

The Modern Age *The 'Death' of phrenitis*

One Story, Three Endings

At the turn of the twentieth century, the state of affairs in the history of clinical pathology changed in a number of ways relevant to *phrenitis*. In pathological doctrine, first of all, the more abstract positioning of a disease within a taxonomy¹ increasingly lost importance to firm localization within the body as a central feature of nosological definition and understanding. The concept of disease changed from that of a lesion that can move around the body, an idea the ancients elaborated with great sophistication – *phrenitis* is an excellent example – to a fixed *place*. In a move away from the past, ‘pathology was [now] related to a lesion located in a particular organ. In a sense, in the new system the disease was, to use Foucault’s words, “entirely exhausted in the intelligible syntax of the signifier””.²

Second, ‘somatism’, the centrality of the body as object, as *res*, triumphed in medicine generally and in psychiatry in particular.³ The equation brain = mind was now generally accepted,⁴ and the dead body provided key insights into the reality of the pathology that had overcome the patient. The *Zentrenlehre* (literally, ‘doctrine about the centres (of the brain)’), ‘phrenologic’ model of the encephalus, had played a fundamental role in shaping these directions during the course of the previous century, although its stronger version was soon disputed.⁵ In general, this ‘somatist’ progression, which does not seem to have ceased even as I write, has increasingly tended to focus on the fine grain of the living ‘matter’ – tissues,

¹ Such as those mentioned in Chapter 9 (pp. 339–40).

² Guenther (2015) 15, quoting Foucault (1963/1973) 10, 90–91.

³ For contemporary trends, see Guenther (2015) 2. For important reflections on trends in modern pathology between histology and anatomy, see Maulitz (1987/2002) 3–35.

⁴ Famously with Rokitansky and Griesinger’s ‘new paradigm’: ‘mental disease is brain disease’ (Guenther 2015, 4, quoting Griesinger). On the multilocalization of mental disease and the non-centrality of the brain until the nineteenth century, see again Berrios and Porter (1995) 4.

⁵ Guenther (2015) 2, quoting Uttal (2001), cf. 7–8, 34–38.

biochemical elements and components – zooming in on the finest details⁶ and looking for smaller and smaller structures.⁷

This story cannot be told in detail here. But this localizing, somatistic framework is useful for understanding the destiny and final disappearance through transfiguration of the concept *phrenitis*. The process can be schematically summarized by looking at three outcomes, the first and central of which is bulkier and bio-medically the most authoritative, while the other two might be described as ‘softer’. As for the first outcome, around the middle of the nineteenth century *phrenitis* began to disappear as a lexical item in medicine; dictionaries and other sources increasingly point out its anachronism and obsolescence, as well as its fundamental reducibility to a version of meningitis.⁸ *Phrenitis* then *becomes* – in a sense *is* – what medicine calls meningo-encephalitis. This is the point of view of the perceived knowledge of medicine at the time of the semiotic ‘death’ of our disease, in the nineteenth century as well as now, where and when I write (in Berlin in 2023). From where we stand, however, we can also see important parts of *phrenitis* end in a different way, realize different outcomes and adopt different names. These outcomes are no longer really *phrenitis*, but they still show their (non-exclusive, partial) relationship to it. One is a symptomatic, syndromic outcome, conceptualized under the name *delirium* (e.g. *Delirium tremens* or cognitive deterioration related to dementia). The third and final outcome of *phrenitis* is a softer, ethically invested notion which had only a brief life in official medical taxonomies, but remains alive and well in popular culture: stress, and with it the shame and regret of modernity connected with our tense, sometimes meaningless work-, consumption- and pleasure-oriented lives. Many other cultural and medical ideas, especially of the softer kind, intersected with *phrenitis* or had a share in it: nothing happens in a void. But I shall concentrate on these three, where the phrenitic face of the disease remains still somehow recognizable.

The Bodily: Meningo-encephalitis

The modern clinical material, the patient histories explored in Chapter 9, have served multiple purposes in this account. One initial purpose was to counterbalance the strongly theoretical anatomo-pathological material, which might have appeared to still be deeply rooted in the received tradition and reliant on ancient authorities. Hippocrates and Galen are in fact quoted abundantly and with erudition by writers such as Boerhaave

⁶ See Bynum (2006) 111–13 on these developments. ⁷ Cook (2006) 2. ⁸ See Appendix 2.

and Van Swieten, who appear to treat the post-mortem evidence mostly as a tool with which to confirm already-known pathological data. But far from being merely a cherished relic of intellectual archaeology, the matching clinical material provided by these authors shows that the ancient concept *phrenitis* was quite alive in the bodies suffering its ravages, which are recognizable in the skin, bones, organs and evacuations, and in the agonies and recoveries, and lives and deaths of actual people and communities from Thasos, to London, to Germany across 2,000 years. The most significant outcome of this story, which has at its centre the powerful bodily signs of fever and inflammation,⁹ as well as a pathological location in the brain,¹⁰ is meningo-encephalitis. It accordingly makes sense to offer a brief sketch of what is meant by this term today – not only in homage to the element of human reality that must remain at the centre of medical history as a kind of gold reserve, but also to locate ourselves, as readers of *phrenitis*, in the relative chronology of the evolving history of science.

If we try to produce an outline of the nineteenth-century clinical material, the following elements come to the fore: possible contagiousness, or at least the possibility of finding clusters of cases; occurrence in children; high mortality; headache and skin-rash, dilated pupils, convulsions and stiff neck; in some cases, permanent damage afterwards. All patient case-based discussions of *phrenitis* by pathologists and clinicians go persuasively in the direction of our meningitis or meningo-encephalitis, viral or bacterial, defined by doctors today as an ‘inflammation of the membranes covering the brain and spinal cord and adjunct areas’. The causes are usually viral or bacterial, but can also involve herpes or ‘chemical irritation, drug allergies, *fungi* (cryptococcal meningitis), parasites, tumors’.¹¹ Bacterial meningitis is known to be more acute and dangerous than viral: ‘Death can occur in as little as a few hours.’ Permanent disabilities (such as brain damage, hearing loss and learning problems) can result from the

⁹ Early historians of medicine reflect this inflammatory perspective: Nasse (1829) emphasizes the feverish quality of *phrenitis*, while Souques, who reads the whole of ancient medicine in terms of its agreement with what he calls ‘neurology’ in his *Étapes de la neurologie dans l’antiquité grecque: (d’Homère à Galien)* (1936), fundamentally understands *phrenitis* or *phrénésie* as disguised fevers (Souques 1936, 69, 171–72). Discussing Celsus, for example, he points out that ‘*phrenitis* is still often confused with the psychoses *stricto sensu*, notably with mania and melancholy. This confusion is flagrant with Celsus, who admits three varieties of *phrenitis*’ (‘la *phrenitis* est encore souvent confondue avec les psychoses proprement dites, notamment avec la *manie* et la *mélancholie*. Cette confusion est flagrante chez Celse, qui admet trois variétés de *phrénitis*.’)

¹⁰ Vidal and Ortega (2017) 130–88 describe a ‘cerebrating distress’ as characteristic of modern and contemporary medical science, although looking to psychiatric classifications, from which encephalitis has already been – so to speak – exiled.

¹¹ <https://medlineplus.gov/ency/article/000680.htm>, accessed June 2023.

infection. The bacteria that cause meningitis can also be associated with sepsis, ‘the body’s extreme response to infection’, which untreated ‘can quickly lead to tissue damage, organ failure, and death’.¹²

Although important aspects encourage this retrospective diagnosis (most notably the inflammation and related symptoms, fever and headache; the stiff neck; the possible involvement of the lungs and stomach; the delirium and swift death), if we compare this *status quaestionis* regarding meningitis to the pre-modern material, ancient and medieval, we are left with questions about missing key elements. Perhaps most conspicuous is the absence of the topic of contagion,¹³ which appears abruptly for the first time in the Westphalian account from 1788,¹⁴ as well as the complete absence of any mention of the permanent disabilities the disease often produces in patients who survive it. It is therefore possible to understand *how* ancient *phrenitis* came to be identified with meningitis by modern readers. But we cannot make the opposite move and offer definitive retrospective claims about the disease. The only way to understand and discuss cultural items that develop historically along a linear chronology is to pose the opposite, prospective question: what happened to full-rounded *phrenitis* after the eighteenth/nineteenth centuries?

The Symptomatic and Syndromic Outcome: *delirium*

One tendency in the mutation of the status of *phrenitis* as nosological entity is its progressive shift from disease with a capital ‘D’ to a cluster of signs, a kind of syndromic status that can be attached to various causes, nosological frames and epistemological contexts. Most notably, *phrenitis* is channelled into an ensemble of psychopathological behaviours and traits that become categorized in the second half of the nineteenth century under the label *delirium*; many of the traits of *phrenitis* converge here.

Delirium, etymologically and literally ‘de-rangement’ (*de-lirare*, ‘to deviate from the furrow’, *lira*, via an agricultural metaphor), is described as a state of acute confusion involving nonsensical talk, compulsive movement of the hands and hallucinatory behaviour. In current diagnostic terms, the syndrome is associated with dementia and cognitive deterioration due to various causes (e.g. intoxication),

¹² <https://www.cdc.gov/meningitis/bacterial.html>

¹³ This is a general trait of ancient medicine, however; the topic is discussed by Leven (1992); Nutton (2000), (2020); Harris (2021).

¹⁴ See above, pp. 347–50.

but most often age,¹⁵ while in intellectual history *délire* already appears in Diderot and D'Alembert's *Encyclopédie ou dictionnaire raisonné des sciences, des arts et des métiers*,¹⁶ with explicit reference to ancient *phrenitis* and Greek medicine.

The seminal formulation of *delirium* is the one accompanied by alcohol abuse, the so-called *Delirium tremens* first described by Sutton in 1813, which I have already mentioned.¹⁷ This pathological state is only one case – although an especially theatrical and moralistically charged one – of the general ‘delirium category’, but it shares a great deal with our disease. The preceding chapters have discussed the links between wine and *phrenitis* throughout the course of its medical history, as well as the aura of debauchery that becomes attached to the disease in non-medical literature. As alcohol abuse and alcoholism became important socio-cultural themes in the nineteenth century, its pathological specifics were described in more detail with their behavioural and psychological characteristics, along with their physiology.

After Sutton's work, *Delirium tremens* entered the realm of acknowledged diseases, and the cognitive and moral deterioration caused by alcohol described in literature and stigmatized by official propaganda clearly exploits some popular traits of *phrenitis*: violence, lack of awareness, ingratitude towards one's family and benefactors, irresponsibility, grotesque behaviour and shamelessness, moral and religious despicability. *Delirium tremens*, like *phrenitis* before it, is cause, illustration and nemesis all in one for the human lusts that sex and alcohol represent – the concept of ‘diseases of the will’, to use Valverde's characterization, that becomes so important in the elaboration of public attitudes towards substance addiction generally.¹⁸

But delirium in modern medicine is, as noted, a more general syndrome than the one associated with alcohol. The latest version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM) describes it very broadly in terms of the following diagnostic criteria (summarized here): a disturbance in attention and

¹⁵ Lietzau (1845) 88, who mentions *phrenitis* as the outcome of brain inflammation (*Gehirnentzündung*) with ‘Exaltation’ as opposed to ‘Depression’; cf. Van Gool, Oudewortel, Hertog (2017) for a modern discussion. On the history and epistemology, see Berrios's extensive work (1981); Berrios and Jacyna (1995) 3–33; Berrios (1996) 85, 249–50, (1999).

¹⁶ Volume 4, 1754; section translated by Berrios (1999). ¹⁷ Above, p. 338.

¹⁸ Valverde (1998), analysing various geographical contexts from the Victorian age to modern policies, emphasizing themes such as ‘the exercise of freedom’, ‘repairing diseased wills’, ‘hedonism’ and ‘governing the self’. On the ancient origins of a disease of the will in the area of food and sex, see my reflections in Thumiger (2018a), (2018b).

awareness, which fluctuates and develops over a brief period of time, accompanied by additional disturbance in cognition (e.g. memory deficit, disorientation, language, visuospatial ability or perception). These symptoms must not be better explained by another existing disorder, and there must be evidence that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal or the like (DSM V-II, 2013).¹⁹ This delirium, as a primarily bodily condition affecting the mind²⁰ and stemming from different causes, begins to take shape in the nineteenth century as a flexible psychiatric construct, a syndrome that can arise in various circumstances (old age, intoxication, fever, other diseases), and whose manifestations correspond to the mental, cognitive and sensory-motoric ones of *phrenitis* (nonsensical talk, altered sensation, hyperreactivity, hallucination, distemper, aggressiveness and fears, compulsive movement of the hands). This is the most plastic outcome of *phrenitis*, rooted by medical science in deterioration or damage to the brain, but described as a syndrome, a state of affairs that can be a consequence of a number of different conditions.

The Psychological and Existential Outcome: 'Stress'

The final outcome of *phrenitis* to be considered here is the softest and most qualitatively and ethically charged: its evaporation into micro-details of behaviour and emotional-physical response to the stimuli and challenges posed by the outside world that compose the concept *stress*. Etymologically linked to the idea of exacerbating tension and torsion (Latin *stringo*), 'stress' entered pathological usage in the 1920s and 1930s, with a physiological and psychological connotation as well as wide folk usage,²¹ and with a particular currency in the development of 'psychosomatic' interpretative frames. It was later labelled 'General Adaptation Syndrome' (GAS) and is currently 'Adjustment Disorder' in DSM-V. The concept 'stress' became accepted and integrated into general understandings of human physiology in the 1990s and is now incorporated into a variety of entries in the DSM (notably 'Post-traumatic stress disorder

¹⁹ The diagnostic discussion is ongoing; for further discussion, see e.g. the (2014) communication by the European Delirium Association.

²⁰ Berrios (1981) 439, tracing a connection between delirium and *phrenitis*. On the history of delirium, see Lipowski (1990).

²¹ Cf. Selye (1936), (1950). For an overview, see Robinson (2018). On the history of stress and 'Adaptation Syndrome', see Kugelmann (1992); Cooper and Dewe (2004); the essays in Cantor and Ramsden (2014); Jackson (2013), especially on the modern and contemporary worlds.

syndrome'²²); as such, it constitutes a branch of medical research in human physiology and psychiatry.

Much greater appeal and diffusion, however, is enjoyed by the popular concept 'stress' with its existential, responsibility-based connotations – a notion most English-speaking readers of this book (and many others as well) will be familiar with from everyday usage. Such 'stress' is indissoluble from the *frenesy*, the *franticness*, the *feverish* lifestyle that modernity seems to impose on us, with its cycles of work and rest, production, consumption and waste, earning and spending;²³ its mood extremes, from depression²⁴ to euphoria; its ideals of superhuman strength and intensity, often delusional or drug-induced; and the fierceness and anxiety²⁵ of the competition it imposes on individuals, and the 'burn-out' it often produces, more debilitating than the most elevated fever.²⁶ Several physiological, psychological and behavioural connotations of *phrenitis*, in medicine as well as in popular sources, have somehow found an aural home in these narratives of stress as 'dis-stress',²⁷ reminiscent of the 'false *tonos*'²⁸ of the phrenitic that Epictetus wrote about almost 2,000 years ago, in a passage I quote again:²⁹

²² DSM V-II, 271–72.

²³ On the link between stress and civilization, see Kugelmann (1992) 157: luxury as vice, as 'not knowing one's limits', plays an important role in the emergence of the stress construct, and again absorbs and elaborates traits of the phrenitic 'debauchery', what we have identified as the 'Falstaff model'.

²⁴ I use the term 'depression' here for the combination of traits and experiences, rather than engaging with the contemporary diagnostic label; I agree with Sadowsky (2021), who recognizes, despite historical variations, the existence of a persistent and cross-cultural nucleus of human experiences at the core of what we refer to by this term.

²⁵ On anxiety in modern psychiatry and *phrenitis*, see Berrios (2014) 112–18, introducing the eighteenth-century treatise 'Febrile Anxiety' by Robert James.

²⁶ Kugelmann (1992) calls this 'engineered grief' and (rightly, in my view) sees it as peculiarly modern, 'a far-flung child of the French revolution' (144). What he envisages is the absorption of a string of pathological and ethical experiences once belonging to *phrenitis* into an area of human self-reflection.

²⁷ With Selye's (1974) distinction between 'eustress' and 'distress'.

²⁸ On the specific use of the Stoic concept *tonos* in Greek medicine, Orly Lewis points at Aretaeus, *Morb. Chr.* (II.3.5 Hude, 23.7–11), who conceptualizes it as a matter of balance and a 'bond of nature' (*tēs physios ho desmos*) (in conversation); Trompeter (2016) on Galen.

²⁹ A basic materiality of the human body as 'matter' is also in question in the vitalist concept of the 'fibre' of the body, which can be variously tense, stretched or relaxed. Thus Boissier de la Croix de Sauvages (1731) on mental disturbance, quoted by D'Aumont in his entry in the *Encyclopédie*, discussing delirium and *phrenesie* (1965, 4:785): 'If fibres maintain the harmonious tension preordained by the author of Nature, the ideas and judgements associated with them will be healthy and natural and correspond to external stimuli. But the tension of fibres may increase or decrease, and then ideas become strong or weak, respectively' (trans. Berrios 1999c, 536). See also Huneman (2008) 626 on fibres and concepts of *phrenesis* in Montpellier vitalism.

For I want there to be tone/nerves in the body, but as in a healthy person, as in an athlete; if you show me that you have the tone/nerves of a phrenitic and boast about them, I will say to you, ‘Sir, find a doctor to care for you. These are not nerves/tones (*tonoi*), but a *lack* of a good tone/nerves (*atonía*).’³⁰

Stress, we should note, with its reference to the ‘matter’ of the body and its state as a whole, is a fundamentally delocalized concept – in ancient medicine, the Methodist notions of ‘constriction’ (*stegnōsis*) and ‘relaxation’ (*rhyxis*, *lassatio*, *solutio*), the two ‘generalities’, or general states common to all bodies, provide an early parallel and antecedent.³¹ At the end of its story as well, the concomitance of psychology and bodily delocalization with *phrenitis* is confirmed.

On the Life and Death of Diseases: A More General Conclusion

Phrenitis dies, and from the bits and pieces of its corpse, as it were, other entities are born. But *phrenitis* simultaneously does not and cannot disappear, since it is substantial to human embodied existence. This is a point Plutarch made long ago.³² There are no ‘new diseases’, nor can diseases ‘disappear’. Instead, their semiology shifts along a range – a limited one, like a boat bobbing about an anchor.³³

We have surveyed a long story, stretching over 2,500 years and involving many different levels of human cultural production: science and medicine, religion, politics, society and literature. The ‘biography of a disease’ is a peculiar brand of medical history,³⁴ with pitfalls and rigidities, but also with the benefit of specific questions regarding the survival of medico-cultural concepts that only a focus on a single case allows. What can such a complex itinerary teach us, in terms of historical developments and larger patterns? The case of *phrenitis* shows that the following elements are key to sustaining the durability of a disease label (and perhaps other bio-medical concepts as well).

First, there is the presence and cooperation of technicality (exoteric, restricted, official uses of the label, as in the first four centuries of *phrenitis*’

³⁰ *Dissertationes ab Arriano digestae* 2.15.2.2–3,3 On this topic, see Chapters 6, 8. ³¹ See Chapter 3.

³² See Chapter 1.

³³ See Thumiger (2021a); Harris (2022). On the ontology of diseases and their ancient classifications, see also Roselli (2018), on the Hippocratic nosological material, and in a comparative context the chapters in Steinert (2020).

³⁴ For reflections on the *genre* and the questions it poses, see King (2004) 61–66 on the ‘new diseases’; Scull (2009) 9–12 on the example of hysteria; Guenther (2015) 99.

existence³⁵), on the one hand, and popularity, lay appeal (the importance of *phrēn-phrenes* beginning in our earliest, archaic sources, and the lay, metaphorical, parodic or merely vague uses of the label *phrenitis* from the early centuries of our era onwards³⁶), on the other. What one might call 'aural' elements play a role here, conveyed by semantic connections or even simple assonance (*phren-* and so forth³⁷), or by participation in more widely recognized experiences of health or lack thereof (such as overheating and dryness, sun and the summer, etc.³⁸).

Second, embedding in larger anthropological models and scientific paradigms and questions is important. *Phrenitis* displays a notable plasticity and adaptability to scientific, medical and philosophical discourses. Some of these are concretely pathological, involving the matter that constitutes the body itself (e.g. inflammation, tumour, putrefaction and overheating). Others are practical (such as the choice between psychotherapeutic vs body interventions, or whether to cure one body part or another). Yet others are more scientific-philosophical (localization vs delocalization;³⁹ the opposition of body and mind; the 'heart' and the 'brain' as competing physiological and philosophical models;⁴⁰ and most conspicuous in this case, the tension between different versions of the disease).⁴¹

Third, there is the stake in what one might call popular ethics: judgments about behaviours and social life; religious themes; reflections on individual responsibility, self-control and free will; self-awareness; and so forth.⁴²

Last but not least, throughout all this, there is the persistence of a repertoire of tangible and visible tokens for the disease. These can be bodily symptoms and affected body parts and physiological substances, but also objects, times and places, even scenes or situations. The window to jump from, the brandished sword, the picking at flocks or dust-motes with the hands, are as important as the fever, headache, white urine and delirium described with a high degree of consistency from the fifth century BCE to the nineteenth century CE.

Once the somatization and anatomization of the physiology of the body was underway, the label *phrenitis* was progressively reduced, or relegated to only one portion of the story it had been telling. When this process was complete, in the nineteenth century, the name *phrenitis* disappeared

³⁵ See Chapters 1, 2. ³⁶ See Chapters 6, 8. ³⁷ See Chapter 1 and Appendix 2.

³⁸ See Appendix 1. ³⁹ Chapter 3. ⁴⁰ See Chapters 4, 8.

⁴¹ See Sakai (1991), who agrees with some of these points and highlights the importance of the case of *phrenitis*.

⁴² See Chapters 7, 9.

progressively but irrevocably, and with it all its ancient suggestions, its depth, complex moral implications, behavioural details and Greek allure. The label was still recalled by one or two generations of doctors afterwards.⁴³ But by the early twentieth century it was merely a bit of historical curiosity evoked through the distancing languages of archaeology and philology, or the shortcuts of sweeping retrospective diagnosis. In the consciousness of the lay population, the death of the idea was complete and definitive: unlike the cherished hysteria or melancholy, no one today, no matter how educated, with the exception of historians of Greek medicine (and the readers of this book), has any idea that *phrenitis*, once a major disease, ever existed.⁴⁴

⁴³ See Appendix 2.

⁴⁴ Although the Swedish Dark ambient project *Atrium Carceri* has an album called after it. Thus Wikipedia: “*Phrenitis*” takes the listener to a twisted place where the walls between worlds are razed. The ruinous cities of wars long past, where time itself is but a prisoner and the warlords roaming their purgatorial halls are free to destroy the very foundations of the natural order.’