What was Tropical about Tropical Neurasthenia?
The Utility of the Diagnosis in the Management of British East Africa

Abstract:

During the first quarter of the twentieth century, tropical neurasthenia was a popular diagnosis for a nervous condition experienced by Europeans in the topics. Tropical neurasthenia was not psychosis or madness, but was rather an ennui or loss of 'edge' brought about by the strains of tropical life, especially the unfamiliar, hot, climate. A catch-all for a wide range of symptoms, many missionaries, colonial staff and settlers throughout Empire were repatriated because of it, although this paper concentrates on Colonial Service employees working in British East Africa.

While histories of tropical neurasthenia have usefully (and correctly) explained this diagnosis as an expression of the anxieties of the colonial regime, this paper adds a new dimension to the historiography by arguing that tropical neurasthenia can only be properly understood as a hybrid form, dependent not only upon the peculiarities of the colonial situation, but also descended from British and American clinical understandings of neurasthenia. Moreover, once tropical neurasthenia is properly acknowledged as being typical of clinical understandings of the time, other reasons for its comparatively long endurance in the colonial situation emerge. This paper shows that tropical neurasthenia remained a popular diagnosis in East Africa not only because (as historians have argued previously) it dovetailed with prevalent ideas of colonial acclimatization, but also because it was a practically useful toolin the management and regulation of colonial personnel,

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One of the key problems faced by colonisers of the tropics was European ill health. Grave dangers included diseases caused by specific pathogens, such as malaria or trypanosomiasis, but also those less easily attributable to a single causative factor, and less precise in their expression, such as tropical neurasthenia, which was a popular diagnosis for European renegade, bizarre or lazy (as well as genuinely neurotic) behaviours in tropical colonial outposts, especially between 1905 and 1920. This paper uses examples from British East Africa before World War Two to make two contributions to the historiography of tropical neurasthenia. First, this diagnosis is argued to have been as much (if not more) derived from accepted conceptual models within British and American psychiatry than from colonial –specific understandings. Second, it is posited that the specifically 'tropical' within tropical neurasthenia was not only the perceived role of the sun in bringing about the disorder, but also the way that the diagnosis was useful in the colonial context as a means of categorising and regulating the behaviours of Europeans abroad. This paper does not deny that, throughout its short life, tropical

neurasthenia was partially a context dependent diagnosis; nor does it quibble with arguments posited by Warwick Anderson and Dane Kennedy that it also can be analysed as revealing of broader colonial anxieties.[1] Rather, the intention of this piece is to subtly reorientate the story of tropical neurasthenia, by also re-introducing the American and European psychiatric and neurological foundations of the theory. It was these which provided the essential epistemological preconditions (as well as popular lay understandings) to allow the tropical variant of neurasthenia to come into being.[2]

In essence, this argument is a reintegration of a colonial medical phenomenon back into the history of psychiatry more generally. As will be shown in the first part of this paper, to be sure, tropical neurasthenia placed greater emphasis on the sun as a causative factor and further delineated the racial hierarchies presumed by colonialism, but neither these environmental or racial components were at odds with the original non-colonial neurasthenic conceptions. Although tropical neurasthenia adapted and extended discourses of colonialism and acclimatization, it was nevertheless a diagnosis entirely typical of late Victorian and early Edwardian medicine. [3]

East Africa is presented here as an example because very little work has examined the emblem of the nervous European in this region.[4] This historiographical gap is in notable contrast to the scholarly attention which has been paid to the history of colonial acclimatization and to colonial psychiatry as applied to indigenous peoples.[5] When the close relationship between European residence in the tropical world and nervous illness has been examined, it has either considered the phenomenon generally, or focused on examples emanating from India and the Far East.[6] Other studies have examined colonial mental health in terms of European insanity, rather than nervousness *per se*.[7]. Furthermore, the condition appears to have been particularly enduring in British East Africa, with diagnostic evidence available right through until the 1930s. The tenacious endurance of tropical neurasthenia in British East Africa therefore raises particularly interesting questions: was this a simple case of a sleepy colonial periphery lagging behind the more dynamically-engaged metropolis? This was part of the explanation,

with colonial doctors—especially psychiatrists—often notably behind their European counterparts in their uptake of new theories, but is by no means the nub of the matter, not least as the leading psychiatrist in East Africa during this period, Henry Laing Gordon (1865–1947), sporadically engaged with relatively modern Freudian ideas. With this in mind, the second half of this paper posits that the 'tropical' in tropical neurasthenia lay in its practical utility as a management tool for colonial personnel.

To this end, a consideration of the predominantly male examples from within the colonial Service, which was the Colonial Office's personnel division via which empire was officially run, is undertaken. Colonial service policy shall be shown to have been tangibly affected by ideas about nervous breakdown in two main domains: namely, the recruitment of staff for an African posting and their management while in their East African location. Central to this argument is the way that the masculine recruit was presented and assessed as an important indicator of mental fitness for colonial duty but also in the way the diagnosis codified the behaviour of colonial servants in post. When the rhetoric of empire readjusted its attention from the management of Europeans to the management of indigenous people, however—as it did progressively from the 1930s—then, and only then, was tropical neurasthenia finally discarded as a convenient explanation for European dysfunction.[8]. By focusing on East African nervousness in such a manner, the conclusion is that it is not only the colonised subaltern that is subjectified in terms of hegemonic ideals of culture, but also that the colonisers themselves were continually at pains to avoid cultural sanctioning from *within* their own cultural milieu with regards to performative criteria such as masculinity, fortitude, and resilience.[9] That is, the colonisers were subjects of colonial bio-power.[10]

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From the outset it is important to stress that both neurasthenia and tropical neurasthenia were constantly moving targets within the history of psychiatry.[11] As has been convincingly argued elsewhere, neurasthenia was more a 'mob of incoherent symptoms' than a specifically defined disorder.[12] In fact, so constantly (and inconsistently) was the phenomenon redefined, that the only regular assumption

about the diagnosis appears to have been that it was a somatic nervous condition, although of indeterminate causation and kind. With this in mind, this paper accepts definitions of 'nerves' and 'nervousness' as part of the general neurasthenic discourses and makes no distinction between the general (tropical nerves) and the specific (tropical neurasthenia) diagnoses, believing the two to be irreducibly related and imprecisely distinguishable.

Lastly, it is worth emphasising that this re-introduction of the metropolitan elements into what has hitherto been recounted as a purely colonial story, is far from saying that there were no distinguishing features between tropical neurasthenia and neurasthenia. The similarities between the domestic and the colonial conceptions of nervous disorders are highlighted throughout this paper although it is accepted that the tropical variants embodied slightly—yet significantly—different nuances, ones which particularly stressed the excessive heat and sunlight and cast the problem as, if not exactly a badge of honour, certainly (even) less stigmatising that its home-grown equivalent.[13] Despite the threat to manly reputation that a nervous diagnosis could point towards (and all that this symbolised in terms of the presentation of colonial hegemonic power[14]), it nevertheless provided a expedient means of categorising European neuroses at a safe critical distance from indigenous mental health problems.

British Nervousness

To reintroduce the British context into the evolution and application of neurasthenic ideas in the colonies, it should be remembered that b y the end of the nineteenth century, a diagnosis of nervousness was widely accepted as well-founded and appropriate within the home context. Although the language of melancholia had been existent since Hippocratic times, it was particularly since George Cheyne's mid-eighteenth century articulation of the nervous manifestations of the privileged classes that the vocabulary of the nerves became a regular part of every doctors' diagnostic compendium.[15] Different variants of nervousness waxed and waned in fashion but the heyday of the nervous diagnosis

was heralded with the American George Beard's articulation of neurasthenia in the 1860s which lasted until around the end of the First World War.[16]

In Britain during this period neurasthenia was not diagnosed for all nervous problems, but it was frequently used as an explanatory model for a "heterogeneous mass of symptoms."[17] It was, as Professor Clifford Allbutt pointed out in 1895, the "fashionable fad of the day,", a fashion so strong that the cynical Allbutt even suggested "what was the 'liver' fifty years ago has become 'nerves' to-day."[18] Precisely because it was difficult to define, professional opinion differed over neurasthenia's aetiology and symptoms, although two dominant associations remained entrenched throughout its lifespan. First, it was generally agreed to be a problem related to the stresses of modern life as opposed to 'real' insanity, and second, it was foremost considered as somatic in both symptoms and origin.[19] The co-joining factor around which both of these central premises were organised accepted the centrality of modern civilisation as the major determinant. Ideas of civilisation were also central to the tropical variant, but, as shall be later discussed, in ways that had to expediently account for the lack of civilisation as an exacerbating factor in the tropical locale.

Neurasthenia, as described by Beard in the 1860s and imported to the United Kingdom in the 1880s, was a disease of modern life.[20] Beard's original 'American nervousness' explicated white middle-class breakdown to the accelerated stresses of an increasingly industrialised and mechanised urban life caused by the "whirl of the railway, the pelting of telegrams, the strife of business, the hunger for riches, the lust of vulgar minds for coarse and instant pleasures."[21] Women had their own form of the problem, resultant from the over-stimulation of their mental faculties through the greater educational and social opportunities which modernity had afforded them.[22] Neurasthenic manifestations were rooted within the body, entirely in accord with contemporaneous ideas about the way nerves acted and the influence they were liable to have upon specific motor activities and therefore wider bodily functions.[23] The varied symptoms included: fatigue, ennui, listlessness, hypochondria, depression, headache, backache, stomach-ache, irritability, loss of appetite, constipation (or diarrhoea), insomnia (or excessive sleep),

poor eyesight or auditory disturbances (such as ringing in the ears), cardio-vascular malfunctions (such as palpitations) and sexual symptoms (ranging from spermatorrhoea to impotence). Although not the focus of this paper, women often additionally experienced disturbed menstrual or uterine irritability. Because of the broad-range of possible symptoms, "confessedly few" of which were regarded as objective, neurasthenia was widely acknowledged as notoriously hard to diagnose: it could be both anything and nothing. [24]

The precise causes of neurasthenia were also the subject of some debates, although medical opinion agreed that it was attributable to "a combination of hereditary predisposition and nerve strain."[25] Roughly speaking this categorised neurasthenia in two broad ways, either congenital (primary neurasthenia) or in terms of a person's inappropriate response to the stresses of the external environment (secondary or acquired neurasthenia). Despite these two explanations seemingly being rather at odds with each other, a recognised link was forged between the two types as it was also thought that those who were predisposed to neurasthenia through poor heredity generally needed some external trigger to cause the onset of their neurasthenic condition.[26] These triggers could vary, but typically included overwork, excessive consumption of alcohol, sexual excesses and the disturbing after-effects of disease (especially syphilis), concussion or surgery. Although these triggers were more likely to detrimentally affect a person with a congenital predisposition, they also could affect people with no family history.[27] The primary neurasthenic had an tendency towards the illness because of their inherent "biological weakness," which could be triggered by any variety of things ranging from "the mere burden of life, the worries and frets the great griefs and responsibilities, the dull routine, the lack of ability to get interested in the game of life, and, on the other hand, playing the game too hard."[28] After world war one, particularly fuelled by experiences of shell-shock, trauma also became accepted as a potential cause for the development of acquired neurasthenia.[29]

Although from the beginning of the twentieth century neurology and psychiatry were increasingly differentiated, the history of neurasthenia does not easily fit with this classic model of the development

of modern psychological medicine into either neurological or psychiatric schools, as physicians from both disciplines continued up to the 1930s to contribute to debates over neurasthenia's aetiology, symptoms and cure. Neurasthenia was a socially talked about problem as well as a medical specialism, with many non-nervous specialists also contributing to the debates.[30]There were a few dissenters to these corporal explanations (notably, Thomas Horder lectured in 1903 that "the real defect is a mental one"[31]) but, in the main, the dominant explanation centred, as Beard's had originally, upon stresses upon the central nervous system, specifically the "persistent weakness and irritability of nerve centres due to chronic overuse of neurones."[32] By the 1930s in Britain (earlier in continental Europe), nervousness became almost wholly re-categorised as a psychological problem.

As opposed to real insanity, neurasthenia was rarely psychotic, although some small proportion of neurasthenics did later become insane. Also, unlike full-blown madness, neurasthenia was thought remediable, even if, as a rule, congenital neurasthenia was more difficult to cure.[33] Although not exactly a positive diagnosis, neurasthenia nevertheless meant that sufferers could live without institutional confinement. People were afflicted with different degrees of severity, with some plagued with it throughout their lives and others recovering in a matter of weeks. As a psycho-somatic problem that carried less stigma than lunacy, the prognosis for sufferers tended to be good, so much so that one general medical text assured its readers that "[m]uch of the world's work has been done by invalids, many of them congenital neurasthenics."[34] As neurasthenia was thought to be caused by excessive nervous expenditure, it was recommended that reserves of nervous energy be gradually reclaimed (or, at least, retained) by "food, fresh air, exercise and happiness," and sufferers were advised to manage their nervous expenditure through maintenance of a "a cool temper and rhythmical work."[35] The most severe cases were usually recommended versions of the fashionable rest cure devised by American neurologist Silas Weir Mitchell, which included isolation, nourishing food (particularly a milk diet) warm baths, the use of therapeutic massage and, when appropriate, mild electric therapy. Light exercise was generally thought to be important, as were quiet and calm surroundings, plain food and regular bowel movements.[36] All stimulants such as coffee, tea, drugs and alcohol were strictly forbidden. Drug

therapy had little part to play, although some physicians used light bromides to combat chronic insomnia, tonics or arsenic for gastric pains, or cannabis to reintroduce wholesome feelings of "*bien-être.*"[37]

Contemporary understandings of neurasthenia were closely bound with broader ideas of class, race and gender.[38] Most important were the social anxieties, which the diagnosis revealed in terms of the maintenance of valued social standards, particularly those of manly fortitude and racial strength. Although these associations were magnified in the colonial context, they were not unique to it and were in line with the original neurasthenic discourses in Europe and America.[39] Neurasthenia made particular comment upon ideals of proper manliness. It was regarded as a worrying tell-tale early sign of neurasthenic onset, for example, if pubescent boys seemed to "cease to take pleasure in active muscular play."[40] The association between the neurasthenic condition and excessive masturbation or homosexuality (a connection which was hotly debated), was also a means of reiterating the ill effects of insufficient or broken manhood. Interestingly a man was only deemed fully recovered when he had managed re-build the physical strength of muscles which had "unduly wasted" through the disease.[41] With these durable associations, neurasthenia should also be understood as a constituent part of general anxieties about degeneration that dominated aspects of European medicine from the mid-nineteenth century (to which this paper will later turn).[42]

Similarly ideas of neurasthenia reinforced racial anxieties. Even in the original American context there was an overtly racial component to the diagnosis. As a white, middle and upper class disease, African-Americans were thought only to suffer from the problem as a result of miscegenation.[43] Indeed, the essential preoccupation with the hereditary component of neurasthenia has been convincingly argued as emblematic of discussions over the fitness of the British race, ideas of predisposition towards certain medical conditions, contemporary ideas of degeneration, and thereafter ideas of eugenics.[44] While a whole thesis could be written on the emergence of the neurological body and its racial connotations, it is only necessary to acknowledge here the importance of neurasthenia as a constituent part of this

history—creating an intellectual environment which was theoretically predisposed to accepting certain explanatory models. Indeed, it could be argued that neurasthenia's home-grown preoccupations with ideas about white masculinity and racial robustness made it ripe for export to the colonial setting.[45]

Tropical Nervousness

The main difference between the tropical and non-tropical formulations of nervousness was the way the tropical variant neatly dovetailed with entrenched beliefs about European acclimatization. The long association between exotic climates and the mental and physical breakdown of Europeans who were lengthily exposed to them meant that climatic contributions to neurasthenic breakdown were easily subsumed, and further stressed, in the colonial context. Although the importance of acclimatization in moulding tropical neurasthenic ideas cannot be disputed, this was only part of the reason why nervousness in the tropics became such a popular diagnosis. Two, mutually reinforcing explanatory models were at work in the formation of the tropical model—on one hand, the language of environmental determinism which provided an easily-understandable idiom for European breakdown; while on the other hand, the imported neurasthenic conceptions further medicalised and sanctioned these same ideas and placed them within contemporary somatic understandings of nerves and their origins. Although intertwined, a subtle distinction in the two historical trajectories can be seen to emerge and converge—namely the dual mapping of the (climatically determined) tender frame of man[46] and that of the (medically understood) neurasthenic body. While the first climatic association has been acknowledged by historians such as Dane Kennedy and Warwick Anderson, the importance of the original clinical context in which neurasthenia gained momentum has been rather downplayed in comparison.[47]

Since the earliest foreign settlements debates existed over the suitability for Europeans to live in foreign climes, especially those with extreme temperatures, unfamiliar physical geographies and foreign diseases, such as Africa.[48] By the final decade of the nineteenth century, however, the acquisition of a large number of African territories made the health conquest of the tropics all the more pressing and

correspondingly, debates filled the medical press over the white man's prospects for long term settlement abroad. Often advances made within tropical medicine were cited as a sign that the tropics could be managed without deleterious medical consequences.[49] Interestingly, despite this optimism, modern medical theory was not able to entirely allay fears over the way the climate may detrimentally interfere with the central nervous system of the European. One guide book to tropical Africa advised that the European would "naturally out of his element" in the heat, so should be prepared to experience "alternate excitation and depression" of function of the nervous system when abroad.[50] As late as the 1930s cautiousness can be seen in medical writing towards hot and foreign places, commonly manifested in a particular need to protect white women and children, but also weaker male constitutions, from what was effectively seen as racial deterioration.[51] In East Africa, this discourse was especially enduring and was regularly debated within the pages of the main medical journal of the region, the *East African Medical Journal*, right up until the commencement of the second world war.[52]

A climatic discourse about place and illness was therefore well-established in the British mentality by 1905, when American doctor Major Charles Woodruff published his formal medical description of neurasthenia specific to hot places.[53] This was originally developed as an explanation for the neurasthenic symptoms experienced by American colonisers in the Philippines, which they had occupied in 1898. The term soon made its way over the Atlantic, however, where it was enthusiastically taken up as an extension of already existent debates about the suitability of the tropics for white settlement—so much so that by 1913 it formed the topic of the Presidential address at the annual meeting of the Society of Tropical Medicine and Hygiene.[54] On close analysis, however, the 'tropical' prefix actually seemed to signify very little different from existing definitions of neurasthenia. Indeed an early American description of the problem actually acknowledged that 'tropical' was more a signifier of "a sense of locality" rather than a means "to characterize any special type of neurasthenia."[55] Symptoms were identical to those characteristic of neurasthenia in the home context and the aetiology also relied on the conventional explanatory models of nerve damage, centring upon problems resultant of the depletion of vital energies and hereditary predisposition. In the most part variations between the

colonial and the home model of neurasthenia were in emphasis rather than kind. The only obvious exception to this was the controversial role of (chemically understood) actinic waves of light in tropical nerve damage, which naturally did not occur in home discussions of the problem.[56] But this too was not as distinct as some contemporary commentators might have its reading audience assume. [57] Even if there was no discussion of actinic waves *per se* in the home context there was certainly a close connection already made between the ill effects of excessive heat and light, on which actinic wave theory intimately relied. Although Beard had played down any specific association between hot climates and neurasthenia,[58] he did concede that "sunstroke may, and very often does, bring on many symptoms of neurasthenia in a person previously well."[59] Notably, many other professional discourses explicitly acknowledged the influence climate had on neurasthenia, indicating that the tropical neurasthenic model, with its dominating focus on the heat and light of the sun as the key trigger for an already present pre-disposition, was in entirely in accord with its parent model. [60] Furthermore, the progress of the disease followed the same fundamental path; with over "expenditure of nervous energy" always at the root of the problem.[61]

Similarities did not stop there, however. As has been already touched upon, the racial, class and gender biases of neurasthenia were also present in the tropical form. Just as in the home context, tropical neurasthenia offered a respectable label for symptoms for the listless or deviant behaviours of middle and upper class white men and, just as at home, it was a diagnosis which considerable social and cultural usefulness.[62] The chief difference in socio-political utility however was the way the tropical neurasthenia was used as a diagnostic marker of white civility, as opposed to black madness. The importance of tropical neurasthenia as a tool for racial differentiation has been well-covered by historians, but above and beyond the implications tropical neurasthenia held for justifying ideas of white superiority and colonial interventionism, were they way neurasthenic worries also neatly dovetailed with the strong concurrent discourse about degeneration, occurring both in America and Europe. Indeed, this link was quite explicit in contemporary commentaries on neurasthenia, with even Woodruff, the founding father of tropical neurasthenia, having published on degeneration. Many other

medical commentators also unambiguously linked fashionable degenerationist fears with concerns over the colonial white man's delicate nerves.[63] Particularly much was made over the fate of the European nervous system over successive generations with worries that it might deteriorate "if not in the first[,]certainly in the second or subsequent generations."[64] Interestingly, however, although the fate of the nation—articulated through concerns over racial degeneration—was especially urgent in the colonial setting, the link was by no means unique to the colonial construction of neurasthenia and was already a recurrent theme within many published discussions about the home-situated condition.[65]

Another difference between tropical and non-tropical neurasthenia was its relationship to the pressures of modern life. Whereas classic neurasthenia was constructed as a reaction to the pressures of modernity, these causes were not easily applicable to the tropical colonies, where Europeans had been removed from western industrialisation and civilised progress. Here the adaptation of the neurasthenic idea to the colonial space is particularly interesting. Just like at home, neurasthenia was a marker of respectability, but different from the home context, it was said to have been brought on by *separation* from civilised life and modernity, rather than *overexposure* to it. The typical colonial officer, posted in a remote outstation, was thought of as particularly susceptible:

> He is exiled from home; often separated from his family; generally unable to make ends meet for some reason or other; suffering, in many cases, loneliness and lack of congenial society; envious of others; disappointed over promotion; with ambition thwarted. Living amidst a native population causes him annoyance at every turn...[66]

New officers to East Africa were warned accordingly that most staff were "employed in the areas inhabited by natives, and cannot expect to be stationed in the areas covered by European settlement."[67] Neurasthenia became reconfigured in its tropical location to take account of this isolation, while at the same time reasserting the inherent superiority of its imperialist sufferers, who were frequently characterised as having been somehow driven to neurasthenia through the "excessive irritation" which

dealing with Africans stimulated.[68] Advice on its avoidance typically centred on maintaining civilised standards and intellectual pursuits typical of one's home milieu, for example, attending lectures, concerts, theatre and debates as often as was practically possible.[69]

The implications of this view for the recruitment and retention of good European personnel were immense and are neatly encapsulated by Morden Carthew's psychological classification of European "wanderers" into the tropics, susceptible to tropical breakdown and mental irritability in different degrees (in descending order of severity):

> (1) *The Adventurer*, who constitutes the majority, goes to the Tropics to better his condition. He works hard and often develops nervous symptoms after a few years. He has to retire comparatively young
> (2) *The Missioner*. He brings all his social instincts and customs into play to force his antagonistic instincts into altruistic channels, in this way relieving the pressure of mental conflict with alien peoples and environment. For this reason he suffers from minor and major psychoneurosis much less than the European or the Adventurer type.
> (3) *The Beachcomber*. This type is composed of men, usually of the lower classes, of weak moral and mental character and of little will power. He will live a contented life with natives, often adopting their customs. He will seldom develop neurasthenic symptoms.[70]

Notably, although Carthew was a convinced psychologist, who preferred to think of tropical neurasthenics as sufferers of psychoneuroses, the assumptions over the most susceptible type of "wanderer" are applicable to older neurasthenic assumptions that members of the higher classes had a particular predilection towards nervousness. Presuming that the colonial servant was in the first group ('The Adventurer'), his high-education, industry and, by implication civility, were precisely the traits which made him more susceptible to tropical neurasthenia, while the less-educated "Beachcomber," happy in native company, was found rarely susceptible.[71]

Aside from the intense heat and separation from civilisation, two further differences between tropical and non-tropical neurasthenia also deserve mention. The first was connected to fears of degeneration and centred upon the belief that tropical neurasthenia was a particularly dangerous risk for European children resident in the tropics.[72] As has been pointed out by Dane Kennedy, this association was not so pronounced in American and European constructions of neurasthenia, where it was predominantly seen as a disease of adults.[73] Second, was the common belief that tropical neurasthenia responded "more readily to treatment than ordinary neurasthenia."[74] Undoubtedly, this more optimistic prognosis was entwined with earlier ideas of acclimatization and the belief that people's physiological equilibrium would be restored once they returned to their home soil. Yet, even though physical displacement was thought to be the most successful cure, the other general treatments proffered for tropical neurasthenia—such as changing the sufferers manner of living, recommending rest, recuperation, good sleep, diet and avoidance of drugs and alcohol—completely corresponded to the treatments of other relations between soma and psyche that had become well-established in European psychiatric discourses since the latter half of the nineteenth century.

It is surprising that more has not been made of home ideas in fuelling the tropical variant: although the debts to Beard and Woodruff have been acknowledged in most secondary writing on the subject, analysis in the main has assumed the tropical model as evolving independently from home medical traditions, or at least has made little comment upon the fashionable appeal of the home context.[75] To be sure, the tropical diagnosis was an expedient means of furthering the colonial political agenda and allaying colonial racial anxieties, but even these wider social and cultural diagnostic functions o did not significantly differ from the functions of the neurasthenic diagnosis back home. This is not to deny that the colonial variant any self-determining dynamic relating to the specifics of its location (for example, its propensity to affect children or its comparative curability), but rather to acknowledge the looping effects of medical knowledge with regards to neurasthenia. Belief in neurasthenia in the home context

fostered its acceptance in the tropical one, which in turn allowed it over time to evolve its own regionally-based permutations.

The close link between the tropical neurasthenic formulation and the metropolitan model of neurasthenia is unsurprising given that doctors working in the colonies were all trained within the British tradition before their posting abroad. In East Africa, the majority of the doctors involved in the categorization of European illnesses were trained in Edinburgh or London,[76] both of which included lectures on mental diseases as part of their general medical training even before the 1920 introduction of the Diploma in Psychological Medicine to formal British psychiatric instruction.[77] As such, although only a few psychiatric specialists in the contemporary London sense existed in East Africa, there were certainly people with educational experience of mental illness in the Colonial Medical Service in East Africa. Medical writing emanating from British East Africa during this period, however, indicates that most doctors working in government service noticeably lagged behind the changing psychiatric fashions of the 1920s and 1930s, frequently still publishing on acclimatization and theories of neurasthenic breakdown relating to place.[78] This was partly because the Colonial Medical Service favoured slightly older doctors in its recruitment policies, particularly those with a few years clinical experience, rather than young graduates straight out of medical school. This age profile, along with the practicalities of working in a remote location, could go at least part way to explaining why the majority of government doctors appeared to have ignored the escalating calls by eminent medical authorities to abandon the dated idea of topographically-based neurasthenia in favour of psychological explanations situated in theories of self and society.[79]

But this demographic profile does not in itself seem sufficient to explain the endurance of tropical neurasthenia and the lack of fulsome engagement with psychoanalysis in the region before 1939. Part of this epistemological backwardness was also due to the peculiar (under) development of psychiatry in the region which was dominated at this time by one eccentric individual, Henry Laing Gordon.[80] Gordon, trained as a neurologist in Edinburgh during the 1880s, was a shameless self-publicist and

tireless campaigner for his own research agenda and it is exactly his dominance which helps explain the lack of systematic interest in remodelling tropical neurasthenia in accordance with metropolitan clinical trends.[81] Indeed, Gordon seems to have indiscriminately deployed psychiatric theories to best suit his argument. On one hand, he was a hard-core biological determinist, claiming that Africans had smaller brain size and capacity than Caucasians, while on the other hand Gordon was open to Freudian ideas of neurosis located in the faulty reactions of the sufferer.[82] This scatter gun approach to psychiatric theory indicates that Gordon was less interested in clearly defining and extending the theoretical underpinnings of his research as he was in promoting his eugenicist interests and position in Kenyan society. [83]

If tropical neurasthenia is to be understood as part of metropolitan clinical understandings of classic neurasthenia, its endurance in the colonial context must surely be explained, not only in terms of enduring colonial preoccupations about acclimatization but also, in terms of the state of psychiatric knowledge in the East African colonies. On one hand, it is unsurprising that the British doctors accepted definitions fashionable during their training, but equally, the older demographic of Colonial Service employees and the almost total dominance of psychiatry by the elderly and didactic Gordon also help explain the comparative endurance of the concept and local resistance to newer interpretations. But this alone is not wholly acceptable as an explanation and other macro factors were at play in the retention of the concept. The final section of this paper posits that the main reason why tropical neurasthenia remained a distinct colonial condition was because it had a largely unacknowledged practical (as well as it acknowledged cultural) usefulness.[84]

Nervousness in the Management of Empire

Time and again tropical neurasthenia was used as a means of regulating the behaviours of whites in the tropics and thus worryingly outside the usual home mechanisms of social control (such as social opprobrium, moral outrage, cultural prejudices as well as psychiatric diagnoses). In Foucauldian terms, tropical neurasthenia can therefore be understood as a means of both state-regulation and self-

regulation, producing behaviours in colonial Europeans. Fears of tropical neurasthenia guided the recruitment of personnel to the East African Empire, helped colonial governments to weed out unsuitable characters, and gave colonials themselves a respectable exit route from colonial life.

Given the undesirability of the nervous Briton representing King and country, the neurasthenic or nervous type was to be avoided when recruiting colonial personnel. Throughout this period, selection to the colonial service was conducted in London at the Colonial Office and, distinct from other Empire services which recruited via competitive examination (such as the Indian the Sudanese Civil Services), successful entrance to the African-based career was predicated upon fulfilling four main requirements: namely, having the necessary qualifications (usually a university degree); fitting the age, nationality and gender requirements of the post; succeeding in interview; and passing the pre-requisite medical examination. The large subjective element of this recruitment process meant that notions of proper character and fitness to rule had a particularly large part to play in the way candidates were chosen.[85] As character (albeit often indicated through physical symptoms) was the core issue at stake in the formulation of the neurasthenic diagnosis, it is unsurprising that ideas of the inappropriate type argued for during the recruitment process closely mirrored images of the neurasthenic patient.

This preference to weed out neurasthenics, or potential neurasthenics, during the selection procedure was explicitly stated within the medical literature, which stressed the political benefits of "correct selection of the men allowed to proceed to tropical countries."[86] The director of colonial service recruitment between 1910 and 1948, Ralph Furse, particularly rigorously applied these medico-social ideals when selecting candidates for service abroad: "The fundamental qualification" for colonial officials he said was "*mens sana in corpore sano*. He must, if possible, not only start fit, but be kept fit; in mind, nerves and body."[87] The concentration upon sound nerves as a marker of good character is significant. Nervous conditions were thought to be revealed through physical symptoms, so for this reason, much rode on first impressions when a candidate went for interview. Furse"s own description

of what to look for at an interview is revealing of this accepted link between physical signs and a neurasthenic temperament:

> Interviewing boards normally sit on one side of a table with their victim on the other. By so doing they often miss significant details. For instance, a man's face may not reveal that he is intensely nervous. But a twitching foot, or hands tightly clenched under the table, will tell you this, and you can make the necessary allowances or deductions, which are often important.[88]

Even as late as 1948 the confidential *Appointments Handbook* (made up of Furse's recommendations, compiled by his deputy) reminded interviewers that body language was all-important: "You will have in mind the truism that weakness of various kinds may lurk in a flabby lip or in averted eyes, just as single mindedness and purpose are commonly reflected in a steady gaze and a firm set of mouth and jaw."[89] Throughout, there was a convergence between ideas of character and good health and the two were linked within the Colonial Office mind as much as they were in popular understandings of neurasthenia. If the prime characteristic of the neurasthenic was ennui, then it is notable that it was precisely the opposite—energy—which the Colonial Office advertised as "most essential" for successful service entrants.[90]

Aside from the subjective impressions formed during interview, nervous conditions had to be ruled out at the formal medical examination which all candidates had to undergo before their appointments were confirmed. Colonial Office recruitment literature explicitly stated that "no appointment will be made unless the candidate is declared to be physically fit for service in East Africa."[91] "With a sound mind in a sound body, at the start, there should then be fine prospect in front of the new entrant."[92] Correspondingly, it was stated that: "[t]hose subject to fits of depression, violent temper, nervous and unbalanced types are unsuitable for the tropics."[93]

> Capacity for "nerve strain," the possession of a placid temperament, coupled with common sense, and good self-control, should be essentials in those desiring to live and work abroad. When there is a decided taint of mental instability in the family history, or where the individual possesses an excitable "highly nervous" temperament, advice should be adverse to their leaving the cooler climates.[94]

The task of medically assessing a candidate's state of mind, although described as the "crux" of recruitment, was nevertheless accepted as being an extremely difficult one.[95] Tellingly, the form candidates had to complete for their physical examination for entry into the Colonial Service asked whether they had suffered from any nervous complaint or if there was a history of insanity in their family.[96] These questions not only suggested a congenital understanding of mental disease within the Colonial Office, but also a conception of it that fundamentally accepted that the perceived stresses of residence in a tropical climate were more likely to draw out latent undesirable psychological traits. This understanding was also in accord with specialised medical recommendations over the best 'type' of colonial recruit:

> The best kind of man to go to the tropics is the good ordinary type of Britisher [*sic*], with a clear head 'well screwed on', an even temper, not over intellectual; one who can take an interest in things around, not unduly introspective, not ever sighing for the flesh-pots of Piccadilly…The unsuitable man is he who is a victim of migraine, headaches, any hereditary mental taint, or epilepsy; who bears heat ill, or suffers from insomnia, or is neurotic in any way.[97]

Similarly, candidates were rejected from the Colonial Service if they had speech impediments on the grounds that "a disability of this kind arising from some nervous disorder is sometimes liable to become worse in the tropics."[98] Indeed, correct medical assessment of recruits was frequently reiterated as one of the most important tasks within recruitment:"[t]ime will always show, but it is important to

make the correct diagnosis early and not late, and therefore it is important to learn the patient's personal and family history."[99] Interestingly, this check of susceptibility via character enquiries was considered so imperative that the medical examination was in fact a second check on mental health, the first having been carried out when referees were called. Notably, the referee testimonial form explicitly asked referees to comment upon the potential entrant's mental stability. It is clear that the Colonial Office was much concerned with nervousness in the way it recruited candidates, which makes it rather less surprising that the language remained when managing the 'deviant' behaviours of colonial civil servants in post.

Unfortunately not all with a susceptibility to neurasthenia were weeded out during selection, as is evidenced by the fact that throughout the pre-World War Two period many missionaries, colonial staff and settlers were repatriated because of it. Indeed, in 1913, the *British Medical Journal* claimed that just over twenty per cent of medically repatriated missionaries and soldiers from Africa were neurasthenic, thus naming it as the single most important explanation for invaliding from the continent.[100] Other estimates related more directly to Colonial Service staff, with Robert Van Someren, an East African medical officer, stating neurasthenia as responsible for "many, if not most, of the cases of invaliding" he came across during his twenty years service in Uganda.[101] Another estimate, for both government and missionary staff found that invaliding rates from neurasthenia were "three times as high" as that for men in government service at home.[102] Even as late as 1935 "nervous diseases" were claimed to be the fourth most prevalent disease for Europeans to succumb to in East Africa.[103] Time and time again "the importance of avoiding nerves" was cited as the central factor in the selection of the right sort of Colonial Service candidate and neurasthenic invalidings were listed in the colonial medical reports until the 1930s.[104] In accord with this, the Colonial Office stipulated in their own guidelines for employment as late as 1939 that the climate in East Africa was "liable to produce nervous manifestations after lengthy residence."[105]

One of the reasons why the Colonial Service was so concerned with the tropical neurasthenic diagnosis was because neurasthenic employees would be an extra financial burden on the government, through their decreased capacity for work. This concern was so pressing that the *Regulations for His Majesty's Colonial Service* explicitly stipulated the need for officers to dispatch their duties in a competent and proficient manner—something which an onset of neurasthenia would not allow them to do.[106] The erosive influence of the heat was accepted and correspondingly tours of service for East Africa were set at "of not less than 20 and not usually more than 30 months," although this was universally bemoaned as still too long and was thought of as not only damaging for European nervous health, but also too isolating from the civilising influences of European society.[107] The Governor of Uganda, Philip Mitchell, thought the regular tour should be halved, as the tropical climate "has a deteriorating affect on mental efficiency."[108] Furse described the worrying results of keeping an officer in a posting too long without leave: "[t]owards the end of a normal long tour too many of the officers I met were, through no fault of their own, mentally tired and not pulling their weight. They were merely 'ticking over', a source of frustration to fresher colleagues, and not least to their juniors. Also they had dropped out of touch with home atmosphere and opinion," which was thought to lead to ennui or mental lethargy.[109] Consequently, one of the remedies proposed for the successful acclimatization of Europeans in British East Africa was to introduce periods of short leave to interrupt their long tours of service.[110] This was supported by medical experts who declared frequent home visits as "essential" if colonial Europeans were to "maintain mental vigour and physical energy at its highest pitch."[111]

The colonies were a showcase for Britishness—"The ability, the energy, the industry, and the probity of the British race naturally and obviously have their reflex in the British Civil Service"[112] and in that overtly celebratory sense one of the foremost aims of the Colonial Service was to effectively remove liabilities.[113] Any Colonial servant who wanted a leave of absence for medical reasons had to obtain a medical certificate from the local Medical Officer and then have this signed by the Governor, although he also had the ultimate right to dismiss or transfer anyone without referral, if they seemed an immediate burden on the bureaucracy.[114] Thus tropical nervous diagnoses were used as a means of

policing the colonisers and trying to control and homogenise behaviours to a model of acceptability. Tropical neurasthenia explained all sorts of aberrant behaviours, from "sudden acts of violence" to "acts of criminal folly."[115] It was even declared the reason behind "certain regrettable incidents between natives and Europeans," and thus should be understood (at least in part) as a useful category to describe and police the acceptable and the unacceptable within colonial behaviour.[116] Suggested solutions included taking up both a hobby and a (European) wife in the remote colonial location to distract the mind and make sure that some civilised home comforts still existed in remote outposts.[117]

Yet, despite the threat to manliness and colonial authority which the diagnosis pointed towards tropical neurasthenia was still crucially a relatively socially acceptable diagnosis, that did not contain the negative connotations of real insanity and displaced the blame for the problem away from the sufferer themselves and onto the environment. It was a means of stressing white civility, by constructing the work of Empire (and by implication trying to rule and administer Africans) as particularly stressful, "harassing in nature" and entailing "much mental effort."[118]

Conclusion

The central question posed within this paper was one asked at the time: "[w]hat is 'tropical neurasthenia,' and does it differ in any particular from neurasthenia observed in temperate climates?"[119] Over time, this problematic seems to have faded out of colonial histories, with the tropical neurasthenic story being primarily retold as a problem specific to Empire, an extension of concerns over acclimatization and indicative of the strains integral to the imperialist project. These were pertinent contextual readings, but did not sufficiently acknowledge the links between tropical neurasthenia and the earlier popularity of neurasthenia within the home disciplines of neurology and psychiatry. Neither did these readings acknowledge tropical neurasthenia as part of concurrent debates about degeneration and pressing pan-European anxieties about the maintenance of national strength and racial purity. It does not seem likely that the existent belief in climatically located illnesses combined with the heightened racial prejudices of the colonial context were alone enough to explain why tropical

neurasthenia should endure well beyond the demise of neurasthenia at home; although these explanations do go part way to untangling the problem. This paper has suggested another interpretive strand in locating the socio-political usefulness of tropical neurasthenia: its utility as a management tool of Empire staff; both in terms of defining (including self-defining) the expectations of personnel and eliminating those perceived as problematic.[120] Although the Colonial Service has been the focus of this paper, the practical, useful and acceptable category of tropical neurasthenia was extended to other groups working in Empire, such as missionaries or company officials—groups which were also recruited and directed from London.[121] In such a light, tropical neurasthenia was a means of controlling British behaviour in the colonial context, in a way palatable to *not only* British sensibilities and cultural prejudices but *also* contemporary understandings of nervous ill health. This paper does not deny the hegemony of British colonialism; rather it stresses both the macro-social and individual levels in which British colonials negotiated their own place in their own culture(s) in an exotic location.[122] The things which the topical nervous diagnosis offered—for example, the further substantiation of ideas of manly fortitude and racial strength—actually regulated and delineated European behaviour, customs and ultimately health. In other words the diagnosis provides an example of the ways elements of white colonial society were described, constrained and othered by the colonial regime.

In drawing out the convergences and divergences between local and metropolitan conceptions of nervousness, it is hoped that this paper has re-situated the tropical diagnosis within it's a larger contextual framework. As Europeans were the patients and specialists who utilised the tropical neurasthenic diagnostic, colonial psychiatry can only really be properly understood as a hybrid shaped not only by the locality in which it was situated but also in the broader intellectual and cultural environment in which it was originally conceived.[123] One of the key reasons for the retention of the model in East Africa was because—as a little corner of civilization in an otherwise foreign field—tropical neurasthenia was an entirely rational means of filtering, regulating and managing the behaviour of British colonial personnel.

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[1] Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in the Philippines*, Duke University Press, 2006; Dane Kennedy, *Islands of White: Settler Society and Culture in Kenya and Southern Rhodesia*, 1890–1939, Durham, Duke

University Press, 1987, pp.109–27;, Dane Kennedy, 'Diagnosing the Colonial Dilemma: Tropical Neurasthenia and the Alienated Briton', in Dane Kennedy and Durba Ghosh, *Decentering Empire: Britain, India, and the Transcolonial World,* Hyderabad, Orient Longman, 2006, pp.157-81

[2] Although there are numerous works on neurasthenia in America, Britain and Continental Europe. E.g., Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia: from George Beard to the First World War*, Amsterdam and Atlanta, Rodopi, 2001; Tom Lutz, *American Nervousness, 1903, An Anecdotal History*, New York, Cornell University Press, 1991; Janet Oppenheim, *Shattered Nerves: Doctors, Patients and Depression in Victorian England*, Oxford University Press, 1991

[3] Anderson has argued that it was the widespread adoption of Freudian models of neurosis which eventually took the 'tropical' out of the neurasthenic diagnosis and made it instead a problem of self rather than of place. Although this is persuasive, it by implication rather minimises the importance of mainstream psychiatry in moulding the way the earlier tropical version was conceived. Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in the Philippines*, Duke University Press, 2006, p.153

[4] The sole study of nervousness in Eastern Africa is within Dane Kennedy, *Islands of White: Settler Society and Culture in Kenya and Southern Rhodesia*, 1890–1939, Durham, Duke University Press, 1987, pp.109–27. See also, for a more general overview, Dane Kennedy, 'Diagnosing the Colonial Dilemma: Tropical Neurasthenia and the Alienated Briton', in Dane Kennedy and Durba Ghosh, *Decentering Empire: Britain, India, and the Transcolonial World,* Hyderabad, Orient Longman, 2006, pp.157-81. Some discussion about the role of European nervousness in constructions of the African environment can also be found in Anna Crozier, 'Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa 1890-1939,' *Journal of Imperial and Commonwealth History*, 35, 3, 2007, pp.393–415, pp.399–401

[5] Contributions to these two areas of research are extensive, examples include: (on acclimatization) Mark Harrison, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India 1600–1850*, New Delhi, Oxford University Press, 1999; Judith T Kenny, 'Climate, Race, and Imperial Authority: The Symbolic Landscape of the British Hill Station in India', *Annals of the Association of American Geographers*, 85, 1995, pp.694-714; David N Livingstone, 'Tropical Climate and Moral Hygiene, the Anatomy of a Victorian Debate', *British Journal for the History of Science*, 32, 1999, pp. 93-110; Karen Ordahl-Kupperman, 'Fear of Hot Climates in the Anglo-American Colonial Experience', *William and Mary Quarterly*, 41, 1984, pp.213–40; (on psychiatry for Africans) Sloan Mahone and Megan Vaughan (eds.), *Psychiatry and Empire*, Basingstoke, Palgrave Macmillan, 2007; Megan Vaughan, *Curing their Ills: Colonial Power and African Illness*, Cambridge, Polity Press, 1991, pp.100–28; Jock McCulloch**,** *Colonial Psychiatry and 'The African Mind*, Cambridge University Press, 1995; Jock McCulloch, 'The Theory and Practice of European Psychiatry in Colonial Africa', in Dinesh Bhugra and Roland Littlewood, (eds.), *Colonialism and Psychiatry*, New Delhi, Oxford University Press, 2001, pp.76–104; Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria*, Berkeley, University of California, 1999

[6]For Example Dane Kennedy, 'The Perils of the Midday Sun: Climatic Anxieties in the Colonial Tropics' in John M MacKenzie, (ed.), *Imperialism and the Natural World*, Manchester University Press, 1990; Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in the Philippines*, Duke University Press, 2006, pp.130-57;

[7] Waltraud Ernst, *Mad Tales from the Raj: the European Insane in British India, 1800-1858,* London, Routledge, 1991

[8] When Freud was routinely applied after the 1940s, it was usually mobilised as a means of explaining the resistant or deviant behaviours of Africans and was rarely applied to colonial Europeans. Suddenly over-exposure to civilisation (precisely the original American/European construction of neurasthenia) became the investigative point for mental instability of Africans. John Colin Carothers, *The Psychology of Mau Mau*, Nairobi, The Government Printer, 1954; Sloan Mahone 'The Psychology of Rebellion: Colonial Medical Responses to Dissent in British East Africa', *Journal of African History*, 47, 2006, pp.241-58

[9] As such, this paper takes issue with the rather hegemonic representation of colonisers offered by Homi Bhabha, *The Location of Culture*, London, Routledge, 1994

[10] To use Michel Foucault's model thus is far from saying that the way this was done was not advantageous to the British or racist to the African.

[11] Ian Hacking, 'Kinds of People: Moving Targets', The Tenth British Academy Lecture, Read 11 April 2006 at the British Academy, *Proceedings of the British Academy*,151, pp. 285–318

[12] Chandak Sengoopta, "A Mob of Incoherent Symptoms?': Neurasthenia in British Medical Discourse, 1860—1920' in Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia: from George Beard to the First World War*, Amsterdam and Atlanta, Rodopi, 2001, pp.97—115

[13] This complicated association of neurasthenia with masculinity has been explored in the context of the Philippines. Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in the Philippines*, Duke University Press, 2006, pp.130-57, which is a reworking of: Warwick Anderson, 'The Trespass Speaks: White Masculinity and Colonial Breakdown', *American Historical Review*, 102, 1997, pp.1343–70

[14] E.g. Helen Callaway, *Gender, Culture and Empire: European Women in Colonial Nigeria*, University of Illinois Press, 1987; Ronald Hyam, *Empire and Sexuality: the British Experience*, Manchester University Press, 1990

[15] George Cheyne, *The English Malady; or, A Treatise of Nervous Diseases*, London, G Strathan, 1733. See also Thomas Trotter, *A View of the Nervous Temperament*, London, Longman, Hurst, Rees and Orme, 1807. See also William F Bynum, 'The Nervous Patient in Eighteenth-and Nineteenth Century Britain: The Psychiatric Origins of British Neurology', in William F Bynum, Roy Porter and Michael Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry*, Vol.1, pp.89–102

[16] For an example of a post-psychoanalytic description of nervousness by a neurologist see Stephen Taylor, 'The Suburban Neurosis', *British Medical Journal*, i, 1938, pp.759–61. For the best survey of neurasthenia see Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia from Beard to the First World War*, Amsterdam, Rodopi, 2001

[17] Thomas J Horder, 'Neurasthenia: a Critical Enquiry', *St Bartholomew's Hospital Journal*, 1902–03, pp.67–73, p.68

[18] Clifford Allbutt, 'Nervous Diseases and Modern Life', *Contemporary Review*, 67, 1895, pp. 210–31, p.217

[19] For more on the 'somatic "essence" of neurasthenia' see Tracey Loughran, 'Hysteria and Neurasthenia in pre-1914 British Medical Discourse and in Histories of Shell-Shock', *History of Psychiatry*, 19, 2008, pp.25–46, pp.32–4 (quotation p.32)

[20] George M Beard, 'Neurasthenia, or Nervous Exhaustion'*, Boston Medical and Surgical Journal*, 80, 1869, pp.217-21; George M Beard, *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment*, New York, William Wood, 1880; George M Beard, *American Nervousness: Its Causes and Consequences*, New York, Putnam's, 1881

[21] Clifford Allbutt, 'Nervous Diseases and Modern Life', *Contemporary Review*, 67, 1895, pp. 210–31, p.214

[22] George M Beard, *American Nervousness: Its Causes and Consequences*, New York, Putnam's, 1881, p.vi; On the rise of female education see June Purvis, *A History of Women's Education*, Milton Keynes, Open University Press, 1991

[23] E.g. See JS Milne, *Neurasthenia, Shell-Shock and A New Life*, Newcastle-on-Tyne, R Robinson and Co., Ltd., 1918, p.19

[24] Thomas J Horder, 'Neurasthenia: a Critical Enquiry', *St Bartholomew's Hospital Journal*, 1902–03, pp.67–73, p.68

[25] Thomas J Horder, 'Neurasthenia: a Critical Enquiry', *St Bartholomew's Hospital Journal*, 1902–03, pp.67–73, p.68

[26] This was typical of a number of psychological 'illnesses' of the period, for example sexual perversion. See Ivan Crozier, 'Introduction' to Havelock Ellis and John Addington Symonds, *Sexual Inversion: a Critical Edition*, Basingstoke, Palgrave, 2008, pp.1-86, p.28

[27] Maurice Craig, *Nerve Exhaustion*, London, J & A Churchill, 1922, p.29–31

[28] Charles Burr, 'Neurasthenia. The Traumatic Neuroses and Psychoses' in William Osler and Thomas McCrae (eds.), *A System of Medicine*, Vol VII, London, Henry Frowde, Oxford University Press and Hodder and Stoughton, 1910, p.725

[29] Ernest S Reynolds, A British Medical Association Lecture on Hysteria and Neurasthenia', *British Medical Journal*, ii, 1923, pp.1193–95, p.1195; See also See JS Milne, *Neurasthenia, Shell-Shock and A New Life*, Newcastle-on-Tyne, R Robinson and Co., Ltd., 1918; Paul Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890-1930*, Ithaca and London, Cornell University Press, 2003; Janet Oppenheim, '*Shattered Nerves:' Doctors, Patients, and Depression in Victorian England*, New York, Oxford University Press, 1991

[30] Particularly, the history of neurasthenia fits in with a growing industry in health cures from the mid-nineteenth century that treated nervous complaints through a cornucopia of diets, exercise regimes, relaxation techniques, massages therapies, etc., all of which were outside specialist medical practices, and indeed sometimes outside certified medical practice altogether. Ernest S Reynolds, A British Medical Association Lecture on Hysteria and Neurasthenia', *British Medical Journal*, ii, 1923, pp.1193–95, p.1193

[31] Thomas J Horder, 'Neurasthenia: a Critical Enquiry', *St Bartholomew's Hospital Journal*, 1902–03, pp.67–73, p.69

[32] Beard declared that 'nothing in the disease can be imaginary'. George M Beard, *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment*, New York, William Wood, 1880, p.80. Quotation from Ernest S Reynolds, A British Medical Association Lecture on Hysteria and Neurasthenia', *British Medical Journal*, ii, 1923, pp.1193–95, p.1194

[33] Clifford Allbutt, 'A Discussion on the Relation of Neurasthenia to Insanity', *British Medical Journal*, ii, 1902, pp.1208–13

[34] Charles Burr, 'Neurasthenia. The Traumatic Neuroses and Psychoses' in William Osler and Thomas McCrae (eds.), *A System of Medicine*, Vol VII, London, Henry Frowde, Oxford University Press and Hodder and Stoughton, 1910, p.731

[35] Clifford Allbutt, 'The Gulstonian Lectures on Neuroses of the Viscera', *British Medical Journal*, i, 1884, pp. 594–99, p.598

[36] JS Milne, *Neurasthenia, Shell-Shock and A New Life*, Newcastle-on-Tyne, R Robinson and Co., Ltd., 1918, pp.21–23. See also Silas Weir Mitchell, *Wear and Tear, or Hints for the Overworked*, 5th ed., Philadelphia, Lippincott, 1887, and Silas Weir Mitchell, *Doctor and Patient*, Philadelphia, Lippincott, 1877

[37] Thomas J Horder, 'Neurasthenia: a Critical Enquiry', *St Bartholomew's Hospital Journal*, 1902–03, pp.67–73, p.70 (original italics)

[38] A Luthra and S Wessely, 'Unloading the Trunk: Neurasthenia, CFS and Race', *Social Science and Medicine*, 58, 2004, pp.2363–2369, p.2363

[39] Chris Forth, 'Neurasthenia and Manhood in Fin de Siècle France' in Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia: from George Beard to the First World War*, Amsterdam and Atlanta, Rodopi, 2001, pp.329–61

[40] Charles Burr, 'Neurasthenia. The Traumatic Neuroses and Psychoses' in William Osler and Thomas McCrae (eds.), *A System of Medicine*, Vol VII, London, Henry Frowde, Oxford University Press and Hodder and Stoughton, 1910, p.723

[41] Ernest S Reynolds, A British Medical Association Lecture on Hysteria and Neurasthenia', *British Medical Journal*, ii, 1923, pp.1193–95, p.1195

[42] Michael Neve, "The Influence of Degenerationist Categories in Nineteenth-Century Psychiatry, with Special Reference to Great Britain," in Yosio Kawakita *et al.* (eds.), *The History of Psychiatric Diagnoses*, Tokyo, Ishiyaku EuroAmerica, 1997, pp.141-63

[43] Charles Burr, 'Neurasthenia. The Traumatic Neuroses and Psychoses' in William Osler and Thomas McCrae (eds.), *A System of Medicine*, Vol VII, London, Henry Frowde, Oxford University Press and Hodder and Stoughton, 1910, p.725

[44] Tracey Loughran, 'Hysteria and Neurasthenia in pre-1914 British Medical Discourse and in Histories of Shell-Shock', *History of Psychiatry*, 19, 2008, pp.25–46, pp.37-41

[45] On this topic see Chloe Campbell's *Race and Empire: Eugenics in Colonial Kenya*, Manchester University Press, 2007

[46] Mark Harrison, ""The Tender Frame of Man": Disease, Climate, and Racial Difference in India and the West Indies, 1760-1860', *Bulletin of the History of Medicine,* 70, 1996 pp.68–93

[47] And to ignore the original clinical context would be to 'miss the distinguishing feature of medical practice.' Barbara Sicherman, 'The Uses of a Diagnosis: Doctors, Patients, and Neurasthenia', *Journal of the History of Medicine and Allied Sciences*, 32, 1977, pp.33–54, p.37. Warwick Anderson, 'The Trespass Speaks: White Masculinity and Colonial Breakdown', *American Historical Review*, 102, 1997, pp.1343–70; Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in the Philippines*, Duke University Press, 2006, pp.130-57; Dane Kennedy, *Islands of White: Settler Society and Culture in Kenya and Southern Rhodesia*, 1890–1939, Durham, Duke University Press, 1987, pp.109–27; Dane Kennedy, 'Diagnosing the Colonial Dilemma: Tropical Neurasthenia and the Alienated Briton', in Dane Kennedy and Durba Ghosh, *Decentering Empire: Britain, India, and the Transcolonial World,* Hyderabad, Orient Longman, 2006, pp.157-81

[48] Dr Teemu Ryymin has usefully pointed out that many of these tropes of mental breakdown (particularly alcoholism and sexual dysfunction) could also be seen in far-Northern, Scandinavian discourses of the same period, but applied to very cold climates. Suggesting that the problem at stake was the negotiation of unfamiliar cultural and environmental differences rather than the heat (or the cold) *per se.*

[49] Robert Felkin, 'On Acclimatisation', *Scottish Geographical Magazine*, 7, 1891, pp.647-56; Robert Felkin, 'Tropical Highlands: Their Suitability for European Settlement', *Transactions of the Seventh International Congress on Hygiene and Demography*, 10, 1892, pp.155-64; Isaac Hull Platt, 'The Problem of Acclimatisation', *Medical Times*, 15, 1885, p.677-8; Luigi Sambon, 'Remarks on the Possibility of the Acclimatisation of Europeans in Tropical Regions', *British Medical Journal*, i, 1897, pp.61–6; Luigi Sambon, 'Acclimatization of Europeans in Tropical Lands', *Geographical Journal* ,12, no. 6, 1898, pp.589-99

[50] J Murray, *How to Live in Tropical Africa: A Guide to Tropical Hygiene and Sanitation*, London, The African World, Ltd., 1912, p.40; see also W Byam and RG Archibald (eds.), *The Practice of Medicine in the Tropics by Many Authorities*, Vol I, London, Henry Frowde and Hodder and Stoughton, 1921, p.5

[51] Anon 'European Women and Children in the Tropics' [Report on a Discussion held at the Royal Society of Medicine], *British Medical Journal*, i, 1931, pp.268–9

[52] Anon 'Editorial, [Effects of the Climate on the Human Constitution], *Kenya and East African Medical Journal*, 8, 1931–2, pp.331; DV Latham, 'The White Man in East Africa' *East African Medical Journal*, 9, 1932–3, pp.276–82; Murdoch Mackinnon, 'Medical Aspects of White Settlement in Kenya', *East African Medical Journal*, 11, 1934–5, pp.376–94; A Walter, 'Climate and White Settlement in the East African Highlands', *East African Medical Journal*, 11, 1934–5, pp.210–25

[53] Charles E Woodruff, *The Effects of Tropical Light on White Men*, New York, London, Rebman Ltd., 1905

[54] R Havelock Charles, 'Neurasthenia, and its Bearings on the Decay of Northern Peoples in India', *Transactions of the Society of Tropical Medicine and Hygiene,* 7, 1913, pp.2-31

[55] WW King, 'Tropical Neurasthenia', *Journal of the American Medical Association*, 46, 20, 1906, p.1518

[56] See for example, Aldo Castellani and Albert J Chalmers, *Manual of Tropical Medicine*, London, Ballière, Tindall and Cox, 1910; JH Sequeira, 'The Influence of Light and Heat on the Human Body', *Kenya and East African Medical Journal*, 8, 1931–2, pp.332–58

[57] Louis H Fales, 'Tropical Neurasthenia and its relation to Tropical Acclimation', *American Journal of Medical Sciences*, 13, 1907, pp.582–93

[58] George M Beard, *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment*, New York, William Wood, 1880, p.189

[59] George M Beard, *A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms, Nature, Sequences, Treatment*, fifth edition, New York, Kraus Reprint Co, 1971 (first published 1880), p.93

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[92] Francis George Heath, *The British Civil Service: Home, Colonial, Indian and Diplomatic*, London, Grafton & Co., 1915, p.71

[93] Colonial Office, *Information as to the Conditions and Cost of Living in the Colonial Empire*, London, His Majesty's Stationery Office, 1937, p.162

[94] G Basil Price in 'Discussion' in R Havelock Charles, 'Neurasthenia, and its Bearings on the Decay of Northern Peoples in India', *Transactions of the Society of Tropical Medicine and Hygiene,* 7, 1913, pp.2-31, p.22

[95] Philip Manson-Bahr, 'Discussion' in Hugh Stannus, 'Tropical Neurasthenia', *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 20, 1927, pp.327-43, p.341. NB this concern was also evident in discussions of recruitment to other services, such as the Indian Civil Service. See R Havelock Charles, 'Neurasthenia, and its Bearings on the Decay of Northern Peoples in India', *Transactions of the Society of Tropical Medicine and Hygiene,* 7, 1913, pp.2-31, p.2

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[120] In other words, tropical neurasthenia made colonial servants subjects of a bio-political regime.

[121] For 'nerves' in missionary recruitment see Georgina H Endfield and David J Nash, (2005) "'Happy is the Bride the Rain Falls on": Climate, Health and "the Woman Question" in Nineteenth Century Missionary Documentation', *Transactions of the Institute of British Geographers*, 30, 2005, pp.368-86

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[123] Asking what is tropical about tropical neurasthenia provides a case study of the broader questions posed recently by Waltraud Ernst about the specifically colonial within colonial medicine. Waltraud Ernst, 'Beyond East and West. From the History of Colonial Medicine to a Social History of Medicine(s) in South Asia', *Social History of Medicine*, 20, 2007, pp. 505–24. Which expands upon Shula Marks, 'What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?', *Social History of Medicine*, 10, 1997, pp.205–19