis microbe.¹⁶ Second, dementia paralytica seemed to be the exemplary disease that would substantiate the medical ambition to find physical causes for mental disorders and thus advance psychiatry as a full-fledged medical discipline. As some

14. Claude Quétel, *History of Syphilis* (Cambridge: Polity Press, 1990), 140–41, 162–63.

15. Quétel, *History*, 325; Magda Whitrow, “Wagner-Jauregg and Fever Therapy,” *Med. Hist.*, 1990, 34, 294–310; Joel Braslow, “The Influence of a Biological Therapy on Physicians’ Narratives and Interrogation: The Case of General Paralysis of the Insane and Malaria,” *Bull. Hist. Med.*, 1996, 70, 577–608, 582–90; Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York etc.: John Wiley & Sons, 1997), 195; Brown, “Why Wagner-Jauregg Won the Nobel Prize,” 378–80.

16. E. H. Hare, “The Origin and Spread of Dementia Paralytica,” *J. Mental Sci.*, 1959, 105, 594–626; Shorter, *A History of Psychiatry*, 53–9.

historians have stressed, psychiatrists were eager to give priority to paralysis as a way to support their own scientific and professional aspirations.¹⁷ Third, dementia paralytica also played an important role in the psychiatric discussion about the social and moral causes of mental disorders and the preventive measures to be taken. In this context, the special interest in this disease was linked up with the popularity of degeneration theory and another professional ambition: the social-hygienic expansion of the psychiatric domain.¹⁸

DEMENTIA PARALYTICA IN THE ASYLUM

The sufferers of dementia paralytica ended up in asylums for the insane or else these patients received nursing care at home or in spas, sanatoria, and convalescent homes. The number of patients outside of the asylums cannot be established. Quantitative data are available about their numbers in asylums, but these statistics have to be handled with caution. They are based on the psychiatric diagnostics of the day, which may entail a distorted image of the actual prevalence of paralysis. Before the introduction of the Wassermann test, there was no hard criterion for diagnosing the disease and physicians depended on outward symptoms. Some of the behavioral and neurological symptoms could also be found in patients suffering from other diseases, such as alcoholism, epilepsy, senile dementia, brain tumors, and other organic brain diseases, multiple sclerosis, manic and depressive (bipolar) disorders, and neurasthenia. Depending on the preoccupations of the physicians involved, both over- and underreporting cannot be ruled out.¹⁹

This lack of diagnostic clarity is reflected in the divergent numbers of paralytics reported at the time, as well as in historical studies. The

17. Quétel, *History*, 61; Engstrom, *Clinical Psychiatry*, 107–10; H. Binneveld and R. Wolf, *Een Huis Met Vele Woningen: 100 jaar katholieke psychiatrie Voorburg 1885–1985* (Vught: Algemeen Psychiatrisch Ziekenhuis Voorburg, 1985), 35; Braslow, “The Influence of a Biological Therapy,” 580–81.

18. George Rosen, *Madness in Society: Chapters in the Historical Sociology of Mental Illness* (Chicago: The University of Chicago Press, 1968), 247–58; G. Berrios, “‘Depressive Pseudodementia’ or ‘Melancholic Dementia’: A 19th Century View,” *J. Neurology, Neurosurgery, Psychiatry*, 1985, 48, 392–400; G. Blok, *Hersenverveking in Nederland: Het psychiatrisch vertoog over dementia paralytica 1844–1930* (MA thesis, University of Amsterdam, 1995); 81–83, 89–90; G. Davis, “*The Cruel Madness of Love*”: *Sex, Syphilis and Psychiatry in Scotland, 1880–1930* (Amsterdam/New York: Rodopi, 2008), 199–231.

19. Hare, “The Origin and Spread of Dementia Paralytica,” 612–14; Rosen, *Madness in Society*, 247–58; G. Berrios, “Depressive pseudodementia”; Blok, *Hersenverveking*, 22–3; Davis, “*The Cruel Madness of Love*,” 104–16, 141–43, 231.

annual reports of the Dutch State Inspectorship for the Insane and the Asylums show that between 1875 and 1915 their share in the total asylum population in the Netherlands rose from over 2 to nearly 7 percent and averaged 5.5 percent.²⁰ These figures are lower than the British, French, and American ones, which fluctuated between 6 and up to 20 percent and more.²¹ Statistical data from some Dutch asylums also point to higher percentages. The average share of paralytic patients among the insane in the Coudewater asylum near 's-Hertogenbosch, for example, was 2.5 percent between 1870 and 1897, but it fluctuated between 5 and 15 percent between 1897 and 1914.²² In the Willem Arntsz Hospital in Utrecht their share was 1.4 percent in 1875, rising to almost 24 percent in 1900, and going down again to 11.8 percent by 1915, while the average percentage was almost 11.²³ However, in their historical studies based on patient records of four Dutch asylums (the municipal asylums of Utrecht and Leiden, the Catholic asylum Voorburg near 's-Hertogenbosch, and the Protestant asylum Wolfheze near Arnhem) Gemma Blok and Joost Vijselaar found that around 4.2 percent of the patients in their samples were suffering from dementia paralytica.²⁴ In our sample of patient records from the municipal asylum in Deventer discussed in this article, 5.6 percent pertain to paralytics.

Based on a sample of anonymized patient records of the St. Elisabeth Hospital in Deventer (a medium-sized town in the eastern part of the Netherlands), it is possible to trace how asylum doctors diagnosed and treated paralytic patients in clinical practice, which causes they identified, and how their response can be understood in the context of the problems they faced and their medical ambitions. The St. Elisabeth Hospital was a town hospital, which dated back to the sixteenth century and was formally recognized as a medical asylum in 1841. Just like many other asylums in urban areas, this mental institution struggled with a lack of space for separating

20. Blok, *Herseweweking*, 15; With respect to the year 1909, however, the statistics of the Inspectorship, covering all Dutch asylums, indicated a much lower percentage: 2.4. Schuurmans Stekhoven, *Ontwikkeling van het krankzinnigenwezen*, Table VIII.

21. Hare, "The Origin and Spread of Dementia Paralytica," 605, 608–9; Quézel, *History*, 161; Brown, "French Psychiatry's Initial Reception," 235; J. Braslow, "The Influence of a Biological Therapy," 581–2, 593; Davis, "The Cruel Madness of Love," 15, 239.

22. J. W. M. Jongmans, *Psychiatrisch ziekenhuis Coudewater 1870–1970. Medisch-historisch verslag* (Rosmalen: s.n., 1971), 70.

23. Blok, *Herseweweking*, 20–21.

24. *Ibid.*; J. Vijselaar, *Het gesticht: Enkele reis of retour* (Amsterdam: Boom, 2010), 50–51, 186.

different categories of patients, as well as a lack of room for medical facilities and insufficient space for gardens and fields where patients could work and recreate. Therefore, a second asylum was built on the premises of the Brinkgreven estate on the edge of town, which opened its doors in 1894. Both asylums were municipal institutions. With around 250 beds each in the first decade of the twentieth century, they were among the country's medium-sized asylums.²⁵ Although the records we studied are from paralytics hospitalized in the St. Elisabeth Hospital, the Brinkgreven asylum is particularly relevant for our analysis because it influenced and changed the psychiatric approach of these patients.

Comparison of our findings with those of Gemma Blok, who conducted similar research on paralytic patients of Utrecht's municipal asylum, the Willem Arntsz Hospital, between 1841 and 1914 reveals somewhat higher prevalence in our sample. With over 400 beds at the end of the nineteenth century, this asylum was considerably larger than the two institutions in Deventer. Blok's sample of 932 records from a total of almost 11,000, resulted in 39 records of paralytic patients, a share of nearly 4.2 percent. Only one of these records dates from before 1884.²⁶

In our sample of 353 patient records from the period 1870–1914, randomly selected from the more than 1,400 records still available of patients admitted to the St. Elisabeth Hospital and the Brinkgreven asylum, twenty pertain to sufferers of dementia paralytica. All twenty were hospitalized in the St. Elisabeth Hospital.²⁷ This amounts to a share of slightly over 5.6 percent of the total number of patients in the sample. One of the paralytic patients was admitted in 1870, three of them between 1884 and 1889, two of them between 1894 and 1897, seven of them between 1903 and 1906, and also seven of them between 1910 and 1914. With one exception, all these paralytic

25. Oosterhuis and Gijswijt-Hofstra, *Verward van geest*, 1401, 1403; cf. C. M. Hogenstijn, *Sint Elisabethsgasthuis en Brinkgreven: Geschiedenis van de psychiatrische ziekenhuizen te Deventer* (Deventer: Arko boeken, 1987); J. Vijselaar, ed., *Over de IJssel, over de schreef: De geschiedenis van de geestelijke gezondheidszorg in Overijssel en van het Psychiatrisch Ziekenhuis Brinkgreven in het bijzonder* (Utrecht: Nederlands centrum Geestelijke volksgezondheid, 1993).

26. Blok, *Hersenverweking*, 6, 20–22.

27. The records are stored in the archive of the regional organization for mental health care, the Archief Adhesie GGZ Midden Overijssel. We established our sample by selecting every fourth record from the box files in which the records are arranged in alphabetical order on the basis of the patients' names. In our references, we indicate the archival number of the record and the years in which the patient involved was hospitalized.

patients died in the hospital, fifteen of them within two years and four within five years.²⁸ They had worked as merchant, baker, blacksmith, laborer, factory worker, military man, civil servant or bookkeeper, or they were retired. In some cases, their profession was not listed. Nineteen patients were married, and one man was a widower. Among the twenty paralytics, there was only one woman.²⁹ Although the share of female paralytic patients in the Willem Arntsz Hospital (18 percent) and in all Dutch asylums (14 percent) was larger, our Deventer sample does reflect the general picture that most paralytic patients (some 75 percent) were men between ages thirty and sixty.³⁰ In order to compare the diagnosis and treatment of dementia paralytica with other clinical pictures, we have also selected and studied ten records of other patients hospitalized in the St. Elisabeth Hospital and the Brinkgreven asylum. These records are about patients suffering from, as the asylum doctors noted down, “hallucinations and delusions,” “depressed temper,” “melancholy,” “vecordia hallucinations,” “secundairy dementia,” “dementia praecox,” “moral insanity,” “neurasthenia,” and “dementia epileptic.” In one of these ten records, no diagnosis is mentioned.³¹

Regardless of the length of patients’ hospitalization, records tend to be no longer than three pages. This limited size and their selective content are related to their function at the time: the reporting primarily served to support the legally required medical certificate of insanity and the court authority required for asylum admission. The Dutch insanity law of 1884 stipulated physicians to record their findings on patients every day during the first two weeks after their admission. These notes were to be used in a medical report sent to the judge in order to request either prolonged admission or the patient’s discharge. After this first period, doctors needed to update reports on a weekly basis in the following six months and on a monthly basis

28. In the Willem Arntsz Hospital, the average admission of paralytics lasted ten months. Blok, *Hersenwekking*, 1995, 18. The statistics of the State Inspectorship indicate that 25 percent of all the paralytics hospitalized in Dutch asylums died within three months and almost 60 percent within a year after admission. D. Schermers, “Eenige statistische beschouwingen over de psychosen in Nederlandse krankzinnigengestichten gedurende de jaren 1875–1900,” *Psychiatrische en Neurologische Bladen*, 1906, 10, 47–50, 47–49.

29. For an overview of the personal and diagnostic information on paralytic patients in the St. Elisabeth Hospital, see [Tables 1](#) and [2](#).

30. *Ibid.*, 47: Blok, *Hersenwekking*, 15–16, 20–21.

31. For an overview of the personal and diagnostic information on these patients, see [Tables 3](#) and [4](#).

TABLE I

Personal and diagnostic information on paralytic patients in the St. Elisabeth Hospital, 1870–1914 (from Patiëntendossiers van het St. Elisabethgasthuis en Brinkgreven, Archief Adhesie GGZ Midden Overijssel)

<i>Record number</i>	<i>Year of admission</i>	<i>Age at the time of admission</i>	<i>Sex</i>	<i>Year of discharge or death</i>	<i>Civil status</i>	<i>Length of hospitalization in years</i>	<i>Profession</i>
1302	1870	46	Male	1872	Married	2	Retired
2052	1884	48	Male	1884	Married	< 1	Retired soldier
402	1886	57	Female	1888	Married	2	Housewife
486	1889	48	Male	1889	Unknown	< 1	Not recorded
692	1894	44	Male	1896	Divorced	2	Not recorded
1031	1897	42	Male	1900	Married	3	Workman
1437	1903	52	Male	1903	Married	< 1	Baker
1521	1903	42	Male	1904	Married	1	Bookkeeper
1622	1904	34	Male	1909	Married	5	Workman
1657	1905	45	Male	1907	Married	2	Workman
1680	1905	45	Male	1908	Married	3	Mechanic
1709	1905	42	Male	1906	Married	1	Merchant
1809	1906	43	Male	1907	Married	1	No profession
2082	1910	58	Male	1910	Married	< 1	Butcher-hand
2249	1912	38	Male	1915	Married	3	Workman
2299	1913	48	Male	1913	Married	< 1	No profession
2379	1913	46	Male	1913	Widower	< 1	Innkeeper
2422	1913	56	Male	1915	Married	2	Blacksmith
2482	1914	34	Male	1914	Married	< 1	Not recorded
2499	1914	39	Male	1914	Married	< 1	Manufacturer

TABLE 2

Personal and diagnostic information on paralytic patients in the St. Elisabeth Hospital, 1870–1914 (from Patiëntendossiers van het St. Elisabethsgasthuis en Brinkgreven, Archief Adhesie GGZ Midden Overijssel)

<i>Record number</i>	<i>Religion</i>	<i>Diagnosis</i>	<i>Recorded cause of suffering</i>
1302	Protestant	General paralysis	Not recorded
2052	Protestant	Dementia paralytica	Quarrel with his boss
402	Nonconformist	Dementia paralytica	Hypochondria; sorrow because of children leaving home
486	Unknown	Paralysis	Not recorded
692	Catholic	General paralysis	Unable to separate from his wife
1031	Protestant	Dementia paralytica	Unrecorded. Patient denies suffering from lues
1437	Protestant	Dementia paralytica	Alcoholism and lues
1521	Protestant	Dementia paralytica	No evidence of having suffered from lues, of alcoholism; has lived a very calm life
1622	Protestant	Paralysis	Not recorded
1657	Protestant	Dementia paralytica	Alcoholism
1680	Lutheran	Dementia paralytica	Unknown
1709	Protestant	Dementia paralytica	Tramping; problem drinking
1809	Protestant	Dementia paralytica	Conflicts with his boss
2082	Protestant	Dementia paralytica	Lues, problem drinking
2249	Catholic	Dementia paralytica Paranoia	Adultery
2299	Protestant	Dementia paralytica	Probably lues
2379	Protestant	Dementia paralytica	Very hectic life; patient denies suffering from lues
2422	Catholic	Taboparalysis	Not recorded (his wife suffers from “lues cerebro spinalis”)

2482	Not recorded	Dementia paralytica	Syphilis: Wasserman test positive
2499	No religion	Dementia paralytica	Syphilis: Wasserman test positive

during the remaining period of hospitalization. The reporting was mostly brief and mainly served to legitimate the patients' diagnosis of insanity and their (prolonged) admission. Admissions were frequently motivated by social concerns rather than by strictly medical ones. The extensive attention for agitated, troublesome, and dangerous conduct underscored the social function of asylum psychiatry: as a diagnosis, dementia paralytica justified court-sanctioned hospitalization to protect the individual patient against himself as well as to ensure the safety of his next of kin and of society.³² One record from 1884, for example, said that the megalomania and hallucinations of one patient made him "completely unsuitable" for engaging in social interaction on his own: his prolonged hospitalization was considered necessary to ensure "public order."³³ A forty-six-year-old man with "general paralysis," who suffered from "symptoms of megalomania and . . . attacks of restlessness," was admitted because it "is dangerous to leave him on his own."³⁴ Another patient was "intolerable" at home and "dangerous to his environment; he wanted to abuse his child and put himself, or his head, into the oven."³⁵

The records underscore the helplessness of paralytic sufferers: many could hardly speak, walk and sit, let alone work—activities which posed no major challenge to many other mental patients. Some of them were so hard to restrain that doctors had to take recourse to coercive means. A thirty-five-year-old factory worker who in 1904 thought that single-handedly he had to end the war between Russia and Japan, could "be brought under control only with great difficulty,

32. Vijselaar, *Het gesticht*, 16–18, 83–122.

33. Patient record 2052 (1884).

34. Patient record 1302 (1870–72).

35. Patient record 486 (1889).

TABLE 3

Personal and diagnostic information on other patients in the St. Elisabeth Hospital and the Brinkgreven Asylum, 1870–1914 (from Patiëntendossiers van het St. Elisabethsgasthuis en Brinkgreven, Archief Adhesie GGZ Midden Overijssel)

<i>Record number</i>	<i>Year of admission</i>	<i>Age at the time of admission</i>	<i>Sex</i>	<i>Year of discharge or death</i>	<i>Civil status</i>	<i>Length of hospitalization in years</i>	<i>Profession</i>
1719	1879	60	Male	1879	Married	0 (died)	Workman
1839	1881	52	Male	1881	Married	0 (recovered)	Baker
1962	1883	45	Male	1903	Not recorded	20 (died)	Not recorded
2042	1884	23	Male	1902	Not recorded	8 (transferred)	Workman
969	1897	53	Female	1901	Married	4 (not recovered)	No profession
1149	1899	33	Male	1905	Married	6 (died)	Butcher
1682	1905	20	Male	1905	Married	0 (recovered)	Shop-assistant
2137	1910	30	Female	1911	Not recorded	0 (not recovered)	Not recorded
2170	1911	Not recorded	Male	1911	Not recorded	0 (recovered)	Not recorded
2389	1913	23	Male	1918	Widower	5 (died)	Not recorded

TABLE 4

Personal and diagnostic information on other patients in the St. Elisabeth Hospital and the Brinkgreven Asylum, 1870–1914 (from Patiëntendossiers van het St. Elisabethsgasthuis en Brinkgreven, Archief Adhesie GGZ Midden Overijssel)

<i>Record number</i>	<i>Religion</i>	<i>Diagnosis</i>	<i>Recorded cause of suffering</i>
1719	Not recorded	Not recorded	Operations of the eye
1839	Protestant	Hallucinations; delusions	Offended sense of honor
1962	Not recorded	Depressed temper	Not recorded
2042	Not recorded	Melancholy	Not recorded
969	Protestant	Vecordia hallucinations	Not recorded
1149	Protestant	Secundairy dementia	Not recorded
1682	Not recorded	Dementia praecox	Problem drinking; epileptic fits
2137	Not recorded	Moral insanity	Unknown
2170	Not recorded	Neurasthenia	Tainted stock
2389	Not recorded	Dementia epileptica	Not recorded

and this repeatedly calls for the use of wet packs and hyoscine.”³⁶ Because of their delusions, interaction with paralytics was frequently hard if not impossible. Still, several records also contained detailed descriptions of their moods and actions. In 1870, one doctor wrote about a patient:

He is satisfied here in the asylum . . . ; all day he is leafing through a book, without reading in it. His conversations are highly childish, his speech is stammering; he staggers; his feeling has dulled, and his constant dirtiness suggests that he fails to notice his natural urges. He eats with vigour, but in this too he shows no sense of taste because he mixes all he’s eating. His condition never shows any change . . . When in need of help, he can be angry and short-tempered.³⁷

References to infirmity, apathy, agitation, and aggression occurred frequently in the records from the 1870s and 1880s. One record notes

36. Patient record 1622 (1904–09).

37. Patient record 1302 (1870–72).

the following about a paralytic characterized as very disturbed and dangerous: “At night he was restless; left his bed to walk out and when stopped, he started cursing heavily.”³⁸ In the record of a fifty-seven-year-old woman one reads:

The sufferer is dazed and does not respond to any questions; . . . does not eat on her own and is expressionless. At night she was unclean; just sits there staring thoughtlessly and is fully in need of help. She lacks any sense of what goes on around her.³⁹

Furthermore, the quite detailed representation in the records of the content of delusions, hallucinations, and megalomania is striking. For example, about a retired military man in an advanced stage of dementia paralytica, the doctor wrote:

He thinks I am the king, regularly calling me “Sire”; believes that through his bravery and heroism he can benefit me greatly; he has plans for various expeditions in the Dutch Indies that he can successfully complete in the wink of an eye, as he, being a Field Marshal with twelve years of experience, did already. . . . Hallucinations, at night he hears his wife, and maidens are brought to his bed. As if being a great hunter, he wants to present to me as a gift his catch: lions, tigers and other wild animals captured alive. He recounts all sorts of stories about his experiences; there is nothing he cannot do, no one has so many achievements as he.⁴⁰

Also in some of the records of patients suffering from other mental disorders, the physicians made much of the content of their delusions. “He believes to be in his own castle, which he wants to reconstruct in the most extravagant way,” one of the asylum doctors wrote about a man whose diagnosis is not recorded.⁴¹ And a baker who was hallucinating “tells various stories, how he has eaten letters . . . how he wants to improve the conditions in prisons and asylums, how he wants to reform the licensing act.”⁴² These records also show, however, that there was more communication between the physicians and these patients and that the physicians took more interest in their experiences. For example, in the record of a man suffering from “depressed

38. Patient record 486 (1889).

39. Patient record 402 (1886–88).

40. Patient record 2052 (1884).

41. Patient record 1719 (1879).

42. Patient record 1839 (1881).

temper,” the doctor expressed empathy for his worries about his family: “he fears that his wife and children are not doing well, he is excited and shows remorse in a childish way.”⁴³ In the record of a workman who was diagnosed with “melancholy,” the physician wrote that “he lowered his eyes . . . and was afraid. When I asked him about his worries he says that his depression has slightly diminished, but that he does not believe that he will recover; only with difficulty and hesitantly he talks about himself.”⁴⁴ Similar information can be found in the record of a neurasthenic patient. Although this record also included entries about body temperature, respiration, body weight, blood pressure, and mental functions, the physician did not act as a detached observer. His notes showed that he talked to this patient and asked him to tell him his life story, of which fragments were recorded; he was particularly interested in how the patient’s fears and worries had come into being and how these were related to his descent and particular dramatic events in his life.⁴⁵

Inasmuch as the doctors recorded their views on the causes of paralysis, they looked for them mainly in relational and emotional factors, such as conflicts and sorrow, as well as in bad habits and an irregular way of life. The record about the female patient referred to above stated that her illness was caused by sorrow because her children had left her.⁴⁶ In the record of a forty-four-year-old man, one can read that “the main cause was that he was unable to separate from his wife.”⁴⁷ And, as the doctor reported, two patients came down with paralysis after conflicts with their boss.⁴⁸ Other causes of dementia paralytica mentioned in the records are syphilis, hypochondria, alcoholism, tramping, adultery, and a hectic life.⁴⁹ In the records of paralytics as well as of the other patients there are hardly any explicit references to somatic or hereditary causes, and little is registered about therapeutic treatment.⁵⁰ Often, the paralytics who

43. Patient record 1962 (1883–1903).

44. Patient record 2042 (1884–1902).

45. Patient record 2170 (1911).

46. Patient record 402 (1886–88).

47. Patient record 692 (1894–96).

48. Patient record 2052 (1884); 1809 (1906–07).

49. Patient records 402 (1886–88); 1437 (1903); 1657 (1905–07); 1709 (1905–06); 2082 (1910); 2249 (1912–15); 2379 (1913); 2482 (1914); 2499 (1914).

50. In the records of the Willem Arntsz Hospital Blok found brief notes about treatments of paralytic patients with medication (bromide, morphine and, from 1914 on, neo-salvarsan),

ended up in the asylum were so ill already that their condition hardly changed, let alone improved. Notes such as “any change for the better is no longer to be expected at this stage”⁵¹ and constantly reiterated expressions such as “condition unchanged,” “the same condition,” “idem,” and “as before” indicate that there was little physicians could do for these patients.

In 1894, the new Brinkgreven asylum opened its doors. It was led by chief medical officer Willem H. Cox, who in 1899 was succeeded by Jean L.C.G.A. le Rütte. These innovation-minded asylum doctors felt that care for the insane should be organized in the same way as somatic medicine. They hired medically trained nursing staff and separated quiet and restless patients from each other. In contrast to the St. Elisabeth Hospital, Brinkgreven had several medical facilities, such as an operating room, a pharmacy, and a laboratory for pathological–anatomic research. Apart from restful bed care, doctors prescribed hydrotherapy and medication, and they applied moral treatment based on outdoor work and relaxation activities. They tried to banish coercive measures as much as possible, but could not refrain from them altogether. Agitated and unmanageable patients were administered large doses of sleeping drugs and sedatives or, in the context of continuous hydrotherapy, they were wrapped in wet packs.⁵² Whereas mental patients considered treatable were admitted to the new asylum, those viewed as incurable, among them all paralytics, stayed behind in the old St. Elisabeth Hospital.

Although the medical–somatic approach in the Brinkgreven asylum did not alter the way the asylum doctors explained the causes of paralysis and did not result in effective therapies for it, the records show that in the St. Elisabeth Hospital this approach did bring about changes in the way the symptoms of this disease were recorded. The reporting on actual abnormal behaviors and mental symptoms such as delusions and hallucinations became more succinct; these aspects were merely observed and concisely noted down. From 1894 doctors paid more attention to the physical condition of patients and

continuing hydrotherapy, restraints, isolation, and “talk in order to calm down,” Blok, *Hersenverweking*, 29–31.

51. Patient record 1680 (1905–08).

52. Hogenstijn, *Sint Elisabethsgasthuis en Brinkgreven*, 70–77; Vjjselaar, *Over de IJssel*, 10–11, 27.

proceeded more systematically. They recorded their pulse, body temperature, breathing and weight, described abnormalities of their motor system, and checked systematically whether patients ate and slept well. Increasingly doctors geared their attention to somatic, especially neurological symptoms, which they indicated in standardized jargon. For example, in a record from 1894, one can read that the patient had “a light attack of apoplexy [seizure]” which “impeded his speech movements.”⁵³ About a forty-two-year-old worker, one record says:

He has a sturdy build, displays anisocoria [unequal size of the pupils], left pupil smallest, paralytic speech disorders, left-sided facial nerve paralysis, innervations disorders, tremors . . . , heightened knee reflexes, does not know what time or day it is, nor his year of admission; cannot calculate his age. Dementia paralytica.⁵⁴

Further, the somatic approach was expressed in questions posed by doctors on the incidence of mental and nervous disorders in the family, an element that suggests increased attention for heredity and degeneration, although these factors are not explicitly mentioned as cause of dementia paralytica.⁵⁵

Blok observed a similar development in the records of paralytic patients in the Willem Arntsz Hospital from 1890 onwards. The volume of records increased after the physicians began to register more information about the life history of patients and their physical examination. Similarly, the records gradually contain more notes about the information that the doctors collected from the patients’ relatives and other physicians, in particular with regard to the possible hereditary background of dementia paralytica.⁵⁶

The records of the St. Elisabeth Hospital from after the mid-1890s indicate that more than in the few earlier records the diagnosis of paralysis had turned into a medical routine. This is exemplified by a record from 1903 of a patient who was lying in bed mostly dull and who occasionally was noisy: “Speech disturbances, defective memory, pareses [muscular paralysis] of his facial muscles, abnormal pupils, dirtiness, susceptibility to bedsores—all part of the normal

53. Patient record 692 (1894–96).

54. Patient record 1031 (1897–1900).

55. Patient records 2299 (1914), 2482 (1914), 1521 (1903–4), 1809 (1906–7), 2137 (1910–11), 2299 (1913), 2422 (1913–15) and 2170 (1911).

56. Blok, *Hersewenweking*, 26–28.

picture of progressive paralysis.”⁵⁷ Other records contain notes such as “typical paralytic speech”; “patient speaks very awkwardly, has strong ataxia [uncertain gait when walking], tremors, dementia, used to have lues. Dementia paralytica nearly follows automatically as diagnosis”; and “suffering from dementia paralytica with all its classic symptoms.”⁵⁸ Likewise, remarks on the prognosis of the disease underscore the increased routine-like approach: “in this advanced stage one is to expect merely further deterioration”; “where all somatic and mental symptoms of dementia paralytica are present, the likelihood of permanent asylum care is very high”; “prognosis highly unfavourable of course; probable duration estimated not to be long.”⁵⁹

The efforts toward more objective observation, more routine-like classification, and emphasis on physical examination suggest a larger familiarity with paralysis. It is not evident, however, that these aspects are also indicative of the professional endeavor of asylum doctors to provide their field with a stronger medical image. The comparison of the records of paralytic patients and those of other mental sufferers from the years between 1895 and 1914 shows that the focus on physical and neurological symptoms was only typical of the psychiatric reporting on dementia paralytica. The asylum doctors also performed physical examinations of other patients, but at the same time they continued to follow an individualized approach and to elaborate on their behavior and experiences. In the record of a workman whose “insanity showed itself in a depressed temper,” for example, somatic symptoms were mentioned (“trembling of the facial muscles, enlarged pupils”), but one can also read about his character and frame of mind. He accused himself of “wrong acts . . . he was afraid and felt gloomy because he was so sinful in everything.”⁶⁰

From around 1895, the asylum doctors followed a neurological approach in their diagnosis of dementia paralytica and their registration of its symptoms, but in their causal explanations this was not the case. At the same time, they also looked to the clinical approach of the German psychiatrist Emil Kraepelin. His method started from detailed and standardized registering of observable symptoms with

57. Patient record 1437 (1903).

58. Patient records 2299 (1913), 1657 (1905–7) and 1437 (1903).

59. Patient records 1437 (1903), 1680 (1905–8) and 1809 (1906–7).

60. Patient record 2042 (1884–1902).

an eye to the statistical basis of diagnosis and prognosis. The patient records suggest that the influence of Kraepelin's disease classification became tangible as of the late 1890s. Prior to that time, diagnosis was mostly based on observation pertaining to the most striking symptom, disturbing conduct, or suspected cause of mental disease. Such approach, according to Kraepelin, was random and speculative; to him, symptoms were only relevant for the diagnosis if these were related to the course of a disorder.⁶¹ Changes in the questions posed by the doctors upon patients' admission suggest that the doctors in the St. Elisabeth Hospital applied Kraepelin's classification. Questions about a patient's "social status," "temperament," and "civilization" receded to the background, as was true of queries on the trigger or occasion of insanity, while questions about the emergence, course, and duration of the disorder gained more prominence. Doctors also considered harmful influences before or during birth, alcohol use, sexual contact, as well as the presence of nervous and mental disease and tuberculosis, syphilis, and alcoholism in the family.

For the treatment of dementia paralytica little changed for the time being, that is, until the arrival of malaria fever therapy around 1920. The sole advantage of Kraepelin's method was that it offered certainty about the disease's fatal outcome. Also, from the late 1890s onwards, physicians referred more often to lues (syphilis). In our sample of patient records, "lues" first appears in an anamnesis from 1897, while later records on paralytics mention it as possible causal factor, often in combination with alcohol abuse, "marital infidelity," and "sexual excesses."⁶² In a record from 1903, for example, the doctor noted that in the past the patient was treated because of a "luetetic infection" and tended to "excesses in Venere and Baccho."⁶³ In two records from 1914, there is the simple brief note saying that the "Wassermann was highly positive."⁶⁴ A formulation like "probable causes" suggests that the doctors assumed a causal relation between syphilis and dementia paralytica, but that they attached as much value to alcoholism and

61. On Kraepelin see Shorter, *History of Psychiatry*, 100–109; on Kraepelin's influence on Dutch psychiatry: Oosterhuis and Gijswijt-Hofstra, *Verward van geest*, 199–200.

62. Patient records 1031 (1897–1900), 1521 (1903–4), 1622 (1904–9), 1680 (1905–7), 2249 (1912–15) and 2422 (1913–15).

63. Patient record 1437 (1903).

64. Patient records 2482 (1914) and 2499 (1914).

sexual debauchery as well as sorrow, conflicts, and particular ways of life (“tramping” and “a hectic life”) as causal factors.⁶⁵

The records the Willem Arntsz Hospital studied by Blok show a similar trend. Syphilis as a cause for paralysis appeared for the first time in 1895. In the period thereafter, the physicians referred in seventeen of the thirty-nine records to syphilis as a causal factor, often together with other causes, such as alcoholism, financial worries, and “trauma capitis.” In five records dating from after 1895, physicians reported that the patients had not contracted syphilis. Strikingly, four records mention positive results of the Wassermann-test, whereas at the same time the cause of dementia paralytica was referred to as “unknown.” In eleven records, there are no notes at all about causes. According to Blok, the more frequent references to syphilis should not lead to the conclusion that the doctors in Utrecht believed in a strong causal link between syphilis and dementia paralytica, as they would also ask patients suffering from other mental disorders about their possible contraction of syphilis. Apparently this question had become part of the medical procedure of all admissions.⁶⁶

DEMENTIA PARALYTICA IN THE PATHOLOGICAL—ANATOMIC LABORATORY

The standardization of the diagnostic terminology, the attention for somatic symptoms, and the effect of Kraepelin’s approach in our sample of records from the mid-1890s onwards reflect the objective of psychiatrists to emphasize the medical nature of their field. However, this hardly made an end to their therapeutic powerlessness. From the angle of curative medicine, the treatment of paralysis was all but an example of triumphant medical psychiatry. In the journal of the Dutch Psychiatric and Neurological Association, the psychiatrist F. Meeus labeled these patients as hopeless “mental cripples”: “They reside in the eternal darkness of the mental night, where, like Dante, one could write on the gates of hell: *Who enters here abandons all hope.*”⁶⁷ On the other hand, the psychiatric discussions on the

65. Patient records 402 (1886–88); 1437 (1903); 692 (1894–96); 1521 (1903–4); 1657 (1905–7); 1709 (1905–6); 1809 (1906–7); 2082 (1910); 2249 (1912–15); 2379 (1913).

66. Blok, *Hersenwauking*, 72–77.

67. F. Meeus, “Over ‘Dementia’ en hare waarde in de hedendaagsche Psychiatrie,” *Psychiatrische en Neurologische Bladen*, 1908, 12, 413–29, 415.

disease's physical basis revealed that psychiatrists capitalized on paralysis to underline their medical–scientific aspirations.

The therapeutic pessimism in the asylums contrasted with the optimistic tone with which they reported on their scientific research of dementia paralytica in publications. Between 1886 and 1914, some fourteen reports on pathological–anatomic research of paralysis appeared in Dutch. In addition, psychiatrists published many case histories of patients. Contributions about this disease in their professional journal outnumbered those on any other disorder. It seems that this growing medical attention ran parallel to the increasingly stronger focus of Dutch psychiatry on neurology. Studies were performed in particular in laboratories of new asylums and clinics that were linked to universities. The authors of the research reports, including the university-professors Cornelis Winkler, Gerbrandus Jelgersma, and Leendert Bouman, and one of the leading asylum doctors, Jacob van Deventer, advocated a science-based psychiatry. They took advantage of this disorder to prove that there was a connection between mental diseases and brain and nervous disorders. They also used dementia paralytica as an example to demonstrate that the insane were “normal” ill people and that it was productive to organize the care for the insane after the model of the general hospital.⁶⁸

Many pathological–anatomic contributions about paralysis came from physicians who worked at Endegeest, the asylum which had laboratories and examination rooms and which was set up in part for psychiatric training by Jelgersma at Leiden University.⁶⁹

68. See C. Winkler, “De psychopathologie als hersenpathologie te midden der klinische wetenschappen,” supplement of *Psychiatrische Bladen*, 1885, 3, 1–24; C. Winkler and P. Wellenbergh, “Bijdrage tot de casuïstiek der dementia paralytica,” *Psychiatrische Bladen*, 1886, 4, 34–59; G. Jelgersma, “Idiotie en dementia paralytica. Pathologisch-anatomische bijdrage,” *Psychiatrische Bladen*, 1886, 4, 92–122; G. Jelgersma, *Psychologie en pathologische psychologie: Rede bij de aanvaarding van het hoogleeraarsambt aan de Rijksuniversiteit Leiden, op 20 september 1899 uitgesproken door Dr. G. Jelgersma* (Leiden: S. C. Van Doesburgh, 1899); J. van Deventer and A. M. Benders, “Twee gevallen van dementia paralytica, na de inwerking van een trauma capitis op den leeftijd respectievelijk van 9 en 11 jaar opgetreden,” *Psychiatrische en Neurologische Bladen*, 1898, 2, 118–21; J. van Deventer and F. Muller, “Een geval van paralyse met innervatorische apraxie en apractische aphagie,” *Psychiatrische en Neurologische Bladen*, 1911, 15, 164–84.

69. J. P. Hulst, “Een geval van infantiele progressieve paralyse,” *Psychiatrische en Neurologische Bladen*, 1900, 4, 101–13; J. P. Hulst, “Een geval van dementia paralytica als paranoia hallucinatoria debuteerend,” *Psychiatrische en Neurologische Bladen*, 1902, 6, 25–34; J. van der Kolk, “De differentiaaldiagnose der Dementia paralytica met de zgn. alcoholische Pseudo-paralyse,” *Psychiatrische en Neurologische Bladen*, 1906, 10, 189–205; J. van der Kolk, “Een geval van tumor cerebri, gedurende het leven gehouden voor een snel verlopenden vorm

Pathological–anatomic research was also performed at other institutions, such as the new Bloemendaal asylum near The Hague. As its chief medical officer A. Deenik wrote: “at Bloemendaal it is common practice, introduced by Prof. Bouman [the former chief medical officer] and systematically continued by me, to cut samples from the brain—both left and right hemisphere—of each cadaver available for dissection.”⁷⁰

The significance of neurological and pathological–anatomic study of dementia paralytica was underlined in the psychiatric textbooks geared to academic education and the training of nurses. For example, J.W.H. Wijsman, in his *Lectures on Psychiatry for Students, Physicians and Lawyers* (1896), extensively addressed the neurological aspects of the disorder: “In recent years our knowledge of the pathological anatomy of dementia paralytica has significantly increased through careful investigations owing to the advances in microscopic technology.” In detail, he described the abnormalities in the brain tissue that would be characteristic of paralysis, such as ganglion cells [neurons] that showed “fatty degeneration, atrophy [decrease in size or wasting away of part of the body] and sclerosis [pathological hardening of tissue]”; damaged nerve fibers in the cerebral cortex and in the great and the little brain; “atheromatosis” [fatty degeneration of the interior walls] of the large blood vessels and “increase of nuclei and colloid [viscous] and hyaline [vitreous] degeneration” of the vascular wall of the small blood vessels; “hypertrophy” [extreme growth] and increase of the “neuroglia” [supporting tissue of the nervous system].⁷¹ Likewise, Van Deventer, in his handbook on nursing and psychiatry (1897), indicated that paralysis was accompanied by

van dementia paralytica,” *Psychiatrische en Neurologische Bladen*, 1908, 12, 9–23; G. Janssens and J. G. Dikshoorn, “Histologisch onderzoek van een geval van paralyse, atypisch, naar de localisatie en atypisch naar de kwaliteit van het proces,” *Psychiatrische en Neurologische Bladen*, 1909, 13, 387–401; G. Janssens and R. A. Mees, “Een geval van progressieve juveniele demetie,” *Psychiatrische en Neurologische Bladen*, 1907, 11, 209–22; G. Jelgersma, “Over de histopathologische veranderingen van het zenuwstelsel bij Dementia Paralytica,” *Psychiatrische en Neurologische Bladen*, 1906, 10, 105–13.

70. A. Deenik, “De genese van het paralytisch insult,” *Psychiatrische en Neurologische Bladen*, 1911, 15, 510–24; see also L. Bouman, “Das relative Gewicht der Grosshirnwindungen von 25 an Dementia Paralytica verstorbenen Patienten,” *Psychiatrische en Neurologische Bladen*, 1904, 8, 199–205; L. Bouman, “Ruggemergsveranderingen bij progressieve paralyse,” *Psychiatrische en Neurologische Bladen*, 1906, 10, 114–24.

71. J. W. H. Wijsman, *Voorlezingen over psychiatrie voor studenten, artsen en juristen* (Amsterdam: Scheltema & Holkema, 1896), 88.

abnormalities in the nerve tissue and he pointed out to nurses the physical disorders found in patients.⁷²

However, the various research articles and textbooks failed to have immediate effects on clinical practice; by and large, their authors remained silent about therapy and cure.⁷³ It seemed they were after something else: through their focus on dementia paralytica they sought to support the assumed physical causes of mental disorders. As the Utrecht psychiatrist H. Buringh Boekhoudt pointed out in 1894, study of dementia paralytica played a paradigmatic role in the association of psychiatry and neurology:

Its strange place as so-called organic psychosis, on account of which both neurologists and psychiatrists consider it part of their domain, ensures that paralysis . . . will long continue to be an element of scientific research. And fortunately so, because a psychosis, which can quickly be lethal . . . and cause its victim's mental bankruptcy in no time, is pre-eminently suited to be studied by them who seek to trace the interconnection between anatomic abnormalities and mental disease symptoms.⁷⁴

In fact, two years later, in 1896, the Dutch Psychiatric Association admitted neurologists and changed its name into Dutch Psychiatric and Neurological Association.

In 1908, Meeus applauded Buringh Boekhoudt, saying “now this was a true medical view.” By then, Meeus claimed, it had been established unequivocally that dementia paralytica, “under a layer of psychological colours,” was actually a disease “with a firm diagnosis and prognosis, based on unchangeable clinical symptoms and fixed analytical data.”⁷⁵ In the eyes of psychiatrists who embraced laboratory research, these findings confirmed the correctness of the neurological shift in psychiatry. If at that point one had not produced a method of

72. J. van Deventer, *Handboek der krankzinnigenverpleging* (Amsterdam: Van Heteren, 1897), 81.

73. This changed only after the introduction of the Wassermann test in 1906, which established the connection with syphilis. See, for example: H. Klein, “Over de reactie van Wassermann,” *Psychiatrische en Neurologische Bladen*, 1909, 13, 316–26.; J. J. P. Hilbers, “Vaccine en serumtherapie bij dementia paralytica en tabes,” *Psychiatrische en Neurologische Bladen*, 1911, 15, 418–27; F. S. Meijers and J. G. Schnitzler, “De salvarsaanbehandeling bij tabes en dementia paralytica,” *Nederlandsch Tijdschrift voor Geneeskunde*, 1916, 57/I, 328–30.

74. H. Buringh Boekhoudt, “De herkenning van dementia paralytica,” *Geneeskundige Bladen uit kliniek en laboratorium voor de praktijk*, 1894, 1/VIII, 201–25, 201.

75. Meeus, “Over ‘Dementia,’” 420.

treatment for dementia paralytica yet, it was the very direction psychiatric research ought to pursue.

DEMENTIA PARALYTICA IN MODERN SOCIETY

Surprisingly, the conviction that on the basis of pathological–anatomic research of dementia paralytica psychiatry had proved itself to be part of medical science in general and neurology in particular, was not reflected in the discussions on the causes of the disease conducted by physicians in both the Netherlands and abroad from around 1880. From the medical perspective, after all, it would have been natural for them to seize upon the suspected relationship with syphilis, discussed in the international medical community as early as 1857, to underline the somatic basis of paralysis. Initially, however, the claim by the French dermatologist Alfred Fournier, in his *La syphilis du cerveau* (1879), and by the German physician Emanuel Mendel, in his *Die Progressive Paralyse der Irren* (1880), that syphilis was the main cause of dementia paralytica hardly reverberated in the medical community.⁷⁶ Although they did not deny that syphilis might be a causal factor, for most physicians it was far from self-evident that it was the only or even the main cause. They felt that syphilis was just one of the causal factors and that, apart from hereditary taint and degeneration, moral, and social–cultural influences—including alcoholism, sexual license, extreme passions, emotions and worries, nervous exhaustion as well as the pressures of modern society—played at least an equally important role. Still, from the mid-1890s syphilis was given a prominent place in the discussions, notably in the light of statistical evidence with regard to the interrelation between this venereal disease and paralysis as well as the debate on the dangers of prostitution and alcoholism for public health.

As of 1883, dementia paralytica figured prominently on the psychiatric agenda in the Netherlands and the Dutch discussion about this disease was strongly influenced by medical discoveries and debates in France and Germany.⁷⁷ At a meeting of the Dutch Psychiatric

76. Quézel, *History*, 160–62, 299; Blok, *Hersenverveking*, 35–38; Brown, “Why Wagner-Jauregg Won the Nobel Prize,” 373–5.

77. S. Brosius, “Over het begin der dementia paralytica,” *Psychiatrische Bladen*, 1883, 1, 92–103; A. O. H. Tellegen, “Discussie over de dementia paralytica, vooral in Nederland,” *Psychiatrische Bladen*, 1883, 1, 193–225; A. O. H. Tellegen, “Nog eens de dementia paralytica in Nederland,” *Psychiatrische Bladen*, 1885, 3, 121–40; A. van der Swalme, “Discussie

Association, the asylum doctor Antonius O.H. Tellegen called upon his colleagues to investigate the disease's prevalence and etiology by establishing statistics on its occurrence among their patients, supplemented by case histories. In his own research of paralytics from the Coudewater asylum, he established that sixty-six of the total number of 111 were "hereditarily predisposed." They contracted the disease either from their parents who also suffered from dementia paralytica (or alcoholism or nervousness) or through "indirect heredity," meaning poor upbringing. As possible causes Tellegen further mentioned "the amorality of cities," theatre and opera attendance, the reading of modern novels, the enhanced struggle for life as well as syphilis. A sensible hygiene and self-discipline would potentially counter the further spread of dementia paralytica: "One should teach young people a sense of duty and self-control. It would certainly be desirable that people live more in line with the Ten Commandments."⁷⁸

The psychiatrists who responded to Tellegen's call considered not only syphilis but also sorrow, alcohol, heredity, and sexual debauchery as causal factors. Some observed that dementia paralytica had an above-average prevalence among certain professional groups, such as railroad men, businessmen, factory owners, scholars, civil servants, and in particular sailors and military men.⁷⁹ According to H. van Cappelle, the last two groups consisted of "men who commonly overindulge in Baccho and Venere, who sometimes suffer great fatigues and various discomforts and who in general lead less ordinary lives."⁸⁰ He also noted that workers and specially farmers were underrepresented. Like Van Cappelle, other physicians assumed a connection between the prevalence of paralysis on the one hand and life in cities or the

over de dementia paralytica, vooral in Nederland," *Psychiatrische Bladen*, 1883, 1, 218–25; N. B. Donkersloot, "Bijdrage tot de statistiek der dementia paralytica in Nederland," *Psychiatrische Bladen*, 1884, 2, 55–56; W. F. Westening, "Ziektegevallen van dementia paralytica," *Psychiatrische Bladen*, 1884, 2, 142–4; H. van Cappelle, "Het voorkomen van paralytic cerebri in de krankzinnigengestichten in Nederland in verband met de beroepen der opgenomenen," *Psychiatrische Bladen*, 1885, 2, 201–24; Winkler and Wellenbergh, "Bijdrage tot de casuïstiek der dementia paralytica."

78. Tellegen, "Discussie," 205, 217.

79. Van der Swalme, "Discussie," Westening, "Ziektegevallen"; "Discussie tussen de aanwezigen bij de voordracht van Tellegen 'Nog eens de dementia paralytica in Nederland' op de vergadering van de Nederlandse Vereeniging voor Psychiatrie te Haarlem, 11 juni 1885," *Psychiatrische Bladen*, 1885, 2, 121–40.

80. Van Cappelle, "Het voorkomen," 202–3.

countryside on the other. It was logical, they claimed, that only few farmers fell prey to the disease: “surely, in the current era individuals who meet with sorrow, experience disappointments, exert their brain and so on will be affected in particular.” Farmers in the quiet countryside doing physical work out in the open air suffered less from the tensions of the hectic “present-day era.” They were “less modern” and “less civilized,” and therefore their brains would be far less affected than those of urban dwellers.⁸¹

From the mid-1890s, syphilis was increasingly mentioned as a major cause of paralysis, but not as its exclusive cause. In 1895, Tellegen, who had earlier minimized the role of syphilis, claimed that the disorder was an effect of syphilis: “two diseases of the nervous system that used to be attributed to a range of causes have to be seen as an effect of luetic infection, namely tabes dorsalis and dementia paralytica.”⁸² The growing attention for syphilis was tied to the publication of a new book by Fournier, *Les affections parasymphilitiques* (1894), in which on the basis of statistical data and clinical experience he again pointed to the connection between syphilis and paralysis. Fournier’s insights were supported by the Austrian psychiatrist Richard von Krafft-Ebing. In the mid-1890s, he injected nine paralytic patients with syphilitic wound discharge, and because in the following year six of them showed no reaction, he concluded that these patients already suffered from lues.⁸³

Increasingly physicians were convinced that dementia paralytica was not possible without syphilis, but they did not exclude other causal factors.⁸⁴ Apparently, syphilis was a necessary condition, but whether it was a sufficient condition for the emergence of the disorder continued to be an unresolved issue. For example, Wijsman summed up various causes in addition to syphilis: “humiliations, frustrations, mood fluctuations, extreme mental exertion, alcoholism, extravagances, isolation, constant exposure to high temperatures, head wounds.”⁸⁵ In his textbook for psychiatric nurses, Van Deventer characterized dementia

81. *Ibid.*, 201.

82. A. O. H. Tellegen, “Het vraagstuk der geslachtelijke onthouding,” *Psychiatrische Bladen*, 1895, 13, 81–109, 90.

83. Oosterhuis, *Stepchildren of Nature*, 91.

84. J. K. A. Wertheim Salomonson, “Boekaankondiging,” *Nederlandsch Tijdschrift voor Geneeskunde*, 1894, 38/II, 1106–7; G. Jelgersma, “Recensie van Fournier,” *Nederlandsch Tijdschrift voor Geneeskunde*, 1895, 39/III, 1088–9.

85. Wijsman, *Voorlezingen*, 85.

paralytica as a disease of civilization that was tied to “the high demands posed by contemporary society. The main cause of this suffering lies in extreme exertion of the body and in particular of the mind, a continuous exposure to mental stimuli, alcohol abuse and several other factors.”⁸⁶

In a report on a statistical study of the prevalence of paralysis at the municipal asylum in Amsterdam between 1879 and 1892, Van Deventer addressed in more detail the connection between the disease and modern civilization. Syphilis and alcohol use, in his view, were the necessary “causal elements,” without which paralysis could not emerge, while other causal factors directly or indirectly served as catalyst: harmful “toxic” and “mechanical” effects on the brain, extreme exertion of the brain and influences weakening people’s integral physical functioning, such as a constantly raised blood pressure. In addition he distinguished “removed” or “predisposing” causes, which in his view were heredity, temperament, profession, age, housing and living environment, and the struggle for life in a highly developed civilization.⁸⁷ Cox, too, assumed that syphilitic infection was the necessary condition of dementia paralytica while still not offering a full explanation. Whether a syphilis patient would fall prey to this disease depended on whether or not hereditary degeneration was a factor.⁸⁸

Although from 1906 it was possible to show the presence of the syphilis microbe in the blood of paralytics, causing more experts to assume that syphilis was a necessary condition for the emergence of the disease, not all were convinced. Gerbrandus Jelgersma, in his psychiatric textbook (1911), still pointed to other, indirect causes. Syphilis constituted no sufficient explanation: the fact that not all syphilis sufferers contracted dementia paralytica suggested, in his view, that individual lifestyle and physical condition were as important as the lues infection. In particular, the disorder’s more frequent occurrence during the nineteenth century signaled that “modern civilisation has had an enormous influence on our way of life.”⁸⁹

86. Van Deventer, *Handboek*, 81.

87. J. van Deventer, “Bijdrage tot de aetiologie der dementia paralytica,” *Psychiatrische en Neurologische Bladen*, 1898, 2, 10–19.

88. W. H. Cox, “Degeneratie (Eene copulativogene correlatiestoornis),” *Psychiatrische en Neurologische Bladen*, 1907, 11, 9–85.

89. G. Jelgersma, *Leerboek der Psychiatrie. Eerste deel specieel gedeelte* (Amsterdam: Scheltema & Holkema, 1911), 173.

Although psychiatrists stressed the biomedical nature of their profession, at the same time psychiatry was governed by a multi-causal logic that assumed the interplay of various biological, physiological, mental, and social influences, which could occur as predisposing and inducing causes. In Dutch psychiatric textbooks that appeared from the mid-1890s, authors described dementia paralytica as a disease that could not emerge without syphilis infection but that was also caused by a set of mutually reinforcing factors: biological (hereditary predisposition), social (civilization), and individual (lifestyle and emotions). The theory of degeneration, which assumed that acquired features were hereditary, suggested the interplay of harmful hereditary and environmental influences.⁹⁰ Until into the 1920s, psychiatrists believed that the emergence of paralysis not only depended on syphilis but also on other causes such as “mental overexertion” or “sociological factors.”⁹¹

That psychiatrists continued to refer to moral and social-cultural factors, despite the evidence in favor of the connection between syphilis and paralysis, was tied to their effort to broaden their sphere of activity. Apart from a somatic explanation they also advocated a social-hygienic approach of mental disorders, thus claiming a social role. Their preventive approach, which for instance was aimed at fighting alcoholism and excessive sexual behavior, was in line with a wider social activism in the Netherlands at the end of the nineteenth century. This involved an increased drive of both private organizations and the government to tackle various social problems and inequalities, in particular the “social issue,” and to elevate the masses in a moral sense.⁹² At that time many saw the spread of syphilis as tied to “immorality” in general and prostitution in particular. Initially most physicians were proponents of regulation of prostitution through police and

90. On the influence of the theory of degeneration in European psychiatry, see: Sander L. Gilman and J. Edward Chamberlin, eds., *Degeneration: The Dark Side of Progress* (New York: Columbia University Press, 1985); Daniel Pick, *Faces of Degeneration: A European Disorder 1848–1918* (Cambridge: Cambridge University Press, 1989); Ian Dowbiggin, *Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth Century France* (Berkeley: University of California Press, 1991); J. Tollebeek, G. Vanpaemel, and K. Wils, *Degeneratie in België, 1860–1940: een geschiedenis van ideeën en praktijken* (Leuven: Universitaire Pers Leuven, 2003).

91. L. Bouman and B. Brouwer, *Leerboek der zenuwziekten: Algemeen gedeelte* (Haarlem: de Erven F. Bohn, 1922), 345.

92. Oosterhuis and Gijswijt-Hofstra, *Verward van geest*, 56–64, 207–21.

medical surveillance, as it had evolved in the course of the nineteenth century. This was based on the notion that prostitution was a necessary evil (because the irrepressible male sexual drive required an outlet), so the harmful after effects in the form of venereal diseases had to be kept under control. In the last decade of the nineteenth century, however, there was growing resistance in society against regulated prostitution. In the 1880s, Protestant-Christian organizations took the lead in the fight against prostitution, which was seen as source of immorality and syphilitic infection. The “abolitionists” also reacted against the double standard that legitimized regulation: because middle-class women should not fall victim to male lust, men had to look for sexual gratification among women from the lower classes. In part because of the rejection of this moral ambivalence, which created different standards for men versus women *and* for middle-class versus working-class women, also feminists, social-liberals, and socialists turned against regulated prostitution.⁹³

Next, an increasing number of physicians spoke up against regulated prostitution. Although in the Netherlands the fear of the population’s degeneration such as through hereditarily transmitted syphilis did not grow to equally large proportions as for instance in France, worries about public health increased among physicians.⁹⁴ Tellegen, for example, argued that sexual self-control was necessary because syphilis was as “a source of all sorts of ailments . . . the largest risk . . . for the population, the family and the individual.” The medical class should “not co-operate in fostering immorality.”⁹⁵ Tellegen’s views, which were shared by other psychiatrists, can explain in part—aside from psychiatry’s multi-causal explanatory model—why they held on to social and moral influences as causal factors in the etiology of dementia paralytica. In line with the growing social activism and the

93. A. Mooij, *Geslachtsziekten en besmettingsangst: Een historisch-sociologische studie 1850–1990* (Amsterdam: Boom, 1993), 30–34, 44–55, 62–63; G. Hekma, *Homoseksualiteit, een medische reputatie: De uitdoktering van de homoseksueel in negentiende-eeuws Nederland* (Amsterdam: Sua, 1987), 149–64; P. Koenders, *Tussen christelijk réveil en seksuele revolutie. Bestrijding van zedeloosheid in Nederland, met nadruk op de repressie van homoseksualiteit* (Leiden: PhD diss., Rijksuniversiteit Leiden, 1996), 47–94. On the moral purity movement see also: D. J. Noordam, “Getuigen, redden en bestrijden. De ontwikkeling van een ideologie op het terrein van de zedelijkheid, 1811–1911,” *Theoretische Geschiedenis*, 1996, 23, 494–518.

94. Oosterhuis and Gijswijt-Hofstra, *Verward van geest*, 207–14; see also Dowbiggin, *Inheriting Madness and Nye, Crime, Madness, and Politics*.

95. Tellegen, “Het vraagstuk,” 90, 107.

progressively stronger moral purity movement in Dutch society, psychiatrists wanted to have, apart from their medical–clinical task, also a social–hygienic task. For this reason, they pointed to the public health risks of prostitution and other sexual debaucheries.

CONCLUSION

The psychiatric interpretation of dementia paralytica took on three forms in Dutch psychiatry around 1900, depending on the context in which psychiatrists practiced their profession and pursued their professional aspirations: (1) the view from the asylum; (2) theories drawn from patho–anatomical study; and (3) the perspective of those engaged in social debates about sexuality, disease, and mental illness.

Clinical practice in the asylum, as the patient records from the St. Elisabeth Hospital show, centred on the need to care for invalid and incurable patients and to control their unruly and restless conduct. Therapy was no option (at least until the 1920s) and therefore paralytics did not fulfill the medical aspirations of psychiatrists such as Cox and Le Rütte. Still, the records from the late 1890s reveal an increasingly standardized and objectified medical gaze. If the new clinical focus did not change the causal explanation of dementia paralytica and did not produce any positive effects from a therapeutic angle, it did provide more certainty on diagnoses and prognoses. To a certain extent this approach reflected the medical orientation in psychiatry and the aspiration to turn asylums into hospitals. The pathological–anatomic studies of the organic basis of dementia paralytica, reported by psychiatrists from the 1880s, also fitted the aspiration to link up their field with scientific medicine, and neurology in particular. Seen through the microscope's lens, dementia paralytica was the disorder that would allow them to present themselves as natural scientists in laboratories. At the same time, Dutch psychiatrists, in the wake of their foreign colleagues and based on statistics and case histories, discussed the divergent causal relationships between dementia paralytica, syphilis, and various biological, moral, and social–cultural factors. They also joined social debates on the moral level of society in general and the dangers of prostitution for public health in particular.

Our and also Blok's conclusion differ from that of some historians who claim that psychiatrists embraced the assumption that syphilis caused dementia paralytica because they were eager to demonstrate

the physical causes of mental diseases.⁹⁶ To be true, this ambition did play a role in their approach of paralysis, but it only offers a partial explanation. Neither do our findings support Margaret Thomson's suggestion that psychiatrists struggled with indications pointing to syphilis as the cause because of the dominant Victorian morality that tabooed open discussion of sexuality, and therefore also of syphilis. If Dutch psychiatrists were not reluctant at all to discuss syphilis as a causal factor, they refused to accept the idea that it was the single and definitive cause for other reasons.⁹⁷ Our conclusions tie in with the argument of German Berrios, George Rosen, and Gayle Davis that nineteenth-century psychiatrists often combined natural–scientific rhetoric with a multi-causal approach in practice. Degeneration thinking, which supposed a combination of heredity and environmental factors, was in line with this approach.⁹⁸ Our findings also correspond to those of Gayle Davis in her study on paralysis in four Scottish asylums in the period between 1880 and 1930. She understands the multi-causal approach of psychiatrists against the background of the tensions between their daily clinical practice, their scientific ambitions, and their broader social and moral concerns.⁹⁹ The Dutch psychiatric approach of paralysis can be explained in a similar way.

If Dutch psychiatrists described paralysis in somatic and neurological terms, they also employed, from a social–hygienic and partly clinical angle, a multi-causal explanation for dementia paralytica. In the patient records as well as in the social–hygienic discourse they looked for the causes of paralysis mainly in emotional, moral, and social factors. That these divergent approaches existed side by side can in part be explained by physicians' inability to treat the disease, which caused the accent to shift from therapy to prevention. By insisting on changes in lifestyle and more individual self-control, as well as on social measures such as the fight against prostitution and alcoholism, psychiatrists presented themselves as hygienists of society.

96. Quétel, *History*, 61; Engstrom, *Clinical Psychiatry*, 107–10; Binneveld and Wolf, *Een Huis*, 35; Braslow, "The Influence of a Biological Therapy," 580–81.

97. Margaret S. Thompson, "The Wages of Sin. The Problem of Alcoholism and General Paralysis in Nineteenth Century Edinburgh," in *The Anatomy of Madness III*, ed. William Bynum and Roy Porter (London: Tavistock, 1988), 316–41; cf. Blok, *Hersenverweking*, 78–80.

98. Berrios, "Depressive Pseudodementia"; Rosen, *Madness in Society*, 247–58; Davis, "The Cruel Madness of Love," 199–231; see also Blok, *Hersenverweking*, 81–83, 89–90.

99. Davis, "The Cruel Madness of Love," 239–45.

Another possible reason why they held on to a multi-causal explanation is perhaps their fear that they would lose their authority on paralysis if it was established that the cause was exclusively somatic and that therefore the disease fully belonged to the domain of neurology or internal medicine. Also, and more in general, Dutch psychiatrists were attached to multi-causal explanations of mental disorders: in order to distinguish themselves from other doctors whose expertise was somatic, they created a distinct profile as experts who were able to interrelate somatic, mental, and social-cultural factors. In clinical practice, as can be observed in patient records, they usually followed a descriptive and individualizing approach of patients, in a more or less intertwined fashion.¹⁰⁰

Dementia paralytica, then, played an ambiguous role in the development of the psychiatric profession in the Netherlands. For asylum doctors with therapeutic aspirations, so the patient records from the St. Elisabeth Hospital and also those of the Willem Arntsz Hospital reveal, paralysis was hardly a disorder that allowed them to boost their medical identity. Conversely, to physicians who performed scientific research and cherished academic ambitions, paralysis served to support the argument that psychiatry should follow the example of scientific medicine. The social-biological view of dementia paralytica as a degenerative disorder of modern civilization legitimized psychiatric participation in the social-hygienic fight against “immorality” and other wrongs in society.

100. Oosterhuis and Gijswijt-Hofstra, *Verward van geest*, 195–207, 241–2.