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TRAUMATIC, NEUROTIC, HYSTERICAL: THE PSYCHIATRIC PRODUCTION OF SOVEREIGN GERMAN ORDER, 1871 – 1969

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STATEMENT

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature:

SUMMARY

This thesis examines psychiatric knowledge and treatment of trauma in Germany between 1871 and 1969. I argue that psychiatric knowledge is more than a technology of security and must be considered a form of statecraft as it produces sovereign political orders. Drawing on the work of Richard Ashley and Sylvia Wynter, I trace how psychiatric knowledge of trauma functions to produce these orders by inscribing figures of ‘Man’ and his human Others. I analyse these processes of inscription through a genealogy of psychiatric statecraft, which I conduct through a reading of psychiatric and neurological textbooks, journal articles, expert statements, and conference proceedings.

I examine three diagnostic disputes over the genesis and treatment of trauma, involving industrial workers in the 1870s and 1880s, WWI soldiers, and Jewish Holocaust survivors in the post-WWII period. In each of these cases, psychiatric practitioners debated whether or not ‘nervous’ symptoms in trauma patients actually resulted from a distressing event and thus entitled sufferers to forms of financial compensation. Many psychiatrists argued that only the expectation of a pension generated these symptoms, and that this was most commonly found in persons with an ‘abnormal’ character or ‘inferior’ constitution.

I observe that the knowledgeable production of political order was subject to shifting dynamics over the 100-year period I scrutinize in the thesis. While some periods were characterized by vigorous disagreement in psychiatric discourse on the ‘proper’ attributes of the sovereign subject, at other times, psychiatric knowledge ossified into an enforced consensus in which political subjectivity was fully commensurate with the ‘fitness’ of the physical body. I find that from the 1910s until the late 1950s, German psychiatry produced an account of political subjectivity which located danger in bodily ‘inferiority’, thus lending authority to a violent politics of marginalization and mass death of racialized and disabled populations.

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I. INTRODUCTION

'In normal times we only diagnose psychopaths – in turbulent times, we are ruled by them'

- E. Kretschmer, quoted in Ammermüller and Wilden, 1953: 263

'In Germany, the term "home" [Heimat] has never described a real place but has always designated the yearning for a particular ideal.'

- F. Aydemir and H. Yaghoobifarah, 2019: 9

The first signs of trouble for the 'nervous' health of German soldiers came in December of 1914. When Germany had gone to war in the summer of that year, only a few months previously, its psychiatrists had still roundly extolled the nation's nervous health. They noted that both the German people and its soldiers were demonstrating extraordinary character and resilience, and that they were submitting to the brutal demands of warfare with quiet discipline and ascetic determination (Binswanger, 1914: 14; 22; see also Goldscheider, 1915; Sommer, 1915). But this period of collective psychic stability waned rapidly as the German *Wehrmacht*, instead of securing an immediate, overwhelming, and decisive victory on its westward march, became mired in protracted and stationary trench warfare (Hart, 2013). No longer buoyed by forward momentum, soldiers began to break down, and German psychiatrists reported a steep increase in so-called 'nervous' casualties: soldiers who, without any apparent physical injury, were suffering from tremors, delirium, or paralysis, and who, in the shifting nomenclature of the time, would be diagnosed with traumatic neurosis, hysteria, or the now-iconic shell shock (*Granatschock*).

Robert Gaupp, director of a psychiatric hospital in Tübingen which cared for a large number of 'nervous' military casualties, later appraised these cases as follows: 'When we were dealing with persons who have always been in good nervous health and

possessed a strong will, these disturbances were usually overcome quickly'¹. Another group of patients, however, gave cause for concern: 'It is a different matter with weak-nerved, inherently nervous persons. The stronger the pathological disposition, the more negligible the triggering cause [for the nervous symptoms] may be, and the more persistent the sickly state proved to be' (1915: 361). At the root of their symptoms, Gaupp explains, one invariably found 'a more or less conscious fear of returning to the front.' This was not a matter of simulation – quite simply, these soldiers' 'nervous system was not made to withstand the stresses and horrors of modern warfare. [...] Possessed by the dark sentiment of losing control and having to accept defeat, their "exhausted" psyche takes flight into illness' (1915: 361).

Gaupp proceeds to identify a number of security threats arising directly from the 'hysterical soul'. First of all, it constituted a drain on military manpower because it 'immediately lapses into this pitiful sickness and remains there as long as it considers itself at risk of being drawn into the war once again'. Second of all, it severely burdened the state's welfare systems because hysterics not only were entitled to a veterans' pension but often 'lacked strong motivation to return to their civilian place of work.' Finally, Gaupp argues, hysterics dilute the quality of German hereditary stock because their exemption from military duty 'increased the negative selection carried out by this murderous war' (1915: 362).

From this bleak state of affairs, Gaupp writes, a critical duty arises for German psychiatrists: 'the most urgent task for the neurologist and psychiatrist is to protect the *Reich* from an accumulation of mental invalids and lifelong recipients of veterans' pensions.' They will achieve this, he explains, by correctly diagnosing these conditions, prescribing a suitable regime of psychiatric treatment, and thus preserving their patients' labour power for the war effort and the nation (1915: 362). In short, Gaupp urges his readers (i.e., members of the psychiatric profession) to mobilize the full might of psychiatric knowledge and practice to confront the threat posed to the German nation by weak-willed, hysterical soldiers.

¹ All translations from German are my own, unless cited from a German-to-English translation in an English-language publication.

Decades of critical scholarship on (global) politics and psychiatric knowledge have made it abundantly clear that Gaupp does not engage in strictly medical practice in this passage. Gaupp uses medico-scientific authority to discipline deviance and to thereby enhance the productivity of hysterical soldier-patients (Foucault, 1995 [1975]; Foucault, 2006). He calls forth technologies of diagnosis and treatment which produce subjects, some aligned with, and some considered threatening to, the governing political ideology of the state (Rose, 1999a; Howell, 2011). The psychiatric apparatus of which he is a part functions as a form of governance, regulating the conduct of populations (Pupavac, 2001; Pupavac, 2004a). But if we look more closely, we find that Gaupp does more: in this ableist and social Darwinist discourse, he makes a claim about the being of Man, thus inscribing a particular version of political order.

The figure of Man is a historically and geographically specific formation which emerged to replace God as the authorizer of political order and scientific knowledge (Foucault, 2005 [1966]; Ashley, 1989; Wynter, 2003). ‘Man’ refers neither to a single person nor any specific, empirically existing group of humans, but is an epistemic formation produced through discursive processes. With the shift to the order of Man, states anchored their sovereignty in his authority and sought to govern according to his interests, while scientific knowledge came to be verified through the power of human intellect. Yet Man does not simply exist in the world but must be produced by knowledgeable discourses and practices. Therefore, in our current episteme, a number of competing knowledgeable discourses and practices operate to inscribe a particular being of Man. This being of Man is pivotal in determining the contours of political orders, because modern states govern according to the perceived interests on Man. In order to make the modern state, one must, therefore, define the being of Man – in Richard Ashley’s words, ‘modern statecraft is modern mancraft’ (1989: 303).

This thesis argues that psychiatric knowledge and practice partake in the crafting of Man and thereby function to produce sovereign political orders. Psychiatric knowledge is a form of statecraft. We can clearly trace these processes in Gaupp’s article, reviewed above: through a differential diagnosis of patients, he inscribes specific attributes as foundational for sovereign political subjectivity and rational

conduct, namely robust nervous health and strength of will. He also identifies inherent bodily weakness as a threat to the interests of Man. Gaupp thereby participates in the construction of a sovereign political order premised on mental and physical ‘fitness’, while cautioning against the dangers of an ‘inferior’ psychic disposition. Such an analysis of Gaupp’s knowledgeable moves builds upon, yet extends, current critical international relations (IR) literature on psychiatry and (international) political order, to ask: how does psychiatric knowledge function to produce the sovereign, German state?

Gaupp’s psychiatric production of political order through the treatment of ‘war hysterics’ was no isolated incident. In the decades preceding and following the First World War, survivors of extreme and distressing circumstances – what we might today call ‘trauma’ – were subjected to the authority of German psychiatry and were subsumed within the circuits of its order-producing practices. In the roughly 100 years between the foundation of the modern German state in 1871 and the establishment of the PTSD (post-traumatic stress disorder) diagnosis in 1980, three groups of trauma patients played an especially prominent role in psychiatric constructions of sovereign German order: industrial workers at the height of the industrial revolution in the mid- to late 19th century, working-class WWI soldiers, and Holocaust survivors in post-WWII West-Germany. As disabled, destitute, working-class, and racialized subjects, these groups found themselves at the centre of some of Germany’s most contentious and lethal political struggles in the century after its foundation. Psychiatric knowledge and practice played a fundamental, albeit frequently overlooked role, in the wider political processes which determined whether these groups were seen as integral or threatening to sovereign German order.

Each of these groups suffered from debilitating psychological or neurological symptoms after undergoing distressing incidents or experiences, meaning they were unable to work, and relied on varying forms of state support. Industrial workers who were paralyzed and anxious after a workplace accident were eligible for unemployment benefits. First World War soldiers who were speechless and shaking after days of shelling were not only withdrawn from frontline duty, but could also, if

their conditions persisted, claim a veterans' pension. Finally, Jewish Holocaust survivors who continued to be haunted by the horrors of the camps, years after liberation, could apply for a health damages pension from the West German state. In each of these cases, psychiatrists were tasked with determining whether the conditions claimants were presenting actually resulted from a traumatic experience, or whether other factors had called forth their debilitation. This means they were responsible for adjudicating not only the psychological health or illness of patients, but also determined whether they would qualify for financial, as well as any other form of, relief. In each of these cases, the psychiatric community was divided, with different practitioners offering contrasting explanatory models for the origin of symptoms, as well as divergent treatment methods. As a result, psychiatric statecraft was often contested, and the shape of German order the object of intense struggle.

I will trace these disputes and struggles across 100 years of psychiatric statecraft, analysing psychiatric journals, textbooks, conference proceedings, and expert testimonies regarding the origins and treatment of trauma to track the production of sovereign order through the psychiatric inscription of figures of Man and his human Others. Through a genealogical reading of these archives, I will excavate concurrent and successive iterations of sovereign German order produced by psychiatric inscriptions of Man, analysing, in each case, how specific epistemic formations made particular socio-political arrangements appear natural, inevitable, and indeed necessary.

In the remainder of this chapter, I will draw out different parts of the argument I make in this thesis and situate it in relation to relevant scholarly literatures. First, I discuss the figure of Man and explain how it operates in the production of political order. In the second section, I argue that psychiatric power routinely appraises its patients not as patients but as political adversaries who pose a threat to the health and order of the nation. I use and further develop Alison Howell's concept of 'martial politics' (2018) to articulate how psychiatric knowledge functioned as a form of warfare, and discuss this claim in relation to recent biopolitics literatures. In the third section, I deliberate how a biologicistic account of trauma, conceptualized as resulting

from different forms of bodily ‘inferiority’, circumscribed possible inscriptions of Man throughout much of the period under investigation in this thesis. I then situate this claim in German historiographical literatures on instances of mass death inflicted by the German state. In the fourth section, I return to the argument made at the opening of this chapter and lay out in more depth why psychiatric knowledge and practice should be considered a political ordering practice. I then position this argument in relation to scholarly literatures on psychiatric knowledge and (international) political order. I conclude by outlining the chapters of the thesis.

1.1 Man, Order, Statecraft

I noted above that what is remarkable about Gaupp’s statement is that he makes a claim about the being of Man, thereby inscribing political order. In this section, I explore this argument in more depth.

By speaking of political order as the result of ‘inscription’, I am invoking a field of critical sovereignty studies literature emerging in the late 1980s (Ashley, 1988; Ashley, 1989; Ashley and Walker, 1990a; Ashley and Walker, 1990b; Walker, 1993; Bartelson, 1995; Weber, 1995; Biersteker and Weber, 1996; Edkins et al., 1999). This literature problematized an orthodox account of ‘order’ in IR, nearly unchallenged at the time and abiding to this day, which rests on the principle of sovereignty. According to this account, sovereignty ensures order within states and denies it among them, thereby enshrining, with elegant simplicity and in a single stroke, the international state system and the disciplinary remit of IR. In these accounts, sovereignty is usually conceptualized as some variant of Francis Hinsley’s classic definition of ‘final and absolute political authority in the political community’ (Hinsley, 1966: 26), and is thereby viewed as a common-sensical principle and fact of political life, something that can be isolated, observed, and measured through disinterested, social scientific analysis (for an overview and discussion of the orthodox account, see Bartelson, 1995: 22-39; Nisancioglu, 2019: 42-43).

Poststructuralist critique begins from the observation that the principle of sovereignty is anything but a common-sensical fact of political life, but the effect of discursive, political practice, offered in response to a crisis: the empirical world is so abundant, ambiguous, and heterogeneous that any statement about it amounts to a hopeless abstraction. Yet in order to exist in the world, to partake in it without being overwhelmed by the ‘infinity of reality’ and to make statements about it, we must engage in such abstraction (Krishna, 2001: 403). The discourse of sovereignty is one such effort: confronted with ‘an unmappable region of ambiguity, uncertainty, and indeterminacy’, it deploys a procedure which transforms open space into delineated territory, amorphous populations into recognizable peoples, and anxious questions into categorical fact (Ashley and Walker, 1990a: 381). In order for this procedure to work, it requires the inscription of a sovereign presence – be it God, monarch, Man, the nation, science, or any other entity deemed capable of resolving ambiguity – to function as the arbiter of uncertainty (Ashley, 1989: 288; Weber, 1995: 27-28). It is the deployment of this procedure which produces the ‘effect’ of sovereignty, not the legislative and constitutional arrangements of states alone (Ashley and Walker, 1990a: 375).

Poststructuralist scholars have offered numerous analyses of the means by which such a sovereign presence might be inscribed, including through the discourse of IR theory (Ashley, 1989; Walker, 1993), discourses of security (Campbell, 1992), diplomatic discourse (Weber, 1995), and immigration discourse (Doty, 1996). In this thesis, I will argue that psychiatric practice must be counted among these discourses which inscribe a sovereign presence and thereby secure a form of political order. To make this argument, I draw on Ashley’s theorization of ‘statecraft as mancraft’, which describes the process whereby inscriptions of sovereign subjectivity determine the politics of a specific political order. According to Ashley, Man is a Kantian figure, defined by specific constitutive limitations to his knowledge and being (1989: 264). Modern states anchor their authority and legitimacy in this figure and seek to protect Man against the dangers entailed by his own, contingent, and necessary limits (1989: 268). This means not only that the limitations identified by modern discourses as constitutive of the being of Man determine the objectives pursued by sovereign,

stately orders, but that such discourses are multiple: the process of statecraft, for Ashley, is characterized by instability and struggle.

I will discuss this theory in detail in the next chapter. For now, I will draw out only one aspect: for Ashley, the figure of Man is open to determination by any discourse. He writes that Man is a “‘form” ... that leaves open the question of “‘content””, and thus might be seized by any modern discourse seeking to make a knowledgeable, ordering statement about the world (1989: 266). Yet in this thesis, as I track psychiatric statecraft across 100 years of German political history, we will find, with unnerving frequency, the sovereignty of Man expressed as an attribute of his bodily ontology. This was the case with the article that opened this chapter, where Gaupp conceptualizes the failings of hysterical soldiers in terms of a ‘pathological disposition’ and ‘inherently’ weak nerves (1915: 361). We will encounter this tendency in the third chapter, where I trace how psychiatrists suspicious of the psychological and neurological symptoms of survivors of industrial accidents identify the ‘worker’s character’ as a source of mental corruption. It manifests in the fourth chapter, where I demonstrate how psychiatric opinion rallies around a eugenic consensus in the wake of the First World War, and routinely diagnoses post-traumatic conditions as a symptom of inferior hereditary ‘stock’. Shockingly, it persists long into the post-WWII period, which I turn to in the fifth chapter. There, I excavate psychiatric knowledge which locates the cause of Holocaust survivors’ enduring trauma in an inferior ‘racial’ constitution. We will thus find that psychiatrists, throughout the period under review in this thesis, repeatedly and consistently identify as the greatest risk to the thriving of Man a body that falls short of perfection inscribed at the level of heredity.

What does this mean for the being of Man, as well as for the possibilities of his emergence? I will argue, based on the persistence of bodily ontology briefly outlined above, that the conditions for the being of Man were severely circumscribed in German psy-scientific discourse from the late 19th until the mid-20th century. I draw on Sylvia Wynter’s work (2003) to theorize this restriction. Wynter argues that Man is the product of the monumental epistemic and political transformations which took

place in the wake of the 15th century colonial ‘encounter’. The assertions of supremacy by the Spanish conquistadors, as well as the expropriation of land and enslavement of Africans and American Indigenous populations resulting from this encounter necessitated an ordering move which divided humans into rational political subjects, entitled to extend their rule across the globe, on the one hand, and irrational savages, unfit for political agency, on the other. Thereby, white Europeans were elevated to the status of Man, while at the same time consigning racialized, colonized subjects, as well as European Jews and the mad, to less-than-human status (2003: 266). Crucially, these restrictive ordering moves upheld the conceit of Man as a universal descriptor for all humankind, thus positioning the wellbeing of a small group of humans as applicable to its entirety.

For Wynter, the conceit of Man’s universality and simultaneous constitutive bordering moves are his defining characteristics. To this day, Wynter avers, Man appears through a gesture of ‘overrepresentation’ whereby a small portion of humanity functions as a placeholder for its totality, thereby occluding from view the routine effects of dehumanization visited upon these populations (2003: 262). This circumscription of Man underwent two phases: in early modernity through the exclusion of the ‘irrational’ (what she calls ‘Man1’), and from the mid-19th century in ‘biocentric’ terms through the exclusion of those human bodies recognized as ‘dysselected by evolution’ (‘Man2’; 2003: 264). Crucially, for this thesis, Wynter’s work provides the tools to comprehend why Man, in the period under consideration, is so stubbornly crafted in terms which articulate hereditary attributes of the body: it is because the modern episteme, effective since the publication of Darwin’s writings on the evolution of the species, prescribes an ‘exteriority’ (Da Silva, 2015: 97) of Man conceived of in terms of his biology. In this period, political order rests on a conceptualization of Man as biological being. Following Wynter, it is thus impossible to theorize ‘modern’ knowledge and ‘modern’ power, i.e., psychiatric and scientific knowledge as well as questions of sovereignty and political order, without firmly situating both in a global context dominated, for the past 500 years, by European colonialism and its attendant translation of human alterity into Man and his human Others.

How might Wynter's insights be mobilized in analyses of international order? Siba N'Zatioula Grovogui's *Sovereigns, Quasi Sovereigns and Africans* (1996), although it predates Wynter's work, is an example of how this might be done, and constitutes a magisterial exposition of the enduring structuring and productive effects of colonial power and knowledge in the contemporary international order. Grovogui demonstrates how international law, including the principle of sovereignty and the norm of non-intervention, are premised on a Eurocentric epistemic formation which recognizes only European Man as rational, agentic subject (1996: 21). This epistemic order casts Africans as Other to European Man, denies them political subjectivity, and thereby authorizes international legislative formations which uphold the influence and power of former colonizers in formally post-colonial, nominally sovereign states (1996: 67). This produces an international order in which African states are not sovereign but *quasi-sovereign*, denied full political subjectivity because the Eurocentric constitution of the present episteme can only recognize African peoples as dependent, immature, and unfit for political self-governance.

Grovogui's work forms part of a larger IR literature which excavates the constitutive role of race, racism, and colonialism in disciplinary IR as well as global politics (Krishna, 2001; Jones, 2006; Jones, 2008; Henderson, 2013; Thompson, 2013; Anievas et al., 2014; Vitalis, 2015; Rutazibwa, 2016; Nisancioglu, 2019; Sabaratnam, 2020). Although this literature most commonly takes to task the orthodox account of sovereignty, statehood, and disciplinary formation, it at times directly addresses critical IR traditions, including poststructuralism, as well. Here, it finds that a lack of interest in histories of colonialism, as well as a cavalier attitude to racism in the present, sometimes produces scholarship that fails to apprehend the abiding and constitutive influence of racist dehumanization on modern and contemporary thought (Krishna, 1993; Rutazibwa, 2016; Howell and Richter-Montpetit, 2018; Howell and Richter-Montpetit, 2019). Yet as I will seek to demonstrate throughout this thesis, 'modern' knowledge – in this case, late-19th-century through mid-20th-century psychiatric knowledge – is saturated with, and to an extent circumscribed by, ideas about the intrinsic worth of humans grounded in a biological ontology of 'race'. Therefore, to write a genealogy of psychiatric statecraft in Germany without

foregrounding the constitutive role of race is to miss a fundamental aspect of this history.

However, attentive readers will have noted that Gaupp, at the outset of this chapter, inscribed sovereign subjectivity not in terms of race, or at least not in terms of race alone. Gaupp instead invoked ‘nature’ and ‘disposition’, which I characterized as a reference to the ontology of the physical body, as well as a means of prioritizing characteristics inscribed at the level of heredity including fitness and bodily constitution. Therefore, conceptualizing epistemic limits in terms of race alone will not suffice to come to grips with the precise nature of psychiatric statecraft as I track it in this thesis. As scholars in critical disability studies, as well as an emerging literature in IR and cultural studies recognize, discourses of madness and disability are equally powerful, and often co-constitutive with racism, in producing persons as tragic, pitiful, and less-than-human, and thereby authorize a politics which rationalizes the institutionalization, sterilization, and murder of the disabled (Mitchell and Snyder, 2003; McRuer, 2006; Howell, 2011; Howell, 2018; Mitchell and Snyder, 2015; Puar, 2017).

I will thus offer a reading of German psychiatric discourse and practice which takes seriously the epistemic boundaries of modern scientific knowledge through discourses of race as well as ability articulated through knowledge about the evolutionary hierarchy of Man. I will trace how certain formations of psychiatric knowledge articulated trauma not as a response to stress, but as a failure resulting from evolutionary lack – an atrophied will, a ‘racially’ inscribed disposition to illness, or an aversion to work which was recognized as typical of the character of members of the working class. In the three empirical chapters of this thesis, I will draw out periods in German psychiatric practice when this epistemic constriction was so severe that a consensus formed around bodily disposition lying at the root of any and all political discord, and that any and all obstacles to political transcendence, to overcoming the hardships, poverty, conflict, and violence of the political present, lay in eradicating those with an ‘inferior’ biological make-up. I will suggest that psychiatric knowledge, during these periods, played a significant role in formations of power-

knowledge which authorized the persecution, debilitation, and mass death of populations on the grounds of their supposed biological, ‘racial’, or cognitive inferiority.

However, epistemic constraint is not the entire story told by this thesis. Despite the devastatingly effective force of discourses of scientific racism, social Darwinism, and eugenics, they were not able to stifle alternative constructions of Man by psychiatric knowledge in their entirety. In all empirical chapters, I identify and track psychiatric debates on trauma which evidenced vehement disagreement on the cause of post-traumatic symptoms, and thereby the being of Man. Across the decades I scrutinize in this thesis, I unearth psychiatric paradigms which located human vulnerability to traumatic injury in the violence of their lived experience: in dangerous working conditions, destitute living arrangements, the horrors of mechanized warfare, as well as the death worlds of the Nazi camps. These psychiatrists, through their medical paradigms and treatment approaches, offered a different view of a just and necessary political order: based on their inscription of Man, a just politics was one which provided for and supported those left without means, which assisted persons cast into precarity through injury, and which lifted them up after violent forces beyond their control had left them devastated.

In the debates between these psychiatrists and their colleagues who remained locked into a constitution-based paradigm of trauma, I will outline a form of statecraft more akin to Ashley’s (1989) theorization: a ceaseless struggle over the true being of Man, the contestation over his needs and fears, the radical openness and contingency of this figure, and the resulting indeterminacy of statecraft and political order. In reading together Ashley’s and Wynter’s account of statecraft – which they term ‘statecraft as mancraft’ and ‘sociogeny’, respectively – I will at no point suggest that one must replace the other, or that one offers a superior reading of politics. What I suggest instead is that a blended reading of statecraft as mancraft and sociogeny offers a nimble theoretical and methodological device, alert to the shifting materializations of power-knowledge in both their restrictive and contingent formations.

1.2 Martial Formations of Psychiatric Power

Returning once again to Gaupp's appraisal of hysterical soldiers, another aspect of his discourse is remarkable: it is the portrayal of a certain set of 'nervous' casualties not as medical or psychiatric patients, but as political adversaries who undermine the health, security, and potentially even the survival of the nation. Recall that Gaupp identified a triple threat posed by these hysterical soldiers: first, their tendency to take 'flight into illness' when confronted with danger constituted a drain on military manpower, second, their lack of motivation to work placed a burden on welfare systems, and third, their exemption from combat contributed to the 'negative selection' carried out by the war, thus undermining the quality of German hereditary stock (1915: 362). For Gaupp, as well as for many of his colleagues, hysterical soldiers imperilled German security no less than the Entente soldiers cowering in trenches not far away from their own, only awaiting their turn to visit devastation on their enemy. And just like a military adversary could only be defeated through overwhelming lethal force, German psychiatrists conceptualized their encounters with hysterical patients as a form of 'battle' (1915: 361), necessarily unrestrained by 'pseudo-moralistic concerns' and 'merciless' in the application of its means (Kehrer, 1917: 2; Hellpach, 1915: 1210).

In this thesis, I appraise the dynamic between certain formations of psychiatric knowledge and trauma patients as martial politics. Coined by Alison Howell, martial politics designates a form of politics which is 'shot-through with war-like relations' (2018: abstract). As a conceptual tool, it will serve in this thesis to articulate the intermittent nature of psychiatric knowledge and practice as a form of warfare, waged by German psychiatric practitioners against their fellow citizens, both during formal periods of warfare and during times of peace. Howell's concept serves to highlight the frailty of knowledgeable separations imposed between civilian and military spheres, between relations that are 'of war' and 'of peace', as well as between 'normal' and 'exceptional' politics, aiming instead to bring into view the necessary imbrications between war-like and civilian logics. These imbrications come into view with particular clarity, argues Howell, if we foreground historically marginalized groups

like Black, Indigenous, disabled, queer, and working-class subjects (2018: 2). Crucially, Howell avers, the exposure to violence and lethality of these groups has been a routine practice in the United States since its establishment as a settler colony, and proceeds in this manner to this today to uphold a White, settler order (2018: abstract). In this thesis, I offer a reading of various German states – the post-1871 Reich, the Weimar Republic, and the post-war, West-German Federal Republic – as also engaging in a politics which proceeds in a martial mode, and I will suggest that the martiality of German politics are a constitutive factor in the progress of its ordering formations.

I argue that psychiatric knowledge and practice, as part of the larger formations of power-knowledge which are effective during this period, engage in a productive ordering of their patients whereby they are assigned positions as either Man or Other in hierarchical political constellations. I suggest that these productions of Man and Other, whereby a sovereign centre grounding political order is inscribed, often entail the enactment of a war-like political order as a matter of course: contrary to an account of politics which conceptualizes difference as plurality, and which resolves this plurality through the administration of equal rights and protections under the law, the framework of martial politics suggests that political order is upheld precisely through the stubborn refusal to integrate Man's Other into a domestic 'we'. In martial politics, the constitutive outside of Man must always retain its character as adversary and threat, and is consequently treated as a security concern.

The framework of martial politics maintains that the political order of the sovereign state, especially in its Western, liberal, colonial formations, rests on maintaining war-like adversarial relations with those produced as Other to Man. For Howell, analysing political formations in the United States, these Others are primarily Black, Indigenous, and disabled communities. In this thesis, I argue that German politics, at least since the emergence of the unified Reich in 1871, must also be conceptualized as martial, despite its many differences to the US context. At the point of its foundation, Germany was neither a liberal nor a fully democratic state (Wehler, 1988), and while it was a colonizing state which founded a settler colony, Germany itself was not itself a settler state, and anxiously glossed over the historical presence of Black populations

within its territory to persistently produce itself as an entirely White nation and population (El-Tayeb, 1999). However, as I will draw out across the three empirical chapters, discourses of race, ability, political radicalism, and class also functioned in Germany to produce parts of the population as Other, and thereby adversarial to, the German nation. These discourses thereby authorized an exclusionary, sometimes violent, and at points lethal politics towards these populations.

While my empirical chapters focus on the psychiatric treatment of traumatized workers, soldiers, and Holocaust survivors, I situate their treatment within larger historical formations of this period. These are, on the one hand, Germany's constitution as a colonial power, and the enactment of the first genocide of the 20th century in its South-West African colonial territories (Zimmerer and Zeller, 2003), and the rise of the Nazi state, with the mass murder of the disabled and the Holocaust of European Jews, on the other. My case studies, perhaps counter-intuitively to the argument I am advancing here, are not situated in German colonial territories, nor do they focus directly on the practices of the Nazi state. I do not analyse German colonial, or 'racial' psychiatry (Adams, 2014), the role of German scientific knowledge in the Herero and Nama genocide (Mamdani, 2001: 12; Eckert and Wirz, 2002; Erichsen and Olusoga, 2010: 442-53), nor German psychiatric support and enactment of Nazi policies of extermination (Blasius, 2015). However, the fact of German colonialism and German fascism, as well as the mass death visited by German militaries, medical professionals, and bureaucrats on African and European populations, will remain a stubborn and ineradicable presence throughout this thesis. Their invocation will function as a refusal to analyse the late-19th century history of German industrial workers as disconnected from the simultaneously unfolding colonial project, and as a resolute drawing together of histories of ableism and racism. I will suggest that these events form part of a shared history in which psychiatric and other forms of scientific knowledge produced certain populations as Other to Man, and thereby as threats to the thriving and survival of the German nation. The concept of martial politics hereby functions precisely to articulate 'the ways in which racial, colonial, ableist violence is foundational to (liberal) civil order', not exceptional (Howell, writing in MacKenzie et al., 2019: 830).

Yet while I situate my case studies in the histories of German colonialism and fascism, the technologies which I designate as martial proceeded in the mundane and decidedly unspectacular manner of bureaucratic enunciation, namely the denial or withdrawal of pensions or benefit payments. Industrial workers, working-class soldiers, and Holocaust survivors, I argue, were subjected by psychiatric knowledge to a martial politics of sovereign statecraft primarily through the means of pension denial. It might, therefore, be considered somewhat polemical to characterize the treatment of these groups as war-like, overstretching what should strictly be defined as ‘reciprocal organized violence’ (Barkawi, writing in MacKenzie et al., 2019: 823) to a much wider set of social relations. There are three reasons, I will argue, why martial politics is nevertheless a fitting descriptor for these political formations.

First of all, as I outlined above, the concept of martial politics offers a different reading of ‘normal’ politics, refuting any characterization of the sovereign state as a pacified realm in which the use of violence is strictly hedged in by law, and ability, racialization, and Indigeneity play no fundamental role in producing certain groups as threats to order and subject to heightened lethality. The framework of martial politics brings into view the fact that in the liberal, Western (as well as in the [post-]colonial) state, the government of certain groups is routinely articulated in the military grammars of warfare (Fanon, 1963; Mbembe, 2003; Mitchell and Snyder, 2003).

Second, I will argue that these military grammars of warfare extend well beyond the ‘reciprocal organized violence’ of the battlefield (or any site of encounter between adversarial armed forces) to include techniques which degrade the health and wellbeing of populations through the withdrawal of welfare. To theorise these techniques, I turn to Achille Mbembe’s ‘necropolitics’ (2003) as well as Jasbir Puar’s concept of ‘debilitation’ (2017). Proceeding from Foucault’s foundational mapping of biopolitics (2002), both Mbembe and Puar note that the management of life and death, charted so meticulously by Foucault in 18th- and 19th-century Europe, takes on a different form in the (settler) colony. Mbembe avers that the subjection of colonized life to techniques of death commonly proceeds both unshackled from legal restraint and by means of ‘siege warfare’, which extends from the fragmentation and

‘splintering’ of territory to the targeted destruction of houses and infrastructure (2003: 28-29). The aim of this politics, writes Mbembe, is not simply to kill but the ‘creation of *death-worlds*’, or environments ‘in which vast populations are subjected to conditions of life conferring upon them the status of *living dead*.’ (2003: 40; emphasis in the original). Jasbir Puar, in turn, uses the term ‘debilitation’ to designate the status of racialized subjects who are maintained in ill health through the denial of essential services. Differently to those formally recognized as disabled and therefore able to ‘aspire both economically and emotionally to wellness, empowerment, and pride’ (2017: xvi), the debilitated are more commonly racialized bodies, simply ‘expected to endure pain’ (2017: xv). In a settler colonial context, Puar argues, debilitation is produced through enactment of a ‘sovereign right to maim’, whereby occupied populations are targeted for injury instead of death, while the erosion of services and infrastructure bars any means to meaningful recovery. By thus suspending colonized subjects between life and death, the colonial state shields itself from international reproach over human rights abuses while extending its control over the vitality of subjects (2017: 143).

Germany in the 19th and 20th century was not a settler colony. Nevertheless, I make the case in the three empirical chapters that forms of biopolitical regulation first observed in a colonial setting can be tracked in the German psychiatric treatment of populations produced as subhuman, and most pertinently in its conduct towards Holocaust survivors. Debilitation, I argue in chapters 3 and 4, is the foremost instrument of a psychiatric statecraft enacted in a martial mode, withholding effective medical treatment and welfare payments from traumatized workers and working-class soldiers made out to be ‘subhuman’. Yet in its treatment of Holocaust survivors (chapter 5), psychiatric practice takes on a necropolitical quality which I term ‘post-genocidal debilitation’. I observe that there is a specificity in the modality of power enacted by psychiatric knowledge and the compensation bureaucracy in this context, in which essential psychiatric care and compensation payments were withheld from the survivors of genocide. The enduring psychological symptoms of Holocaust survivors were so severe that one (sympathetic) psychiatrist described these patients as ‘walking corpses’ (Niederland, 1981: 421). As I draw out in the chapter, the

debilitation of Jews in post-war Germany was not the incidental and aberrant pursuit of a small number of unrepentant Nazis in the psychiatric profession and compensation bureaucracy, but the predictable outcome of a form of statecraft still fully grounded in a race-based, eugenic paradigm. The harm thus inflicted – deliberately – on survivors of genocide was so severe that their treatment by German psychiatric and compensation administration authorities functioned, in a sense, to ‘return’ them to the camps. Further, their persecution proceeded on such a large scale that it must be considered systemic, and to the extent that it reflected a persistently widespread anti-Semitism found even at the highest levels of government, deliberate. Significantly, as this continued persecution unfolded in a legally authorized and psychiatrically sanctioned context, it nevertheless permitted the post-war, West German state to present itself as repentant and reformed, and thus to shed its international pariah status.

Third, as I explained in the previous section, and as I draw out in the third empirical chapter, I suggest that the treatment meted out by German psychiatry to industrial workers, working-class soldiers, and Holocaust survivors forms part of a larger process of power-knowledge constitutive of German politics in which political subjectivity became a function of bodily ‘fitness’, materialized through imbricated discourses of race, ability, and anti-communism. I argue that the casting into precarity of traumatized workers, soldiers, and Holocaust survivors is an – admittedly milder – expression of the same martial politics which also authorized and called for the genocide of the Herero and Nama people, the mass murder of the disabled, as well as the Holocaust. What these groups share, I will insist, is a casting out from the German body politic, and a denial of fully human status, on account of a ‘flaw’ or inferiority located at the level of bodily ontology. While this ‘flaw’ was believed to lie at the root of a number of different bodily and behavioural formations variously articulated as Blackness, disability, working-class degeneracy, ‘primitivism’, or other evolutionary lack, it sufficed, across these groups, to justify martial methods of containing and overwhelming the threat these groups were said to pose to German national thriving. I thus argue that the period of German political history under scrutiny in this thesis is one constituted, in part, by a biologized hierarchy of political

subjectivity in which sovereign order was enacted by means of a martial politics, encompassing a range of instruments from the sovereign ‘must die’ to the biopolitical ‘let live’ and ‘will not let die’ (Puar, 2017: x).

By mobilizing concepts like martial politics, necropolitics, and debility, I am invoking a branch of Foucaultian scholarship which is characterized by a methodological and political commitment to foregrounding power relations governed by discourses of race and ability, as well as a historiographical posture which comprehends European and North American histories as global, imperial histories. I am setting in motion these literatures to theorize relationships of scientific knowledge and political order because they address and remedy head-on some of the shortcomings identified in Foucault’s scholarship. Edward Said notes that Foucault ‘showed no real interest in the relationships his work had with feminist and postcolonial writers facing problems of exclusion, confinement, and domination,’ concluding that ‘his Eurocentrism was almost total’ (1988: 9-10). Discussing Foucault’s theorization of sovereignty, Gayatri Chakravorty Spivak writes that the context of imperialism which enabled the transformations in power relations in Europe in the 17th and 18th centuries are entirely absent in Foucault’s analysis (1999: 279). This means that many of the core concerns of Foucault’s theorizing – the management of space, the formation of administrative institutions, and the government of ‘peripheral’ populations – remain confined to a European setting. Yet notably, Spivak avers that this omission is not an oversight but forms part of a posture of ‘sanctioned ignorance’ of the global makings of European politics (ibid.). This not only produces an incomplete account of power, but can obstruct global justice movements (ibid.; see also Stoler, 1995; Shilliam, 2011; Weheliye, 2014; Da Silva, 2015).

Using the Foucaultian toolbox without these methodological, political, and historiographical commitments can lead to a theorization of modern power, knowledge, and order in which the sharp edges of statecraft appear strangely blunted. Nikolas Rose’s work on psychiatric power and the formation of the modern liberal subject is an example of this. In his monograph *Governing the Soul* (1999a), Rose outlines how, since the 19th century, the psychiatric sciences have played an essential

role in producing and sustaining the liberal, governmentalized state. These processes are frequently misunderstood, Rose argues, as coercive mechanisms designed to ‘crush subjectivity’ (viii). We learn that an appraisal of psychiatric power as monstrous, evil, and repressive haunts certain anti-psychiatric literatures which construe it entirely in terms of coercion, confinement, and control. Yet according to Rose, this misses the multiple avenues of productive power by which psychiatric knowledge generates the liberal state: not only is our understanding of autonomy and self-realization – both characteristics prized by liberal orders – ‘essentially psychological’ (x), but psychiatric practice functions to ‘actually fabricate subjects ... capable of bearing the burdens of liberty’ (viii). More specifically, through multiple technologies of measurement, self-optimization, and correction, psychiatric knowledge operates to instruct subjects to seek and value precisely those attributes which fuel the reproduction of liberal order. The only coercive characteristic of this power-knowledge is to produce subjects that are ‘obliged to be free’ (ibid.).

Rose’s work, including but exceeding *Governing the Soul*, has been significant in identifying psychiatric power as a key player in the formation of advanced liberal governmentalities, tracing how its practitioners, as well as its techniques of diagnosis and treatment, function to produce and govern liberal subjects (Miller and Rose, 1994; Rose, 1996; Rose, 1998). However, his chronicling and analysis of psychiatric history is less interested in the persistently martial character of psychiatric practice, which I track in this thesis, but instead foregrounds its successive governmentalization. For Rose, the history of Western psychiatry describes a trajectory from confinement to administration. The first stage in this development is the confinement of the insane in the asylum from the mid-19th century (1996: 6). This phase is followed by the extension of psychiatric authority beyond the asylum over all those populations deemed ‘degenerate’ in the early 20th century, which in turn predates the subsequent deployment of ‘mental hygiene’ as a means to prevent wider social dangers from the 1920s and 30s onwards (1996: 9-10). The evolution of psychiatry concludes with the establishment of community treatment in the post-war period, whereby psychiatric knowledge functions across multiple sites and through multiple actors to enjoin those in need of mental health assistance to learn the tools of self-governance (1996: 14).

While Rose notes that psychiatry played a role in implementing eugenic policies in Nazi Germany (1996: 9), and that it has also worked in the service of authoritarian regimes (1998: 15), these instances appear as exceptional and aberrant from a general psychiatric historical arch which invariably bends towards governmentalization. For Rose, the abiding importance and influence of psychiatric knowledge is that it fosters the technologies and rationalities for liberal subjects to learn how to govern themselves. He has little to say about those psychiatric patients who inevitably fail in this endeavour, and who are produced as being outside the confines of liberal subjectivity. It thus appears as though, in his effort to push back against facile critiques of psychiatric knowledge as entirely monstrous, Rose has overlooked how psychiatry, both in the past and the present, necessarily and routinely includes martial practices. More generally, Rose's account undertheorizes how routine violence like the enactment of debility and precarity, including through the denial of compensation payments, is as much part of psychiatric reproduction of liberal order as the production of liberal subjects who are 'obliged to be free'.

Nor is Rose alone in this appraisal. Some of the most well-known theorists of governmentality offer an account of stately order in which productive power only ever meets eager vessels, each submitting enthusiastically to the constraint of self-realization as a (neo-)liberal subject (Lemke, 2002; Rose et al., 2006; Jessop, 2007; Lemke, 2007). These scholars read Foucault's lectures on governmentality (Foucault, 2008) as an evolution in his scholarship and interests, away from a focus on discipline and docile bodies, towards an analytic of government understood as the 'conduct of conduct' (Lemke, 2002: 52). This analytic favours an appraisal of power relations as 'neither warlike nor juridical' but as a form of guidance which 'shap[es] the field of the possible' (ibid.). In these accounts, the modern state appears as the result of a process whereby power relations at a micro level, such as the 'government' of a family or religious community, come to be 'colonized and articulated into more general mechanisms that sustain more encompassing forms of domination' (Jessop, 2007: 36). In this state, the conduct of the conduct of subjects proceeds not through techniques of coercion and domination, but through 'positive techniques of government' leading to the responsabilization of the individual, empowerment, and privatized risk

management (Lemke, 2007: 45). It is decisive that in these accounts, the autonomy, responsabilization, and empowerment of citizens is not enforced through coercive measures but is eagerly taken on and replicated by the governmentalized subject. As Thomas Lemke writes, governmentality designates a collapsing of both the 'polarity of subjectivity and power' and of the 'dualism of freedom and constraint', instead opening a view onto those processes whereby power produces the subject, and whereby constraint enables and conditions freedom (2002: 59).

Yet in this reading of (state) power and subjectivity, pursuant to the collapsing of polarities between subjectivity and power, how is it possible to appraise the routine practices of dehumanization which are such a constitutive mechanism of modern statecraft? If there is no polarity between subjectivity and power, how to read those practices which deny subjectivity? And finally, how is one to understand those forms of constraint which do not lead to freedom but to precarity, debility, and the camps (for an account of how even liberal governmentalities rely on 'authoritarian' practices like incarceration for those deemed risky and dangerous, see Dean, 2002)? Throughout the three empirical chapters of this thesis, I trace how certain forms of psychiatric knowledge and practice enacted a martial politics whereby some patients were produced not as empowered, responsabilized subjects, but as threats to Man. Through techniques of diagnosis and treatment which characterized post-traumatic symptoms not as a response to stress but as the materialization of an inferior constitution, they denied these patients any form of political subjectivity, and subjected them to the endemic precarity of untreated illness, inability to work, and denial of state support. I argue that these formations of psychiatric power-knowledge were not incidental to psychiatric practice, or restricted to periods of outright fascism, but form an intrinsic part in the production of stately order. An account of modern statecraft which glosses over the routine and necessary (for the production of order) casting into Otherness of those recognized as threats to Man is incomplete.

1.3 Biological 'Inferiority' and Mass Death in German Historiography

Returning for a third time to the text which opened this chapter, this section will probe the implications of Gaupp inscribing nervous ill health into the bodily being of soldiers. If we recall Gaupp's reasoning for the breakdown of hysterical soldiers, we note that he insists their reactions were not called forth by exposure to the unprecedented horrors of mechanized warfare, but were an expression of the 'pathological disposition' of 'inherently nervous persons' (1915: 361). Gaupp thereby locates nervous aetiology in the physical being of the body, and conceptualizes its failings as preordained by hereditary fate. This move anchors sovereign subjectivity in the ontology of the body, which is a theme that will appear persistently across the three empirical chapters of this thesis. In the first empirical chapter, I discuss how psychiatrists sceptical of the traumatic neurosis diagnosis, which conceptualized post-traumatic nervous symptoms as a result of both physical trauma and mental shock, were increasingly drawn to explanatory models which privileged the worker's character as a fount of pathology. According to this approach, it was the workers' inherent aversion to work and vulnerability to seduction by overly generous pensions packages which produced incapacitating nervous conditions, not the accident itself. This shift of the psychiatric gaze inwards, towards a biologically or 'constitutionally' inscribed psychic disposition to breaking down, became increasingly pronounced during the early years of the 20th century, where it commingled with eugenic, degenerationist, and social Darwinist discourses of 'racial' and 'national' fitness. During the latter years of the First World War, what had previously been a multifaceted debate on the causes of traumatic injury (and by extension, on the being of Man) congealed into a monologue of 'psychopathic constitution', ringing in an era of German psychiatric knowledge in which biology was inscribed as destiny. This hegemonic discourse of trauma as a result of inferior constitution would remain effective throughout the years of the Weimar Republic and the Third Reich, which it would outlast by more than a decade. Only in the late 1950s would German psychiatrists mount a serious challenge to the psychiatric dogma on trauma, thereby undermining the biologicistic foundations on which Man had been constructed for several decades.

The stubborn and persistent inscription of political subjectivity in terms of hereditary attributes of the physical body, especially in a German context, raises the spectre of biological essentialisms associated with race and ability, and elicits the question of how scientific knowledge, including psychiatric knowledge, functioned to produce, authorize, and effectively circulate these essentialisms in political discourse. Foucault argues that the late 19th century witnessed a linkage between biological theory and political discourse, whereby a set of notions around evolutionary theory, pronounced within but exceeding Darwin's theory, encompassing notions of evolutionary hierarchy, processes of selection, and survival of the fittest, were coherently articulated as a means of conceptualizing politics (Foucault, 2002: 256-7). Thereby, relationships which may previously have been expressed as a form of political enmity or social deviance now became conceptualized as biological difference and threat. For Foucault, of course, the establishment of this link constituted a watershed moment in the history of modern power relations, from which point forward the sovereign state asserted its sovereign power as biopower, summoning the notion of 'race' to justify the mass death of populations in the service of 'racial' purification (2002: 258; see also Neal, 2004).

While Foucault's discussion of race in this lecture is not without controversy (Weheliye, 2014: 56-63), what I wish to draw out from his comments is the theme of political subjectivity articulated in biologized terms. The idea that the being of Man is tethered to evolutionary or racial attributes of the physical body will appear across the three empirical chapters of this thesis, and I will argue that psychiatric knowledge articulated and produced political subjectivity, as Foucault elaborates, through a biologized imaginary and nomenclature. As I already broached in the sections above, I suggest that this enunciation of sovereign subjectivity by psychiatric knowledge helped to produce the conditions whereby the three German genocides of the 20th century – of the Herero and Nama, of the disabled, and of European Jews – became 'conceivable' (Zimmerer, 2003: 62-3), and contributed to a politics in which these genocides appeared reasonable, rational, and necessary. I will submit that German politics, from the late 19th and early 20th centuries, evidenced a dominant formation of power-knowledge in which political subjectivity was increasingly conceptualized as

arising from attributes of the physical body. German psychiatric knowledge thereby helped to articulate a biologized hierarchy of being in which colonized, Jewish, and disabled subjects appeared as a ‘threat to the race’, and in which political opposition – as working-class socialists and communists, for example – could be conceptualized as arising from a bodily inferiority.

This argument troubles one of the most widespread approaches in German historiography to explaining the rise of the Nazi state. This approach, known as the *Sonderweg* (special path) thesis, avers that 19th-century Germany was burdened by the unresolved tension between a rapidly progressing industrialization and concomitant transformation of social relations on the one hand, and an ‘outdated’ authoritarian, semi-feudal political structure on the other (Wehler, 1988: 71). Instead of pursuing the ‘normal’ path to modernity taken, for instance, by England, France, and the United States, traditionalist elites in Germany blocked all attempts at meaningful democratization, thus ensuring that its state form remained mired in an ‘autocratic, semi-absolutist pseudo-constitutionalism’ (1988: 68). For Wehler and other *Sonderweg* historians, the stunting of liberalism and attendant forestalling of a ‘society of politically mature [*mündig*], responsible citizens’ was ultimately to blame for the ‘catastrophe of German fascism’ (1988: 11-12; see also Fischer, 1961). Significantly, the *Sonderweg*-reading of history grounds a view of the ‘exclusivity and uniqueness of [Germany’s] genocidal past’, stemming, as this reading would aver, from the atypical nature of Germany’s political development (Fitzpatrick, 2008: 481).

The most serious challenge to this thesis, until recently, flared up in the *Historikerstreit* (historians’ dispute) of the 1980s, in which a group of conservative historians around Ernst Nolte sought to characterize National Socialism as merely an episode in an intra-European confrontation between Bolshevism and ‘Western civilization’, and to cast Nazism as the anxious response to the murderous politics unfolding in the East (Nolte, 1994a; Nolte, 1994b). Jürgen Habermas, in a protracted exchange with these historians, led the charge against what many viewed as an attempt to normalize Germany’s Nazi past and sought to discredit it by stressing the historical uniqueness and incomparability of the Holocaust (Habermas, 1994). The skirmishes between

Sonderweg historians and their conservative challengers dominated German historiography of fascism and the Holocaust for many decades, restricting possible appraisals of Germany's past to either exceptionalism or apologia, to either an appraisal of the Holocaust as unprecedented mass death, or the relativizing wink-and-nudge of a historical assessment which seeks to finally draw a line under Germany's past, put to rest unending debates on the extent of German culpability, and return to the 'normal' business of expressing pride in nation and Fatherland (note Nolte's distress at a 'past that will not pass', 1994b: 22).

The *Sonderweg*-thesis, in this confrontation, carries enormous historical and political responsibility: confronted, both during the *Historikerstreit* of the 1980s as well as the present, with a resurgent xeno-nationalism and fascist apologia of Nazi crimes (consider, for instance, AfD party chairman Alexander Gauland's characterization of the Third Reich as simply a 'speck of bird shit' in Germany's 1000-year history, *Gauland: Hitler nur ein ,Vogelschiss'*, 2020b), it is tasked with proving as untenable any relativization of the Holocaust, and thereby with invalidating any attempts to lessen German historical guilt. Yet problematically, the *Sonderweg* reliance on an unreconstructed account of Western liberalism makes it ill-suited to this task. Explaining German-inflicted, racially motivated genocide as an aberration from liberal political culture is a hair-raising proposition, overlooking, as it does, centuries of colonial bloodshed perpetrated by European and North American armies and settlers, as well as the 20th century genocide of the Herero and Nama enacted by German colonial troops. The *Sonderweg* thesis, by diagnosing a deviation from liberal democracy as the root cause of genocidal fascism, obscures its emergence from forms of power-knowledge which produce populations as biologically 'inferior' – a form of power-knowledge which may readily be found in liberal democracies, including the West-German Federal Republic (chapter 5).

A vibrant German post-colonial literature emerged in the early 2000s to challenge this restrictive reading of Germany's past (Zimmerer, 2002; Zimmerer, 2003; Zimmerer and Zeller, 2003; Zimmerer, 2005; Zimmerer, 2008; Zimmerer, 2011; Kundrus, 2003a; Kundrus, 2003b; Dhawan and Castro Varela, 2015). Jürgen Zimmerer, in a

string of publications on German colonialism and Nazism, compellingly argues that colonial genocide, the Nazi war of extermination, and the Holocaust share conditions of emergence in a social-Darwinist ‘racial ideology’ which pits populations against one another in global struggle over limited space and resources (Zimmerer, 2008: 100). Writes Zimmerer, ‘This biological interpretation of world history – the conviction that a Volk needs to secure space in order to survive – is one of the fundamental parallels between colonialism and Nazi expansion policy’ (2008: 101). The Holocaust, according to this argument, is not unique but ‘an extremely radicalised variant’ (2008: 116) a race-based genocidal logic extending from settler colonial massacres at the American and Australian frontiers, to the German genocide of the Herero and Nama, to the industrial-scale mass killing of the Holocaust. While careful not to draw any simplistic equivalence between these events, Zimmerer avers that they are jointly undergirded by a shared ‘readiness to wipe out whole peoples’ (2008: 116).

The scholarly gesture which situates Nazi atrocity within longer (and more geographically widespread) histories of violence against dehumanized populations has a long tradition in anti-colonial thought and critical historical investigation. Writing in the 1950s and 60s, Aimé Césaire, Frantz Fanon, and Hannah Arendt identified German fascism as a ‘colonial system in the heart of Europe’ (Fanon, 1967: 33), and as a system whose instruments and governing rationalities had first been developed and elaborated in extra-European ventures (Césaire, 1972 [1950]: 36; Arendt, 2004 [1951]). Anti-colonial scholars thereby not only declined to entertain any thesis of the uniqueness of the Holocaust, but situated its occurrence within a global history structured, at this moment, by a European thought and a European politics premised on the exclusionary being of Man, which ‘reduced [humanity] to a monologue’ (Césaire, 1972 [1950]: 74). This monologue articulated European history as the history of political liberalization, scientific advancement, and increased standards of living through industrialization, interrupted, in the case of Germany, by a sudden descent into genocidal fascism. A breaking up of this monologue by bringing into view European and German histories as global, colonial histories foregrounds the fact that such narrations of history are incomplete at best, and more accurately obscure the

historical *longue-durée* of dehumanization and mass death inflicted onto colonized populations.

Relatedly, Zygmunt Bauman has debunked the notion, proffered by the *Sonderweg* thesis, that a deficit of modernization enabled the rise of Nazism (2013; 1989). Wehler and other *Sonderweg* historians conceptualize the history of Western sovereign statehood as proceeding teleologically along a linear, ‘normal’ trajectory, during which various modernizing processes – constitutional, social, economic – culminate in the formation of a modern liberal order with secure bulwarks against authoritarian rule and extra-legal violence. Bauman, however, contends that modernity itself furnished the conditions and necessary instruments for the genocides witnessed in the 20th century. Two aspects of modernity make it conducive to the enactment of mass death: first, Bauman contends that natural science since the Enlightenment had proven to be fertile ground for theories of scientific racism. Enlightenment philosophy was guided by the conviction that ‘Nature’ implanted attributes like character, temperament, and intelligence into a person, and that their precise inflection found expression morphologically, as ‘records written down in a code which science must crack’ (1989: 70). On this basis, scientific racism could arrogate to itself scientific authority for any claims about a ‘natural’ difference between human groups with distinct physiognomies (ibid.). Second, through rationalization and bureaucracy, modern states acquired the means to translate the specifically *modern* dream of a ‘pure and transparent social order’, cleansed of ‘social pollutants’, into reality (2013: 71). When the leadership of the Third Reich took the decision to purge its territory of all Jewish life, ‘[i]t went about it the way all bureaucracies do: counting costs, measuring them against available resources, and then trying to determine the optimal combination’ (1989: 78). Modernity, therefore, does not inoculate societies against genocidal tendencies, but engenders the means for their realization.

The analysis of psychiatric discourse and knowledge of trauma offered in this thesis seeks to make a modest contribution to this scholarship by situating the history of German (state) violence within larger epistemological and political formations which naturalize and call for the death of ‘subhuman’, racialized, and disabled subjects. I

trace how these formations took shape in the wake of an enforced biologized consensus in the discipline of psychiatry during WWI, and how this consensus remained effective into the post-WWII period. I will draw out how during this period, psychiatric knowledge entrenched a paradigm of Man articulated entirely in evolutionary, biologicistic terms, and in which political and social deviance became conceptualized as arising on account of hereditary, ‘constitutional’ inscription.

1.4 Psychiatric Knowledge and Practice in International Politics

In this final substantive section of the chapter, I return to its opening claim about the function of psychiatric knowledge in (international) politics, and scrutinize it in relation to existing literature in IR on psychiatric knowledge and practice. At the outset of the chapter, I argued that psychiatric knowledge and practice constitute a political ordering process which produces sovereign states and hierarchical global orders. Existing literature in IR on psychiatry largely falls into two camps: those which draw on psychiatry as a knowledgeable resource, and those which consider psychiatry a participant in political processes, and thereby an object of study. I will briefly explain this division and sketch out scholarly positions in each group, before situating the contribution made by this thesis within these literatures.

The use of psychiatric knowledge as a resource appears predominantly in the field of international political psychology, which draws on models from behavioural psychology to understand and predict the behaviour of various actors in international politics, including statespersons, diplomats, INGOs, publics, and others (Jervis, 1976; Tetlock and McGuire, 1986; Kaufmann, 1994; Tetlock, 1998; Goldgeier and Tetlock, 2001; Mercer, 2005b; Mercer, 2010; Sasley, 2010; Wong, 2016; Holmes and Yarhi-Milo, 2017; Yarhi-Milo, 2018; Cohen and Rapport, 2020; Bayram and Holmes, 2020). An especially generative subfield of international political psychology uses prospect theory, a hugely influential theory from the field of behavioural economics developed by the Nobel-Prize-winning cognitive psychologists and economists Daniel Kahnemann and Amos Tversky. IR scholarship mobilizing prospect theory typically

seeks to explain state agency in situations of duress, examining under which conditions states are more or less likely to engage in risky behaviour (Levy, 1992; Farnham, 1994; Weyland, 1996; Levy, 1997; McDermott, 2001; Levy, 2003; Mercer, 2005a; McDermott et al., 2008).

Another use of psychological knowledge as resource appears in constructivist IR. For instance, Alexander Wendt draws on the psychological model of the self developed by George Herbert Mead to theorize state identity as a set of attributes which are the product of interaction with external social forces, but which ultimately belong to a being which itself has ontological primacy (Wendt, 1992; Wendt, 1999). By thus ‘uncritically import[ing] from psychology’ the notion of a coherent self – very different from psychoanalysis, for instance, which denies the possibility and existence of such a coherent self – Wendt theorizes the state as an actor with modifiable interests and identity, but whose being itself must not be questioned (Epstein, 2011: 328). Further, since the early 2000s, subfields in constructivist IR, including interactionist role theory and ontological security literatures, have partaken in a socio-psychological turn. These literatures also draw on models from social psychology, specifically social identity theory (SIT), to argue that international actors possess a self which is formed and stabilized through various forms of societal interaction (Finnemore and Sikkink, 1998; Shannon, 2000; Flockhart, 2006; Greenhill, 2008; Klose, 2020).

The second set of IR literatures on psychiatry consider psychiatry not a knowledgeable resource but a site of practice, and therefore a field which in itself merits (international) political analysis. As Alison Howell cautions, ‘[w]hile not necessarily anti-psychiatry per se, a critical approach to the psy disciplines begins by assuming that they have nothing of use to tell us. They should be treated as empirical artifacts rather than sources of theoretical guidance’ (2013: 295). This thesis is guided by this methodological caution and considers psychiatric knowledge and practice as ‘empirical artifacts’ which play a substantive role in political ordering processes. Despite the importance of psychiatry in the constitution and reproduction of political orders, critical IR research on psychiatry is a very small field, made up largely by the

work of Alison Howell (discussed below), which itself draws heavily on Foucault's work (Foucault, 1965; Foucault, 2003; Foucault, 2006). In the following paragraphs, I offer a brief overview of Foucault's research on madness, psychiatry, and the asylum, as well as of Alison Howell's theorization of psychiatry as a technology of international security and order, before outlining the contribution of this thesis to this field.

Foucault published three major works on madness, psychiatry, and the asylum: *Madness and Civilization* (1965, originally published in 1961), as well as two series of lectures held at the Collège de France between 1973 and 1975, published as *Psychiatric Power* (2006) and *Abnormal* (2003). While different in focus and approach – *Madness and Civilization* is an archaeological work, focussing on representations of madness in art, literature, and various branches of scientific knowledge, while the latter two use the genealogical method to analyse the discipline of psychiatry and its institutional site, the asylum, as domains encompassing intricate networks of power relations – these works, read together, provide the foundation for casting doubt on the utility of psychiatry as a knowledgeable resource, and for recognizing instead the multiple ways in which it partakes in social and political ordering processes.

Madness and Civilization chronicles the history of madness not as the history of a medical condition, subject to successively more humane and effective treatment methods, but as the history of the constitution of madness as object, performed through its division from reason, and its gradual submission under the authority of medical, psychiatric authority (1965: ix). Foucault tracks conceptualizations of madness from the middle ages, where madmen were considered figures rich with symbolic meaning and were subject to ritualistic expulsions on 'fool's ships', which cruised the rivers of medieval Europe with a cargo of the perpetually troubled and insane in order to perform both a form of 'social exclusion' and 'spiritual reintegration' (1965: 7). During the classical age, the mad were swept up in the proto-bourgeois ordering moves which cleared the poor, vagrants, petty criminals, perverts, and madmen off the streets and into Houses of Confinement, where they were not only removed from view but where their idleness was channelled into productive

labour. During this period, writes Foucault, madness became associated with moral fault, and was perceived primarily through the lens of a 'condemnation of idleness' (1965: 58). Throughout the centuries of the classical age, the mad were thus shut away to prevent a feared disturbance to public order, and were put to work.

The present perception of madness as pathology, which can be treated or even cured under competent medical supervision, is a relatively recent invention and dates back only to the late 18th and early 19th centuries. During this period, which is now famous for spawning philosophies of the rights of Man and republican revolutions, psychiatrists liberated the mad from the dungeons where they were housed like animals, and unshackled them from the chains which were still used as a routine method of restraint. Yet Foucault insists that we read this frequently narrativized moment not as a blossoming of humanitarianism but as the birth of a new form of power whereby control of patients is established through techniques of 'surveillance and judgement', not the brute force of the whip (although these methods continued to be used; 1965: 251). The relocation of the mad, from Houses of Confinement to the asylum, signalled a shift towards treatment approaches which relied less on the use of brute force and instead capitalized on the authority of the medical personage. Madness thereby evolved from a moral fault to an illness, something which the patient could be educated and trained to leave behind (1965: 252).

Foucault returns to this aspect of psychiatric knowledge and power in the subsequent lecture series *Psychiatric Power* and *Abnormal*. Taking place shortly after the completion of *Discipline and Punish* (1995 [1975]), one of the most persistent and notable themes in these lectures is the asylum as a site for the production and diffusion of technologies of discipline (2006: 29). The foremost innovation of the asylum, writes Foucault, is the elaboration of a new form of power based not on the sovereign violence of torture and restraint, but on the subjection of the will of the madman, brought about through relationships of discipline (ibid.). This new disciplinary system became effective through an intricate system of relays in the hierarchy of the asylum, as well as through a 'microphysics of power' whereby the mind and body of the patient were bent to the order of the asylum through a methodical regime of training

and submission (2006: 27). Part of the reason why psychiatry plays such a critical role in the formation of modern political and social orders is that it helped to diffuse technologies of discipline throughout the social body, thereby establishing one of the core networks of contemporary political order. Psychiatry did this, in part, by offering its expertise to criminology, where it positioned itself as the holder of a unique and valuable expertise, namely the ability to explain apparently motiveless crimes, and diagnosing its perpetrators with a specific form of mental pathology (2003: 119). Psychiatry thereby not only established itself as a field with rare and necessary insight, but as privileged in its ability to diagnose and prevent dangers to society. Through its disciplinary techniques, it offered a view of social problems as objects which could be identified, named, brought under the remit of medical authority, and finally remedied through the application of rigorous treatment.

Read together, Foucault's work on madness, psychiatric knowledge, and the asylum offers an invaluable resource. Through recourse to this oeuvre, we are able to apprehend madness as the product of multiple and shifting historical constellations, and we recognize its association with danger, criminality, and pathology as contingent. Further, we note that the socio-political utility of psychiatric knowledge is both curative and ordering: its authority rests both on its claim to offer effective treatment to the mentally ill, as well as its function as a technology of socio-political order.

Alison Howell has undertaken the pioneering task of demonstrating how Foucault's insights on psychiatric power open up rich and generative research fields for the study of international politics. Across numerous publications (2010; 2011; 2012; 2013; 2014; 2015a; 2015b; 2017; 2018), Howell demonstrates that psychiatric power plays a significant role in international ordering and securing processes. In her 2011 monograph, *Madness in International Relations*, Howell investigates how psychiatric power renders different populations which are relevant for the maintenance of international security visible in the registers of psychiatric expertise, and offers tools for their effective and appropriate management. She traces how psychiatric power is mobilized to render each of these populations in a way which is amenable to the maintenance of international security – detainees in Guantanamo as threats,

‘traumatized’ populations in post-conflict settings as victims, and Canadian soldiers as security providers – and subjects them to different, albeit mutually reinforcing, regimes of sovereign, disciplinary, and governmental power (2011: 19). Elsewhere (2012), Howell tracks the rise of the PTSD diagnosis as a tool of discipline and self-governance. Chronicling the history of its emergence and its use both in military and post-conflict settings, she demonstrates how, in the case of soldiers, the diagnosis is wielded to ‘privatize’ their experience of warfare and to withhold disability benefits from them (2012: 221). Turning to the analysis of the PTSD diagnosis in post-conflict populations, Howell argues that it ultimately functions to place these populations under the administration and surveillance of international aid organizations, and thereby operates as a technology of governance (Howell, 2012: 218; see also Pupavac, 2001; Pupavac, 2002; Pupavac, 2004b).

Howell, by applying Foucaultian insights on psychiatric power to matters of international security, thereby does for the international what Nikolas Rose did for the domestic sphere of politics. Also drawing on Foucault’s work on madness and psychiatric knowledge, Rose (1999b; 1998) tracks how psychiatry first constructed the mad as a threat to social order and national security, before offering its technologies and expertise in their identification and treatment. Psychiatrists have thus inserted themselves into the frameworks for the maintenance of stately order and cast themselves as indispensable in this endeavour. The aim of this thesis is to make a modest contribution to this (currently still) small field of critical inquiry into the role of psychiatric knowledge and power in international politics (although I examine the production of stately order, I repeatedly situate these ordering processes within larger, global dynamics). Like Howell and Rose, I draw on Foucaultian insights to argue that psychiatric knowledge is a producer of sovereign, political orders and wields its expertise as a technology of security. Differently from Howell, I argue that this proceeds, in important measure, through the inscription of figures of Man and his human Others. I argue that psychiatric knowledge is a specific formation of modern scientific knowledge which, through these human inscriptions, is fundamentally entangled with the production and entrenchment of both sovereign, national, as well as international and global orders.

An important point of note here is that I mobilize Foucaultian concepts to think through the production of stately orders, a field in which Foucault himself at times expressed a lack of interest (in his lectures on psychiatric power, Foucault argues that an inquiry into disciplinary power ‘entails leaving the problem of the State, of the State apparatus, to one side’; 2006: 40). Although Foucault certainly did not remain true to these exclamations and spent ample time theorizing the formation of the state (2007; Foucault, 2008), this attribution may have contributed to Foucaultian scholarship shying away from theorizing matters of state. This thesis, however, does precisely that: it will use Foucaultian tools, modified by post-colonial and critical disability scholarship, to think through the production of stately order through psy-scientific knowledge.

1.5 Overview of Thesis Chapters

This final section of the Introduction provides an overview of each of the chapters of this thesis.

The following chapter sets out the theoretical framework for this study and elaborates its research methodology. In the theoretical section, I argue that psychiatric knowledge of trauma forms part of networks of power-knowledge-Man, which function to produce political orders by inscribing figures of Man and his human Others. Two accounts of the role of Man in modern formations of power-knowledge are relevant to this study: Richard Ashley’s (1989) and Sylvia Wynter’s (2003). Both draw on Foucault’s (2005 [1966]) theorization of successive and distinct epistemic orders to argue that the emergence of Man marks a transformation in the production of knowledge and the entrenchment of political order, both of which were now seen to be authorized by the human. While Ashley argues that the processes of the inscription of Man are perpetually contested, resulting in competing accounts of what kind of Man ‘really’ authorizes the political order of the sovereign state, Wynter cautions that the figure of Man is strictly circumscribed, and only few are able to appear as Man in the first place. I explain how Ashley and Wynter can productively

be read together to account for the specific production of German sovereign order by psychiatric knowledge. I proceed to explain that psychiatric practice functions, in part, through what Foucault terms ‘disciplines of the body’ (1995 [1975]), and that the exchanges between psychiatric patients and psychiatric practitioners are often characterized by war-like, adversarial relations (Howell, 2018). These adversarial relations, in turn, are expressed as a form of power pursuing the (at times necropolitical) debilitation of patients through the withholding of welfare (Mbembe, 2003; Puar, 2017). I conclude the theory section by arguing that read together, these concepts furnish the constitutive elements of what I term ‘psychiatric statecraft’. This term designates the functioning of psychiatric knowledge as a political ordering practice, proceeding through the production of patients as either sovereign subjects or their human Others. I subsequently outline the methodological procedure applied in this study, namely a genealogy of sovereign German order, generated by means of psychiatric statecraft. I outline the analytical steps, including the crafting of figures of Man through psychiatric paradigms of trauma, the inscription of descriptive statements by means of ‘disciplines of the body’, and the circulation of figures of Man and his Others in order to naturalize the political order of the sovereign, German state.

The first empirical chapter (chapter 3) traces the diagnostic dispute in the German disciplines of psychiatry and neurology over the ‘nervous’ conditions of factory and industrial workers in the 1870s-1900s. These workers had survived an accident in their workplace without any apparent physical injuries but suffered from a range of neurological and psychological ailments including anxiety, insomnia, partial paralysis, and bodily tremors. These accident survivors were the beneficiaries of Germany’s recently enacted welfare legislation, passed both to offer some support to unemployed and disabled workers, and as a means to withdraw workers’ support for the (recently prohibited) Social Democratic Party. Psychiatrists and neurologists clashed in their assessments of these patients, with only some recognizing a clear causative relationship between the ‘shock’ of the accident and subsequent post-traumatic condition, and thereby supporting their patients’ disability pension claims. Others suspected that not the accident itself, but the worker’s character was the decisive

factor, generating neurotic symptoms on the basis of a powerful desire for the material relief that a pension would bring. The chapter tracks how each psychiatric paradigm crafted competing figures of Man and his Others, and thereby produced different accounts of what constituted political subjectivity and a 'reasonable' politics to serve it. The competing political orders thus inscribed were the welfare state, offering material support to persons injured at their place of work, and a martial politics containing the threat posed by the worker, whose 'inferiority' was implanted into the being of his character.

Chapter 4 traces the evolution and escalation of this dispute in the context of an outbreak of 'hysteria' among soldiers during the First World War. As described at the outset of this current chapter, soldiers began suffering from mental breakdown on a massive scale after the initial war of movement had turned into a stationary trench war. Like the industrial workers of previous decades, these casualties appeared to have suffered no physical injuries, but were admitted to military hospitals with violent tremors, paralyzed limbs, stutters, muteness, and blindness which appeared to follow from particularly frightful experiences in combat. Psychiatrists and neurologists still disagreed over the aetiology, or cause, of these conditions, with some seeing the event, others a 'desiring wish' for personal safety, as generative of these conditions. However, in the context of the heightened stakes of warfare, this difference of opinion was deemed untenable, and the events-based diagnostic approach taken in previous decades deemed detrimental to military objectives and national security. The latter approach, which linked the breakdown of soldiers to a psychic wish for safety, became the dominant method for the diagnosis and treatment of trauma. In a heightening of the previous psychiatric tendency to link some post-traumatic conditions with a patient's predetermined 'inferiority' and character weakness, military psychiatrists increasingly appraised (working-class) soldiers who had been pulled from the trenches stammering, shaking, and paralyzed as being 'constitutionally' predisposed to breakdown. Through the catch-all term 'constitution', psychiatrists identified and fixated on a flaw in the bodily being of the hysterical soldier which was said to call forth their psychic collapse. The chapter closes with a brief survey of the political and psychiatric landscape following the war, when

psychiatrists increasingly voiced open support for a national politics guided by eugenic principles, and assumed an active role in suppressing the post-WWI revolutionary socialist movement.

Following the enforced diagnostic consensus of WWI, there ensued more than four decades during which the hysteria paradigm of post-traumatic injury, which posited that these conditions were always rooted in the desiring wish of a patient with an ‘inferior’ constitution, was hegemonic. As a result, throughout the years of the Weimar Republic and the Third Reich, psychiatric knowledge of trauma operated according to a diagnostic consensus which viewed hereditary ‘stock’, and thereby an ontology of the physical body, as decisive in producing symptoms of hysteria. German psychiatry also applied this orthodoxy to the claims of Holocaust survivors, who became eligible for compensation – in the guise of a health damages pension – from the West German state in 1953. The chapter (chapter 5) tracks how psychiatric practitioners appraised these survivors according to a paradigm deeply structured by ‘knowledge’ about the inherent attributes of the Jewish body, and about the origin of post-traumatic symptoms in a pathological, or psychopathic, disposition. I discuss how this formation of power-knowledge continued to produce a sovereign German order which cast Jews as the enemy of the German people long into the post-war period. I then track how a group of reforming psychiatrists challenged the hegemony of this diagnostic paradigm, thus insisting that the experience of persecution, dehumanization, and mass death enacted through the Holocaust was sufficient to produce long-term, chronic psychological symptoms in survivors. I close the chapter by reflecting on what kind of political order these reforming psychiatrists were thus authorizing, and how the figure of the Jewish survivor was mobilized to certify Germany’s transformation from genocidal pariah-state into a repentant and law-abiding democracy.

In the final chapter of this thesis (chapter 6), I review its core arguments and contributions. I briefly discuss the competing figures of Man and his human Others produced by the different paradigms of post-traumatic injury, re-examine the versions of sovereign German order they each authorized, from the welfare state, to the racist

and eugenic Darwinian state premised on notions of bodily fitness and disposition, to the post-fascist, post-Holocaust state keen to carve out a legitimate and respectable role for itself in the post-war, Western global order. Based on the long period of diagnostic consensus from the First World War until the post-World War II period, framed, in turn, by periods of psychiatric contestation and debate over the aetiology of trauma, I deliberate what this might mean for theorizations of statecraft, and whether it more typically proceeds in registers of radical instability, or through the restricted grammars of a modern episteme which must articulate Man in very limited ways. I then proceed to discuss the contributions of this thesis, which I locate in the identification of psychiatric knowledge and practice as a form of statecraft; in a blended reading of Richard Ashley's and Sylvia Wynter's account of the knowledgeable production of sovereign political order; in a characterization of many instances of psychiatric practice as a form of martial politics; and in the situating of instances of 20th century German (state) violence in epistemic and political formations which naturalize and call for the mass death of 'subhuman', racialized, and disabled subjects. The chapter, as well as the thesis, concludes with a discussion of the extent to which German psychiatric statecraft was typical of other psychiatric knowledgeable formations in Western Europe and North America, and deliberates to what extent an exceptionalist reading of German scientific violence, specifically against the racialized and disabled, is bound up with fascist state formations. I also offer reflections, in this final section, on the conduct of German psychiatric professionals in the 1990s, when yet another form of entitlement – in this case, the right to asylum – became caught up in debates over the aetiology of trauma and the supposedly fraudulent intentions of asylum seekers.

II. THEORY & METHODOLOGY

Knowledge and treatment of trauma are embedded in a number of complex relationships. On the one hand, they form part of an order of knowledge: the clinical observation, diagnosis, and treatment of patients with post-traumatic conditions occurs on the basis of conventions for the production of ‘true’ scientific knowledge. On the other, they form part of orders of power: psychiatric-scientific knowledge production emerges through, as well as re-inscribes, political orders. Both of these orders – of knowledge and power, of scientific ‘truth’ and politics – are structured, grounded, and guided by a particular understanding of who we are as humans: Man, and his human Others.

This chapter will set out how these networks of power, knowledge, and Man function, thereby elaborating a theoretical framework which will guide how I answer the research question of this thesis: namely, how psychiatric knowledge produces sovereign, stately orders. I argue that psychiatric knowledge entrenches unequal political orders and produces sovereign states by diagnosing and treating patients in relation to specific ‘descriptive statements’ of the human: Man and his human Others. Based on a reading of Richard Ashley’s and Sylvia Wynter’s theorization of the constitutive role of Man in modern orders of knowledge and power, I submit that psychiatric knowledge plays a fundamental role in crafting states and (inter)national orders by producing sovereign subjects and their dangerous Others. This proceeds through both discursive and bodily means of subjection, as I discuss in relation to Michel Foucault’s account of the ‘disciplines’ of the body. In closing, I turn to Alison Howell’s concept of ‘martial politics’ to explain how psychiatric practice frequently appraised its patients not as patients, but as political adversaries. Through their diagnostic and treatment practice, psychiatrists exposed these patients to warlike methods of government which most frequently took the form of withdrawal of welfare support, thereby exposing them to heightened precarity. I consider these warlike techniques of government in relation to Achille Mbembe’s notion of ‘necropolitics’ (2003) and what Jasbir Puar calls ‘debilitation’ (2017).

Read together, these concepts provide a lens for apprehending and theorizing what I term ‘psychiatric statecraft’: the functioning of psychiatric knowledge as both knowledgeable-scientific and political ordering practice which crafts its patients as either constitutive of, or threatening to, sovereign orders.

In the first part of this chapter, I outline theoretical concepts which elucidate how these complex networks operate, including Richard Ashley’s ‘statecraft as mancraft’, Sylvia Wynter’s theorization of knowledge, order, and Man, Michel Foucault’s ‘disciplines of the body’, and Alison Howell’s ‘martial politics’. In the second part, I explain how this theoretical framework translates into a methodological procedure for analysing psychiatric statecraft, and I detail the practical steps through which I conducted my research.

2.1 ‘Statecraft as Mancraft’ and the Inscription of Sovereign Order

This thesis argues that psychiatric knowledge produces stately orders by inscribing figures of sovereign Man and his human Others. To make this argument, I rely principally on the work of two theorists: Richard Ashley (1989) and Sylvia Wynter (2003). Both draw on Foucault’s theorization of successive and distinct epistemic orders in *The Order of Things* (2005 [1966]), where he makes the case that Man is a contingent feature of a specific (and finite) order of knowledge. While largely in agreement over the way in which Man as sovereign figure functions to authorize and ground political orders, Ashley’s and Wynter’s approaches differ in important respects. I will explore these divergences and argue that they can be productively mobilized to theorize the precise functioning of psychiatric statecraft.

In *The Order of Things* ([1966] 2005), Foucault argues that the figure of Man emerged in the context and as a consequence of Kant’s Enlightenment philosophy of knowledge. In this philosophy, he locates an epistemic break between the classical and modern orders: whereas the classical order had ‘known’ the world as arranged by God in a Great Chain of Being which humans could comprehend in a ‘true’ fashion

through linguistic or ideational representations, Kant inaugurated a new epistemic order by invoking the 'heroic figure of reasoning man' (Ashley, 1989: 264). Through use of his reason, this figure could know and interpret the world, not according to an orderly plan in which God had arranged it, but by appraising phenomena in their own right. However, Kant qualified, modern, reasoning Man is not God-like, and thus unable to behold the world from a purely objective position of detachment. Instead, Man is part of that same world of objects he is seeking to understand. He is entangled in, shaped by, and subject to the same social, political, historical, and natural scientific forces he seeks to know and analyse. Kant's epochal innovation was to recognize these limitations to Man's total knowledge as the *conditions* through which he is able to know in the first place. While Man's perception may be contingent on factors like subjection to space, time, and causality, Kant argued that it was precisely these factors which *enabled* Man to gain true, accurate knowledge. Therefore, the way in which modern man 'knows' results precisely from his peculiar 'limitation' as both transcendental subject and empirical object of knowledge (Foucault, 2005 [1966]).

The Kantian-Foucaultian figure of modern Man invoked by Ashley is thus defined by a 'critical limit attitude', or a particularly modern way of knowing and interpreting the world: he 'recognizes some specific limitations on his doing and knowing, not as external constraints, but as virtually constitutive of his autonomous being' (Ashley, 1989: 266). Thus, different versions of modern Man emerge, depending on which limitation is identified as both the condition of and constraint to Man's attainment of total knowledge: this might be the liberal 'possessive individual man', the Marxist 'laboring Man', the Freudian 'man of basic drives', or any interpretation of Man as sovereign subject both grounded in and limited by a modern way of knowing (*ibid.*).

What does the figure of modern, reasoning Man have to do with the sovereign state? As mentioned in the previous chapter, many 'modernist' IR theories of international order simply gesture to the state as factual, empirical entity and invoke the principle of sovereignty to denote its absolute and final authority within defined territorial boundaries. However, Ashley cautions that such an understanding of sovereignty – as the ultimate adjudicator of competing authority claims, or as resolver of all disputes

– is itself the result of epistemic moves around the figure of Man. Further, the state as sovereign entity only emerges in response to the perceived needs and requirements of this figure. I will address each of these arguments in turn.

Regarding the paradigm of sovereignty, Ashley explains that the modern episteme of reasoning Man entails a specific way of ordering, structuring, and spatializing the world. Whereas in the classical order, humans could trust that their ideas of the world truly represented God's arrangement of it, in the modern episteme Man himself is charged with knowing which discourse is true and authoritative, and which is false and dangerous. Now, to view the world and uncomplicatedly recognize the division of territories into neatly bounded, sovereign states is to prioritize and naturalize one interpretation of global 'order' over innumerable potential others. It means to discern from the 'polyphony of human conduct in history ... what shall count as the definite presence of a hierarchical center of rational decision' (1989: 292). It means to impose and wield a paradigm of sovereignty grounded in and authorized by a specific 'interpretation of man as sovereign being' (1989: 269). Coupled with a Cartesian practice of spatialization, whereby an inside 'space of identity and continuity' is carved out and separated from an outside 'space of difference and discontinuity', this sovereign procedure neatly and authoritatively orders the world. Crucially, it is only through the imposition of this paradigm – or a specific version of this paradigm – that one can determine 'what states, domestic societies, their boundaries, and their historical problems and dangers are' (1989:270).

Further, according to Ashley, not only the principle of sovereignty but the construct of the state itself emerges in relation to the figure of Man. As outlined above, in modern discourse, Man is both knower and known, transcendental subject and empirical object. This epistemic complication is expressed in questions of political rule and ordering practice: in modern discourse, the state exists precisely to enact laws and unleash targeted violence to protect Man against dangers entailed by his known, contingent, and necessary limits. In this sense, Man's authority as 'knower' and transcendental subject 'supplies the constitutive principle of ... the modern state' (1989: 268). At the same time, Man is also 'known' – he is ruled by the laws, norms,

and threats of violence he himself, as ‘sovereign Man’, has enacted for his own wellbeing. As a result, domestic society emerges as that space in which reasonable, sovereign Men submit to the state’s laws and violence in order to live to their fullest potential whilst being protected against essential threats (ibid.). The existence of such a ‘domestic society’ is crucial for the correct functioning of modern discourses of sovereign statehood, as this construct grounds the existence of a coherent, bounded, and discernible ‘people’, while also serving as that entity which is ‘represented’ by governing structures (Weber, 1995).

Ashley calls these ordering, spatializing, and territorializing moves which produce the sovereign state ‘statecraft’. With this term he refers to ‘all those local practices of differentiation’ which function ‘to differentiate a sphere of man and domestic society by setting it in opposition to things fearsome beyond’ (1989: 302). It thus encompasses the whole range of complex epistemic and political practices detailed above which order the globe, ground the principle of sovereignty, justify and call forth the state, and craft domestic populations as the ‘territorial ground of state legitimation’ (1989: 303). Importantly, all these practices operate in relation to, and are guided by, figures of Man. In Ashley’s terms, ‘statecraft’ is thus ‘mancraft’: by defining who, or what, Man is, one determines *that* the state must be (as defender against the essential limitations of Man), *what* the state must do (who it must guard against), and *who* the state is authorized by (the ‘domestic society of sovereign men’). As a result, all those practices which determine the characteristics of Man and use them to both cohere domestic populations and to craft sovereign, rational subjects must be understood as constitutive of (inter)national orders and sovereign states. This certainly applies to psychiatric knowledge, which in its diagnostic and treatment practice determines the being of Man by defining his essential limitations (i.e., ‘constructing his problems, his dangers, his fears’ [303]), which it in turn materializes by diagnosing, treating, and thus producing patients in relation to specific descriptions of Man.

2.2 Knowledge, Order, Man – Sylvia Wynter and the Coloniality of Being/Power/Truth/Freedom

Sylvia Wynter (2003) makes an argument about the production of political order by means of knowledgeable discourses of Man which is broadly similar to the one advanced by Ashley. She argues that ‘descriptive statements’ of Man and his ‘Human Others’ are embedded in discursive regimes which produce stratified political orders (2003: 262). These networks of power-knowledge-Man function as follows: orders of knowledge, which encompass the totality of what is ‘thinkable’ within the confines of any given regime of truth, are grounded in, and consistently reproduce, figures of the human and his Other. Political order, in turn, emerges in a ‘law-like manner’ from the ‘general order of existence’ articulated through the knowledgeable production of human figures (2003: 267; 279). Therefore, in medieval Christian Europe, a descriptive statement of humans as either ‘Fallen Flesh’ or ‘Redeemed Spirit’ undergirded a theocentric political and scientific order. According to this ‘general order of existence’, most humans, as descendants of Adam and tainted by his Fall, lacked the means to understand God’s grace and providence, and thus could never hope to gain true knowledge of his creation. This grounded an epistemic order which recognized ‘supernatural causation’, and in which scientists were constantly preoccupied with ‘sav[ing] the phenomena’, or adjusting the observed paths of celestial traffic in order to preserve the Earth’s position at the centre of the universe (2003: 272). It also sanctioned the political hegemony of the Church, whose clergy alone was deemed capable of guiding the fate of men in accordance with the will of God.

Mobilizing a concept coined by Frantz Fanon, Wynter calls this process ‘sociogeny’: while in evolutionary biology, ‘ontogeny’ describes the development of an individual organism and ‘phylogeny’ designates the evolutionary development of a species, ‘sociogeny’, for Wynter, defines the process whereby a social, political, and hierarchical order is produced through the specific constraints of a discursive regime of truth. Sociogeny is thus a particular (and productive) form of discursive constraint – some things are ‘thinkable’, others are not – through which the world is crafted and

apprehended. It designates the ‘lawlike manner’ by which discursive regimes based on figures of the human produce selves, others, and socio-political worlds (2003: 268). It is on this basis that Wynter famously links ‘Being/Power/Truth/Freedom’, arguing that our ‘Being’, or way of being human, is intimately connected to systems of social and political order (‘Power’), our systems and statements of knowledge (‘Truth’), and paths to emancipation (‘Freedom’) (ibid.).

What ‘statecraft-as-mancraft’ is to Ashley, ‘sociogeny’ is to Wynter: both turn to the figure of the human, or Man, to articulate how the production of political and stately orders proceeds through inscription of figures of Man by means of knowledgeable discourses. Yet Wynter’s account departs from Ashley’s in one important respect: she avers that the idea of a ‘by-nature’ difference between humans, enforced, for the last 500 years, by the concept of race, is fundamental to the creation and emergence of the figure of Man – for Wynter, neither this figure, nor the scientific and political orders supporting it, are thinkable without it (2003: 297). I already sketched out how a ‘by-nature’ difference between ‘Fallen Flesh’ and ‘Redeemed Spirit’ structured knowledgeable and political orders in medieval Christian Europe. In this order, the division between terrestrial and celestial realms, between the spheres of divine spirituality and degraded materiality, were actualized in an ‘ontological value difference between clergy and laity’ (2003: 314). The structuring force of this ‘by-nature’ difference remains in the two modern epistemic orders outlined by Wynter, realized in the figures she terms ‘Man1’ and ‘Man2’. Yet while the ‘by-nature’ difference in medieval Christian Europe drew a line between groups of humans, modern dividing practices parse Man as ‘generic, supracultural human’ from his ‘subjugated Human Others’ (2003: 288), thus limiting fully human status to a specifically circumscribed group.

Wynter explains that this division took place in the context of the Spanish conquest of the Americas, when the Spanish Crown sought new grounds from which to justify the ongoing enslavement and expropriation of American Indians. Under the prevailing Christian order, territory could only legally be expropriated if it was a ‘terra nullius’ and did not belong to a Christian Prince. Yet while this premise permitted

land to be taken from ‘pagan-idolators’ and ‘Christ-Refusers’ like Muslims, the fact that Christ’s gospel had never reached the Americas, and that as a result thereof Indians could hardly be termed ‘refusers’, troubled Spanish legitimacy of its transatlantic ventures (2003: 291; 293). This legitimacy was soon provided by 16th century Spanish theologian Ginés de Sepúlveda, who put forth the argument that the Spanish conquest was justified not by the Indians’ refusal of Christ, but by their irrational, inhuman, and uncivilized nature (2003: 286). For Sepúlveda, the cultural practices of American Indians, which included human sacrifice, demonstrated a barbarism and lack of natural reason which proved their status as ‘natural slaves’ (2003: 297). It was thus on the basis of their lack of an essentially human attribute – natural reason – that Sepúlveda authorized Spanish colonization, enslavement, and expropriation of American Indians. But not only that: this novel distinction between Man, figured as rational, and his irrational Other, also provided the basis for an explosion in scientific activity. The scientific breakthroughs commonly assembled under the rubric of scientific revolution were enabled, argues Wynter, by the shift from supernatural to natural causation grounded in the inscription of Man as rational being. This novel dividing practice between Man and his ‘subrational’, ‘subhuman’ Others was thus the ‘foundational basis of modernity’ (2003: 288).

Already in this early modern era, what animates the ‘by-nature’ difference between Man and his Others is the concept of race: in this new order grounded in the figure of Man as rational being, the phenotypal and cultural differences between humans began to be understood as the materialized expressions of a natural order willed by God, articulated by means of a Great Chain of Being in which all forms of life were arranged hierarchically, running from lowest to highest. It is thus that we find, in Linnaeus’ taxonomy of the species, ‘the Negro’ placed on the lowest rung of this chain, constituting the ‘missing link’ between humans and beasts (2003: 306; see also Bauman 1989: 70). The ‘idea of race’, therefore, long before any notion of scientific racism or concepts of biological race, instates the dividing practices between Man and his Others which will function as the foundation of modern political and scientific order. Yet the descriptive statement of rational vs. irrational inaugurated by ‘Man1’ also served to mark as ‘subrational’, and therefore lesser humans, populations within

Europe, permitting the mad to be recognized as subhuman and authorizing the custodial purges of the 18th century Great Confinement (2003: 304). Similarly, ‘that other major Other figure’, the Jew, was identified in successive epistemic and political orders as outside sovereign subjectivity – be it as ‘Christ-refuser’ in the medieval Christian order, as someone of ‘impure blood’ in the early modern period, or as ‘racially deficient’ under the strictures of the present episteme (2003: 307-8).

The epistemic shift to ‘Man2’ is brought about by a dual redescription of Man: as ‘optimally economic’ being by liberal humanists on the one hand, and as ‘purely biological’ being by Darwin’s theory of evolution on the other (2003: 314). In the context of this redescription, the ‘by-nature’ difference between Man and his Others comes to be located in the level of a person’s eugenic ‘selectedness’ (and hence as the outcome of an evolutionary process of natural selection), seen to determine a person’s ‘success or failure in life’ (2003: 310). This means that this modern formation of power-knowledge doesn’t simply pair whiteness with success and Blackness with failure but operates to obscure the human-made character of global inequalities as the result of an already inscribed genetic giftedness. If Black populations in Africa and North America are barred from economic thriving, this is known as the result of the ‘agency of Evolution and Natural Selection’, as well as of the ‘Invisible Hand of the Free Market’ (2003: 317), not the systemic racism inherent in a hegemonic knowledgeable formation.

The dually economic-biological being ‘Man2’ functions in two interconnected ways: its Darwinian element reduces the human to a natural organism, entirely produced and governed by the forces of natural selection. In ‘Man2’, evolutionary heredity inscribes fate into the biology of the body. As in the previous episteme, race is effective in modern knowledgeable orders as a marker of Otherness, latching onto ‘climactically determined phenotypal differences between human hereditary variations’ to ground a supposed ‘by-nature’ difference between humans (2003: 315). ‘Man2’s’ second defining element derives from the 18th century philosophy of Malthus, which situates humans in a perpetual struggle against overpopulation and natural scarcity. Besides being known as ‘eugenically selected’ being, ‘Man2’ is thus

figured as ‘jobholding Breadwinner’ and locates his Other in an ‘archipelago of Human Otherness’ including the jobless, homeless, criminalized, and ‘underdeveloped’ across the globe (2003: 321). It is thus that bio-evolutionary ‘selectedness’, in concert with a perceived ability to master natural scarcity, will function as an ordering principle which naturalizes local and global inequalities, and makes them appear as the result of a natural (i.e., inscribed by evolution) order.

2.3 Statecraft as Mancraft, Sociogeny, and the Shifting Dynamics of Order: A Joint Reading of Ashley and Wynter

Reading Ashley and Wynter together, we find that both offer an account of how knowledgeable practices, by crafting Man and his Others, inscribe and naturalize sovereign political orders. Especially Ashley’s theorization of ‘statecraft-as-mancraft’, through the specificity of the notion of ‘essential limitation’, provides a useful theoretical and methodological device for tracing how psychiatric knowledge produces sovereign order by casting the causes of traumatic injury as both condition and constraint to Man’s attainment of mastery. For instance, we will see in chapter 3 that survivors of industrial accidents were first perceived by psychiatrists as suffering from psychic shock as a result of the distressing experience they underwent. By supporting these patients in their claims for a disability pension, psychiatrists inscribed industrial modernity as both condition and constraint for the emergence of Man as sovereign figure: industrial modernity as condition because it promised the means to material fulfilment, yet as constraint by placing Man under the threat of physical destruction. Man crafted in this way requires certain services and protections from the state, including first and foremost an accident or disability pension in case of injury from the forces of industrial modernity. In this way, ‘statecraft-as-mancraft’ is able to capture many of the complex processes whereby psychiatric knowledge inscribes sovereign figures and thereby grounds sovereign, stately order.

Yet at the close of chapter 3, throughout chapter 4, and at the beginning of chapter 5, we will encounter an epistemic field in which some psychiatrists insist that the only

acceptable way to diagnose patients is in terms elaborated by Wynter: as entirely biological organisms, fated by evolutionary inscription to either withstand traumatic stress or to be knocked down by it. These psychiatrists will argue that not the traumatic event itself, but a patient's constitution was the ultimate cause for their psychic breakdown. Very frequently, these patients were working class, socialists, communists, or Jewish. We will thus repeatedly encounter psychiatrists mobilizing evolution and natural selection as an explanatory model to authorize notions like 'racial' disposition to breakdown, and to inscribe a pre-existing 'inferiority' into the bodies of workers, socialists, and communists. In these psychiatric discourses, sovereign subjectivity will become an attribute of the physical body, something which has either been ordained by 'eugenic selectedness' or denied by 'dysgenic dysselectedness' (Wynter, 2003: 325). Through Wynter's caution about the colonial context of Man's emergence and the continued, evolutionarily inscribed, racializing operation of modern knowledgeable discourses, we will be able to apprehend and track clearly what is unfolding in these psychiatric discourses.

Drilling down into the respective dynamics of ordering practice Ashley and Wynter each describe, using the concepts 'statecraft-as-mancraft' and 'sociogeny' respectively, we find that they suggest different levels of stability and instability, contingency and determination, openness and restrictiveness in the process of their formation. For Ashley, the process of statecraft through inscription of a sovereign figure is fundamentally open: Man is a "form" that leaves open the question of "content", and might be summoned and filled with meaning by any modern discourse seeking to make a knowledgeable, ordering statement about the world (1989: 266). For Ashley, statecraft always is and remains a contested process, as competing knowledgeable discourses inscribe different sovereign figures and thereby seek to secure their claim to authority over sovereign order. Yet again, Wynter alerts us that this process can come to a near-standstill, as regimes of truth become so restricted that they lead to an 'ossification of our present order of knowledge and its biocentric paradigms' (2003: 330). For Wynter, the productive ordering processes of sociogeny are scripted to operate in what she terms a 'lawlike manner' (2003: 267), assigning persons their role within hierarchical socio-political orders through knowledgeable

discourses hinging on specific discourses about the being of Man – as either rational or irrational figure ('Man1'), or a biocentric *homo oeconomicus* using his eugenically assigned gifts to struggle against natural scarcity ('Man2'). It is only during periods of epistemic transformation – the humanist challenge to a theocentric order of the Church, or the bourgeois-liberal challenge to the order of the absolutist state – that disputes around the being of sovereign figures surface. Wynter locates the emancipatory struggles of the 1960s as the most recent, albeit failed, instance of such a contestation, during which Man's 'overrepresentation' – the conceit that the figure designates all humans, while in fact encompassing only a small, economically privileged subset – was attacked, and attempts took place to reinscribe human being outside of its present terms (2003: 267).

Based on this blended reading of Wynter and Ashley, we are able to articulate how 'statecraft' proceeds in shifting modalities and through psychiatric-scientific and other knowledgeable discourses operating in relation to figures of Man. However, as the following empirical chapters will demonstrate, psychiatric knowledge also functions by observing, confining, submitting to pain, training, and exercising the individual *bodies* of its patients. These forms of bodily subjection, we learn from Foucault, are not an expression of cruelty or random violence. Instead, they are both means to, and support for, a 'modern' set of power relations which disperses rule throughout the entire population and implants specific fears, desires, and identities within the subjects themselves, who are thus charged with governing their own 'selves'. For psychiatric knowledge, these 'disciplines of the body' are an indispensable means by which patients are diagnosed and treated in relation to descriptive statements of Man.

2.4 The 'Disciplines of the Body'

Foucault famously argued that the nature of power relations shifted at the end of the classical period, fracturing from a purely sovereign mode into sovereign, disciplinary, and governmental procedures by which individuals and populations were governed. These shifts, Foucault argued, could best be traced by analysing power's hold over

the body. Early modern, sovereign orders exalted the bodies of kings and publicly eviscerated the bodies of regicides, but remained mostly uninterested in the bodies of regular subjects. By contrast, disciplinary and governmental orders seize both the body of the individual and the massified body of the population, on which they train mechanisms which extract knowledge, produce subjects, trace regularities, foster longevity, and manage morbidity (Foucault, 1995 [1975]; Foucault, 1978; Foucault, 2002; Foucault, 2007). Importantly, it is precisely by finding its ‘footing’ in these various, dispersed, and localized mechanisms that the contemporary state can appear and function as simultaneously administrative, juridical, disciplinary, and biopolitical entity (Foucault, 1994: 123; see also Jessop, 2007: 37; Lemke, 2007: 50).

While psychiatric knowledge is engaged in all three of these power relations, I want to specifically foreground their disciplinary, bodily procedures in this section. This is important because part of the labour of statecraft theorized by Wynter and Ashley proceeds by crafting individuals as *subjects* in relation to descriptive statements of the human. The subject, as a modernist form of conceptualizing individuality and agency, can be produced by various means, including scientific knowledge, different ‘dividing practices’, as well as technologies of the self (Foucault, 1982: 777-78). However, without an account of the bodily means of subjectivation, a significant portion of what I will term ‘psychiatric statecraft’ will remain illegible.

The innovation of disciplinary regimes was to ‘discover ... the body as object and target of power’ (Foucault, 1995 [1975]: 136). In a number of different sites including the asylum, the monastery, the prison, army barracks, and the school, individuals were subjected to newly developed methods known as ‘disciplines’. These disciplines included different means by which bodies could be made ‘docile’, or amenable to meticulous control, such as through the rigorous training of bodily movements, the rational division of space, the implementation of precise timetables, and subjection to an unflinching and constant gaze (1995 [1975]: 136-7). It is precisely this type of disciplinary regime which we will encounter in descriptions of psychiatric treatment for hysteria, which function by training the movement of every muscle and imposing the force of the ‘will’ over unruly affect. Yet for all their cruelty, it would be a mistake

to characterize the disciplines as regimes of wanton violence. Their primary effect is the production of a 'soul', 'psyche', or 'subjectivity' by which disciplinary aims and procedures are internalized. The soul is 'the machinery by which ... knowledge extends and reinforces the effects of this power', meaning that disciplinary objectives hence become the subject's own objectives (1995 [1975]: 29). A successful disciplinary procedure will result in the subject internalizing and governing desires, preferences, enmities, and prohibitions in themselves.

Foucault's conceptualization of the 'disciplines of the body' constitutes an important complement to the account of psychiatric statecraft sketched out so far. With its focus on bodily means of subjection, it provides the tools to apprehend how psychiatric knowledge crafts individual patients as subjects in relation to descriptive statements of Man and his Others. But before closing out the theoretical section of this chapter, I will explore in more detail one element of statecraft which is implicit in the account presented thus far. As detailed above, psychiatric knowledge operates in relation to descriptive statements of Man and his Others. This means that in any given context, some patients will be recognized, diagnosed, and treated as/in relation to Man, while others will be known and treated as his dangerous, pathological 'Other'. In empirical terms, this means that some patients will receive excellent treatment (i.e., treatment that is requested, required, and effective) while for others, 'treatment' functions as nothing but a form of 'defense of society' (Foucault, 1995 [1975]: 90) against the threat they are known to incarnate. As the following chapters will demonstrate, the treatment offered by the psychiatric sciences to these 'Others' recognized and produced as essential threats to the well-being of the society of Man functioned primarily to naturalize their proximity to destitution, precarity, and death. Psychiatric knowledge thus enacts and engages in a form of politics which secures sovereign order by confronting 'threats' in a war-like manner, or what Alison Howell calls 'martial politics'.

2.5 Martial Politics, Necropolitics, Debilitation

Most ‘modern’ accounts of politics theorize violence, war, and statehood through an analytic of division: the ‘inside’ is cleaved from the ‘outside’, war from peace, and ‘normal’ from ‘exceptional’ politics. This division not only sustains a theory of the sovereign state as bounded, territorial, agentic entity, but carves out a domestic realm of peace in which conflicts are resolved through rule-based mechanisms and the targeted, reasonable, and legitimate use of force. The analytic of martial politics challenges this division: based on the assertion that relations of war and peace, military and civilian spheres, as well as concerns of national and social security are not distinct but historically co-constitutive and imbricated, it designates a state of affairs in which ‘war-like relations of force’ are not exceptional but common to liberal orders (Howell, 2018: 2). More specifically, it highlights that violence against marginalized populations including racialized, Indigenous, queer, poor, and disabled groups is not an aberration from liberal norms of governance but intrinsic to the functioning of a white supremacist, socio-economically stratified, and ableist liberal order.

Howell develops the theorization of martial politics from a critique of the before/after temporality inherent in concepts like militarization and securitization. These concepts imply that prior to an issue becoming a concern for the military or security apparatus, it was confined to an entirely civilian, peaceful realm of ‘normal’ politics. However, close historical analysis of the formation and development of the police, the university, and other sites which supposedly have been ‘militarized’ or ‘securitized’ conveys that these sites, regimes, and activities have always been imbricated with warlike relations of white supremacy, colonialism, and compulsory ableism, and thus have always been ‘of war’ (ibid.). For instance, Howell evidences the historically martial character of policing by foregrounding its emergence in the United States from slave patrols, and draws attention to the routine deployment of military or extra-legal violence to quell Black dissent. She thus rebuffs claims that policing has only recently become ‘militarized’ and instead identifies it as a technology of white supremacy which routinely wields violence against racialized populations to uphold a racially stratified status quo (2018: 6-7).

This applies equally to appraisals of scientific knowledge and healthcare. Howell notes that contrary to claims made by theorists of securitization theory that health has recently become ‘securitized’, it is more accurate to think of medicine as ‘a kind of normalizing and biopolitical “social warfare”’ (2014: 970). Medicine is not a walled-in sector, operating according to purely medico-scientific rules and standards, striving only to meet medico-scientific objectives. Instead, it is part of the same networks of power, knowledge, and Man which characterize, structure, and form scientific knowledge production and the reproduction of sovereign orders. As a result, an order which routinely recognizes and crafts racialized, poor, and disabled subjects as ‘naturally’ closer to death will not carve out a ‘neutral’ sphere of medicine which operates independently of these constraints. Instead, medicine is as ‘war-like’ and martial as the university and the police. Historical analysis demonstrates that medicine makes its greatest ‘advances’ in the context of warfare, and that medical professionals eagerly deploy their expertise in the service of genocidal political ideologies (ibid.). Therefore, ‘[i]t is not that (medical) science has been encroached on by war, or “weaponized”, rather it is that these two things have been producing each other and working through the same logics[...] of population health and enhancement for quite some time’ (Howell, 2017: 150).

This conceptual frame brings into view the production by psychiatric statecraft of an Other known and treated as a threat to the sovereign order. This thesis will focus on three groups of post-traumatic patients which became subject to martial, psychiatric statecraft, namely the industrial worker, the hysterical soldier, and the Holocaust survivor. It will analyse how these groups were recognized as something Man must fear, and how psychiatric knowledge was deployed to naturalize and foment these groups’ exposure to destitution, precarity, and death. I will argue that this was neither an accident nor an expression of random violence from a depraved psychiatric institution, but a result of psychiatric statecraft’s production of these post-traumatic patients as a danger to the well-being of Man, and as such, a ‘normal’ expression of the operation of psychiatric knowledge.

The following chapters will show that psychiatric patients were rarely killed outright – something one might expect of a form of psychiatric knowledge theorized as ‘martial’. Instead, psychiatric knowledge in its martial mode functioned first and foremost to withhold entitlements, such as accident and disability pensions or compensation payments, from sufferers of post-traumatic conditions. This was coupled with a diagnosis which pathologized patients, minimized their suffering, charged them with duplicity, and located the origins of their symptoms in either their own obstinacy or genetic inadequacy. As a result, martial psychiatric practice subjected its patients to an attrition of their health and vitality by barring access to effective medical-psychiatric treatment and denying welfare and compensation payments. How to theorize the specific mode of power wielded over those populations produced as ‘subhuman’ threats to Man, and targeted with the withdrawal of welfare?

Recent scholarly engagement with Foucault’s biopower (2002) thesis provide a useful lens for the appraisal of the precise operation of psychiatric statecraft in relation to patients treated in an adversarial and martial mode. Biopower, Foucault suggests, is a modification of forms of rule occurring over the 18th and 19th centuries. During this period, the distant and transactional nature of sovereignty as the ‘right of life and death’ (2002: 240) began to transform: power, actualized until that time as a ‘levy’ on products, the harvest, labour, and courage (2006: 43) henceforth inserted itself as a constant companion into all aspects of human existence. Through a range of technologies, it claimed authority over both the individual bodies of persons and the mass of population, seeking to cultivate their health and productivity (2002: 242). Biopower, as the form of power seeking to foster the health of populations, installed mechanisms to monitor their vitality and morbidity, to regulate the incidence and severity of illness, and to forestall death (2002: 243-5). Whereas sovereign power traditionally had been the power to ‘take life and let live’, biopower extended its aims to seek to ‘make live and let die’ (2002: 241).

In the context of a new form of power seeking to foster life, the ‘power to kill and function to murder’ (2002: 255) took on a novel, and particular, function. Race,

Foucault suggests, had until then simply ‘designate[d] a certain historico-political divide’, or a binary structuring device of the social (2002: 77). Yet in the 19th century, this notion of race underwent a transcription into biological forms, reframing political enmity in evolutionary logics as a struggle for survival between competing human ‘races’ (2002: 80). For Foucault, the articulation of political enmity in terms of ‘race struggle’, in the context of an accelerating transformation of forms of power trained on life and the body, culminated in the Nazi state. This state, argues Foucault, exemplified a political formation in which sovereign, disciplinary, and biopower had reached their fullest extreme, enacting an ‘absolutely racist State, an absolutely murderous State and an absolutely suicidal State’ (2002: 260).

Despite the teleological inflection of this argument, leading from the rise of biological racism to the Nazi death camps, Foucault is comparatively opaque on the specific modalities of death and dying under biopolitical regimes. Except to argue that racism ‘fragment[s] ... the field of the biological’ (2002: 255), Foucault divulges few details of the biopolitical enactment of lethality.

The death-bringing function of biopolitics has been a highly generative field of theorizing, with Giorgio Agamben (1998) analysing death and dying in the Nazi camps, and Achille Mbembe (2003) and Jasbir Puar (2007; 2017) scrutinising the management of life and death in the colony. I argue that specifically these latter engagements are generative for coming to grips with psychiatric practice in its martial mode, as the treatment of patients produced as ‘subhuman’ by German psychiatry proceeds through logics akin to those tracked by Puar and Mbembe in a colonial setting. These logics encompass both the production of debility by means of a sovereign ‘right to maim’ (Puar, 2017) and the necropolitical enactment of ‘death worlds’ (Mbembe, 2003). I will briefly discuss each.

For Puar, debilitation designates the status of a segment of the population which suffers from ‘precarity and (un)livability while being denied the status and services available to the disabled’ (2017: xiv-xvi). Differently to those formally recognized as disabled and able to ‘aspire both economically and emotionally to wellness,

empowerment, and pride' (2017: xvi), the debilitated are more commonly racialized bodies, simply 'expected to endure pain' (2017: xv). Debility thus constitutes a useful rubric to apprehend the psychiatric treatment of those patients who, on account of their 'subhuman' status, are never permitted to recover from their psychic injuries and are maintained in an endemic status of 'slow death' through permanent ill health and denial of essential services (Berlant, 2007).

Puar argues that debilitation, as enacted by the Israeli Defense Forces (IDF) through its policy of 'shooting to maim' Palestinian protesters and its targeted destruction of infrastructure in Gaza, does not fit within the established 'four quadrants' of biopower encompassing make or let live, and make or let die (2017: 140). Instead, the dual practice of targeted injury and attrition of infrastructure must be understood as a sovereign gesture in its own right, seeking neither to make live nor let die, but *refusing to let die*. Subject populations are thereby suspended between life and death, and are cast into 'perverted versions of life [which] seem and feel like neither life nor death' (2017: 139). The status in which these populations are maintained ultimately track neither towards life nor death, but remain moored in the liminal status of permanent injury.

In the three empirical chapters (3, 4, and 5) I argue that certain groups of trauma patients were dehumanized by psychiatric knowledge on account of a purported lack of evolutionary 'selectedness' and were subsequently subjected to debilitation through the withholding of welfare. This functioned to diminish their health and vitality, and to suspend them in a state of permanent injury, while withholding the means through which they might seek designated support and recognition as 'the disabled'. Yet in its encounter with Holocaust survivors, this debilitation takes on a necropolitical quality.

Necropolitics, according to Mbembe, designates a 'formation of terror' (2003: 23) specific to the extra-legal realm projected onto the outside of Western, sovereign order. In these spaces, power functions to dismantle and newly reassemble existing spatial and social relations, replacing functioning human communities with 'death-worlds' in which sociality, bodily integrity, and full citizenship are perpetually denied

(2003: 40). Mbembe tracks the creation of ‘death-worlds’ across multiple historical and geographical sites, from the slave plantation to the modern and late-modern settler colony, noting that it encompasses a variety of instruments to divide space, upend property arrangements, enact surveillance, craft ‘cultural imaginaries’, and articulate and enforce newly created hierarchies (2003: 25-27).

From these multiple modalities scrutinized by Mbembe, one is particularly resonant with the treatment of Holocaust survivors by the West-German state: it is the rending of the social world in the lives of slaves. This rending is enacted by means of a ‘triple loss’ – the ‘loss of “home,” loss of rights over his or her body, and loss of political status’ (2003: 20). Through this loss, slaves are cast into a form of ‘social death’ (2003: 21), signified by the inhibition of community, speech, and agency on the plantation. Holocaust survivors arguably underwent a similar ‘triple loss’ in the camps, suffering first through the expropriation of their property and subsequent deportation, then enduring the utter subjection to unbridled violence and lethality in the camps. All of this, of course, had been subtended by the revocation of citizenship for Jewish Germans in a series of laws issued between 1933 and 1941 (*Restoration of German Citizenship*, n.d.). I suggest that the torment enacted by German medical and administrative authority on Jewish survivors of genocide resonates with the sundering of social worlds enforced on the plantation. German psychiatric power in the post-WWII era prolonged and extended the anti-Semitic, race-based persecution of the Nazi State through its dehumanizing treatment. By withholding treatment and perpetuating experiences of dehumanization, psychiatric practitioners ensured that states of terror and abandonment first actuated in the camps remained active after liberation. The effect of this perpetuation of psychic suffering, of the re-enforcement of their sense of isolation and loss of sociality, was to allow the ‘death-worlds’ of the camps to linger long into the post-war period.

For Puar, biopolitics in the colony unfolds in a strategic manner. Puar theorizes ‘shooting to maim’ as a means to ‘achieve the tactical aims of settler colonialism’ through the dual enactment of debilitation (2017: 143). This dual enactment proceeds as follows: first, by maiming protesters in a context of ‘utter deprivation’ which denies

them any means to ‘capacitation’ through effective treatment, rehabilitation, and eventual empowerment through claiming the status of disability, and second, through the ‘maiming of infrastructure’ as a means to ‘decay the able-bodied into debilitation’ (2017: 144). This not only enables heightened control over a chronically weakened population, but through the avoidance of mass death, Israel articulates the sovereign techniques of maiming and debilitation in the benevolent terminology of a ‘humanitarian approach to warfare’ (2017: 129). This obscures the deliberate and targeted deployment of maiming and infrastructure destruction as techniques of sovereign power which serve to uphold settler colonial rule.

In chapter 5, I argue that a comparable instrumental use of biopower was at play in German psychiatric treatment of Holocaust survivors. By withholding treatment and welfare from survivors, German medical and administrative authorities perpetuated a form of anti-Semitic persecution and produced debilitation among survivors. Yet at the same time, while enacting this enduring persecution through the entirely legal mechanism of the negative outcome of a psychiatric exam, conducted within the framework of federal compensation legislation, Germany fulfilled the strategic aims of shedding its status as pariah state, and regaining access to the hallowed circle of ‘respectable’ Western democracies. It is in this way, I suggest, that psychiatric statecraft in post-WWII Germany both simply proceeds according to the rules of a Darwinist, biocentric episteme while also pursuing the strategic aims of re-admission to the club of Western powers.

Nazi politics of genocide and mass death, its wars of territorial expansion and extermination, cannot be collapsed into an analytic of colonialism. However, it is nonetheless productive to think 20th century German statecraft and violence as unfolding in overlapping and mutually reinforcing colonial and Nazi formations. This allows us to take seriously – and to bring into view as a deployment of sovereign power – welfare withdrawal from dehumanized populations, in this case Holocaust survivors. Through the rubrics of Puar’s sovereign ‘right to maim’ and Mbembe’s ‘necropolitics’, this practice emerges as an extension of a Nazi politics which permanently denied Jewish persons access to human status on account of a perceived

‘constitutional’, or ‘racial’, inferiority. Psychiatric practitioners, by diagnosing traumatized Holocaust survivors as ‘psychopaths’ and denying their applications for health damages pensions, thus enacted a martial politics of post-genocidal debilitation on Jewish Holocaust survivors by suspending them in a state of reduced vitality and slow death. It achieved this by continuing to produce, through knowledgeable psychiatric discourse and practice, Jews as ‘subhuman’ threats to sovereign German order and by shifting its biopolitical appraisal of them from ‘must die’ to ‘will not be seen to let die’. This, in part, permitted the West German state to reap the benefits of international re-integration with Western powers and to claim prestige from performing atonement through compensation of those who had survived its death camps.

2.6 Psychiatric Statecraft

Reading these concepts together, psychiatric statecraft emerges as the process whereby psychiatric knowledge produces political orders and sovereign states by inscribing descriptive statements of Man and his Others within a complex network of order, knowledge, and Man. These relationships are not causative but genealogical, or ‘complexly interconstitutive’ (Brown, 1995: 183), the operation of each inscribing, re-enforcing, and sustaining the other. Yet the role of Man is fundamental to its functioning: specific descriptive statements of the human ground the ability to make knowledgeable statements, to compartmentalize space, to naturalize socio-economic and other global inequalities, and to ‘see’ the sovereign state as cohered by a rational, sovereign centre. Reading Wynter and Ashley together, I argued that the figure of Man must be understood as an epistemic construct forged in the historical context of colonization and confinement. As such, the descriptive statements of the human grounding the modern episteme are framed by Man as *homo oeconomicus* and natural organism, and his inhuman Other, recognized in all those who are ‘dysselected’ by evolution and fail to succeed in the mode of economic self-actualization. By layering Ashley’s account of ‘statecraft-as-mancraft’ with Wynter’s theorization of ‘sociogeny’, I am able to track the shifting dynamics of psychiatric statecraft across different

temporalities which evidence unequal openness or restrictiveness in knowledgeable inscriptions of the figure of Man. Joining these readings with Foucault, Howell, Puar, and Mbembe, I argue that psychiatric knowledge operates, in part, by crafting subjects through bodily means of subjection, and that these practices form part of a martial politics of statecraft whereby groups constituted as threats to the wellbeing of Man are confined to situations of debility, precarity, and unliveability.

In closing, if systems of power, knowledge, and Man articulate and sustain each other, what are the possibilities for resistance? The account of these systems sketched out so far appears rigid – I have argued that psychiatric knowledge, in order to be understood as ‘true’, must be articulated according to specific epistemic precepts grounded in descriptive statements of the human (which, in turn, craft and authorize these descriptive statements), and that political orders both find their footing in and naturalize these descriptive statements. However, these political and epistemic orders are not set in stone. First, descriptive statements of the human are open to contestation, and as Wynter demonstrates, have been revised a number of times already, resulting in a fundamental re-ordering of knowledge and political order. Second, while the current order of Man, both in its Renaissance humanist and Darwinian iterations, has evidenced remarkable staying power, it is not invulnerable. According to Wynter, we must abolish Man – not in order to inscribe a different sovereign figure, but to instead engage in a ‘science of the Word’ which appraises humans as produced by both physiological and cultural-psychological processes (2003: 331). By renouncing a descriptive statement of Man as natural organism ‘selected’ by evolution, this alternative conception grasps humans as simultaneously natural and cultural organism, and as materially and narratively produced. Chapter 5, which considers the legal and epistemological confrontations of Holocaust survivors with the German state and German psychiatric orthodoxy, will explore the question of resistance in more detail, and will deliberate whether the challenge articulated by an ‘emancipatory’ form of psychiatry was able to topple, however briefly, the episteme of Man.

2.7 A Genealogy of Psychiatric Statecraft

This thesis excavates a history of psychiatric statecraft in Germany from 1871-1969. Focusing on three disputes concerning the nature and correct treatment of post-traumatic conditions, it will analyse how psychiatric practice secured successive orders of Man and inscribed sovereign German order through its diagnostic and treatment methods. Rooted in the tradition of genealogy, the aim of this history is to infuse with contingency our understanding of German political order, specifically in relation to psychiatric authority and practice. As I have laid out in the introduction, a widespread understanding of German history since the foundation of the *Reich* in 1871 places Germany on a stunted path to liberal modernity, bogged down in dead-end trajectories of ultra-nationalist conservatism and exultant militarism, only to emerge redeemed, after having passed through the ‘purgative rigors’ (Fitzpatrick, 2008: 481) of National Socialism, in the post-war period as a model-student of liberal, Western statehood. This *Sonderweg* reading of German history suggests an orderly (albeit troubled) progression of German statehood from an illiberal modernity into a liberal present, veering from the ‘normal’ path of sovereign Western order by way of exceptional violence, only to cathartically resurrect from the rubble of WWII as a reformed and law-abiding *Rechtsstaat*, or state governed by the rule of law. A *Sonderweg* account of the role of psychiatric knowledge in the production of this order would suggest that German psychiatry, along with German politics, was deviant from larger psychiatric and scientific trends in other Western states, and aberrant in its eagerness to produce patients as constitutionally ‘inferior’. It might read the close imbrication of scientific knowledge production and political order in Nazi Germany, which mutually reinforced a politics which inscribed citizenship in ‘racial’, or evolutionarily ‘selected’, attributes, as just another symptom of German anomaly, an irregularity which would be corrected after Germany’s reconfiguration as a liberal-democratic state in 1948.

A genealogy of sovereign German political order produced by psychiatric statecraft corrects this impression. As a method of ‘descent’, genealogy declines to search for any present or historically coherent orders, subjects, categories, or objects, but instead

identifies in each the specific historical forces sustaining their temporary appearance of fixity: ‘it disturbs what was previously considered immobile; it fragments what was thought unified; it shows the heterogeneity of what was imagined consistent with itself’ (Foucault, 1998 [1977]: 147). German political order was not teleologically impelled towards transcendence as a liberal democratic state, and the genocidal violence of the Nazi state was not the necessary corrective for an improperly cherished militarism. Instead of analysing modern German political history from a presentist vantage which recognizes purposive direction in the unfolding of historical events, genealogy instructs us ‘to maintain passing events in their proper dispersion’ (1998 [1977]: 146). As a result, a genealogy of German political order identifies in each historical formation of sovereign German statehood the ‘errors, the false appraisals, and the faulty calculations that gave birth to those things that continue to exist and have value for us’ (ibid.). It shows that in each historical period, including the present, formations of political order were sites of struggle, where numerous interpretations competed for authority.

2.8 Case Selection

Germany is often invoked as the nadir of a biopolitical logic fuelled by ‘state racism’, propelled by the Nazi state to its genocidal conclusion (Foucault, 2002: 258). By analysing psychiatric statecraft in Germany, I am therefore tracing the unfolding of a biopolitical process – the designation of who ‘must live’, ‘must die’, and who ‘will not be permitted to die’ – in a polity deeply resonant with biopolitical processes and logics. Yet recent uptakes of biopolitical scholarship have criticized a resultant tendency to theorize biopolitics as building up towards and cresting with the Holocaust, which both ignores the imperial context of Europe’s 19th century transition to biopolitics and (falsely) imputes a receding of its racial logics in the post-WWII period (Weheliye, 2014; Howell and Richter-Montpetit, 2018; Schuller, 2018). By scrutinizing a biopolitical process in Germany while maintaining a theoretical and methodological commitment to post-colonial critique, I aim to offer a reading of modern sovereign statecraft which is attuned to the mutuality of different practices of dehumanization

mobilized in the service of sovereign order, and which appraises European colonialism and German Nazism as imbricated projects wielding multiple death-and-debilitation-producing technologies with the aim of enforcing the supremacy of a sovereign 'we' rooted in a 'racial', 'eugenically selected', superiority.

I selected the three case studies of this thesis by identifying the major 'diagnostic competitions' (Howell, 2011: 17) over post-traumatic conditions which took place in Germany since its formation as German Reich in 1871. These disputes were waged over competing diagnostic paradigms: the 'truth' of symptoms of traumatic neurosis in the 1870s and 80s (chapter 3), traumatic neurosis vs. hysteria during WWI (chapter 4), and hysteria vs. the Holocaust syndrome, one of the immediate precursors of PTSD, in the late 1950s and 1960s (chapter 5). Each of these diagnostic debates pitted one psychiatric explanatory approach of post-traumatic symptoms against another, and each took a side in the disputes over entitlement claims of specific groups of traumatized patients: industrial workers, soldiers, and Holocaust survivors.

The status of these groups in German political order was fiercely contested: industrial workers, as members of the rapidly expanding urban working classes, and as (suspected or actual) sympathizers of the Socialist Party, were feared by Bismarck and the landholding as well as industrial elites as potential revolutionary challengers to the imperial political and capitalist economic order. As I will lay out in chapter 3, the 1870s and 1880s witnessed multiple battles waged against the power and influence of the Socialist Party over the working classes, including the outright ban of the party in 1878, of which psychiatric claims to authority over ascertaining the normality or deviance of workers was one important aspect. This political battle between ultra-conservative, monarchist political order and (perceived-to-be) socialist and working-class subjects continued during WWI, which I will trace in chapter 4. As hopes of a brief military campaign were dashed and increasing numbers of soldiers suffered psychic collapse after enduring days of shelling in muddy trenches, psychiatrists speculated whether the workers' adversarial attitude towards monarchical order might not also manifest in a sluggish psychic response to combat stress, as well as only faint enthusiasm for military sacrifice. Political contestations between psychiatric

knowledge and working-class soldiers intensified in the immediate post-war period, as former soldiers joined revolutionary movements and ousted the Hohenzollern monarchy. Psychiatrists joined a broad right-wing counter-revolutionary coalition which used multiple technologies to pathologize, institutionalize, incarcerate, and murder socialist, working-class veterans and revolutionaries. Chapter 5 jumps forward in time to the post-WWII period and examines the confrontation between psychiatrists and Jewish Holocaust survivors. In this instance of diagnostic struggle, Jewish Holocaust survivors who suffered long-term psychic symptoms from the abuse endured in the camps were examined by German psychiatrists as part of the application process for a health damages pension. Psychiatrists again appraised these trauma patients in a politically adversarial manner, diagnosing Jewish claimants as ‘psychopathic’ and ‘constitutionally weak’ and thus barring their access to financial entitlements. Therefore, by selecting psychiatric debates over the correct diagnosis and treatment of traumatized workers, soldiers, and Holocaust survivors, I am tracing some of the most fiercely contested and anxiously drawn fault lines inscribed by multiple knowledgeable discourses between sovereign German subjectivity and its ‘subhuman’ Other.

2.9 Situating the Archive

The relationship between critical scholarship and the archive is a vexed one. Noting Jacques Derrida’s description of the archive as *arke*, or domicile of law and site for the exercise of authority and social order (1995: 9), critical scholars usually approach this site with a fair amount of trepidation, knowing they will enter into a citadel held by power. These scholars commonly expect the archive to be inhospitable to their research interests, containing incomplete or hostile records produced by those social and political forces which simultaneously enact their dehumanization.

In response, such scholars have developed a number of different techniques to reckon with the silences, erasures, distortions and insults of the archive. One tactic is to launch an expedition into the archive in hopes of finding previously ignored or

overlooked scraps, thereby correcting the historical narrative of power by articulating the history of the marginalized and excluded in different grammars (for a critical discussion of these 'activist archival efforts', see Rao, 2020: 18). A second technique is to step into these spaces left empty in the archives and forge creative tools to fill them. Saidiya Hartman pioneered such methods in her long-term project to 'recuperate' the lives of slaves from the reticent and mercantile annals of transatlantic slavery (2008: 3; 1997). The recovery of these lives, for Hartman, will not proceed through scrupulous excavation and interpretation of archival traces, but through the deployment of 'speculative arguments', 'critical fabulation', and by 'exploiting the capacities of the subjunctive' (2008: 11). Similarly, Carmen Maria Machado, in querying how to fill the 'holes', 'gaps', and 'lacunae' in the archives of queer intimate partner violence, turns to memoir, thus hoping to 're-create the past, reconstruct dialogue' (2019:25).

In their turn toward narrative and memoir, both Hartman and Machado touch on another archival frustration: even if these archives contained ample evidence of the lives of marginalized communities, these traces are not independent from the discourses which produced them. As Derrida cautions, an archivist is not an archaeologist: while for the archaeologist, 'stones talk!' and quite willingly relinquish their secrets, the question of the truth of archival inscriptions is more troubled and troubling (1995: 58). Rahul Rao, in his deliberation of how to produce an account of the past which avoids both the 'ventriloquising' and 'vulgar empiricism' of the archival expeditions mentioned at the outset of this section, turns to memory (2020: 19-20). Through perusal of the narratives which are currently circulating, Rao hopes to elicit a reading of the specific ways in which past events continue to germinate in the present, without recourse to the doubtful authority of discoursing rocks.

2.10 Archives of Psychiatric Statecraft

Although this project is also critical in its aims and methods, I did not approach the archives of psychiatric knowledge on trauma with any trepidation comparable to the

approaches just sketched out. This is because I was looking neither for hidden histories, nor to correct a slanderous historical portrayal of marginalized communities. Instead, my aim was to revisit an existing and well-known (in specialist circles) historical record, and to submit it to renewed scrutiny and analysis.

I assembled the archive of this study by mining secondary historical accounts of each of the diagnostic conflicts outlined above and identifying primary sources in their bibliographies. Esther Fischer-Homberger's *Die traumatische Neurose* ('Traumatic Neurosis') (1975) offers a detailed account of the diagnostic debate surrounding traumatic neurosis in the 1870s and 80s, and provides a comprehensive list of practitioners and publications partaking in the debate. Paul Lerner's *Hysterical Men* (2003) and Peter Riedesser and Axel Verderber's *Maschinengewehre hinter der Front* ('Machine Guns Behind the Front') (1996) track psychiatric diagnoses and treatment of trauma from the late 19th century until the early Weimar Republic and early Federal Republic, respectively, and both provide detailed historical accounts of psychiatric practice during WWI. I surveyed the bibliographies of both works for key publications in the debate between traumatic neurosis and hysteria. Finally, I consulted Dagmar Herzog's chapter on the compensation claims of Holocaust survivors in *Cold War Freud* (2017), as well as Christian Pross' *Wiedergutmachung* ('Compensation') (1988) to identify psychiatric practitioners, publications, and in this case also collections of expert opinions in compensation cases in the post-WWII period.

From the abundance of archival material thus identified, I tapered down the selection by privileging the most well-known, and most frequently cited psychiatric practitioners, and by discarding publications not directly relevant to the diagnostic competition (for example, articles on the precursors of 'traumatic neurosis', on diagnostic debates in other countries, or on the relationship between mainstream psychiatry and the emergent field of psychoanalysis). I further narrowed down the selection by identifying segments in longer publications (like textbooks) directly relevant to the research question, for instance by seeking out chapters setting out the challenges of examining claimants in a traumatic neurosis pensions claim, and which

offered instructions on how to distinguish malingerers from true sufferers. From the list of sources remaining, I retrieved every available item from libraries and archives in Berlin, namely the *Charité Medical Humanities* library and the *Staatsbibliothek*.

I identified a small number of additional relevant sources as I was locating these publications in different archival holdings, for instance, by noting further publications from a relevant author, or by consulting the bibliographies of other primary sources I had already tracked down. However, the bulk of archival sources I assembled are gleaned from the overview texts listed above.

How is this engagement with the archives of psychiatry different from the anxious engagements sketched out above? Not because I hold any naïve conviction about privileged access to interpretive authority: quite simply, I am advancing the suggestion that the archives of psychiatric knowledge are insufficiently understood as precisely that – an *arkhe*. I am not entering into these archives to retrieve hidden figures or lost histories, but simply to indicate that this house is a house of power, enunciating laws which are effective in the production of modern political order. The critical scholarly effort offered up here is to identify the archives of psychiatric knowledge as archives of political order and sovereign ordering practices. Instead of embarking on an expedition to resuscitate psychiatry's forgotten victims, I caution that before that, much is still to glean and learn from those archival traces which are out in the open.

This is not to say that my scrutiny of these archives will simply reproduce the analyses of existing histories of German psychiatry. Instead, the critical merit of such a project is two-fold: first, by reading these three cases together, I am able to draw out shared logics across historical temporalities and German state formations. Existing histories of psychiatric debates on trauma in Germany, including the works cited above, privilege a particular historical period, diagnosis, or site (like military psychiatry). By assembling different targets of German psychiatric statecraft across 100 years of psychiatric and political history, I am able to discern continuities in psychiatric knowledgeable-as-politically-ordering practice which remain largely obscured in existing literatures. Second, I am approaching these archives from a different

theoretical posture. By conceptualizing psychiatric knowledge and practice as a politically productive endeavour, I approach the archives of German psychiatry as both a medical and political archive. I thus analyse psychiatric knowledge of trauma as intimately entangled in those processes which shape sovereign German order across a 100-year period, and am able to read its martial, debilitating practices as (dis)continuous attempts to craft a sovereign figure by means of dehumanizing populations deemed ‘racially’ or ‘evolutionarily’ unfit.

2.11 Steps of the Methodological Procedure

The steps of the methodological procedure unfold as follows, and result from the theoretical reflections outlined above:

I) Analyse the characteristics of Man and his Other inscribed by paradigms of post-traumatic injury.

Wynter and Ashley argue that descriptive statements of Man and his human Other ground epistemic and political orders. But how can we identify these figures and locate them in a text? Both Wynter and Ashley give precise instructions on how these figures appear and function: Wynter contends that they operate as a ‘master code of symbolic life... and death’ (2003: 287), while Ashley designates their ‘essential limitation’ as formative (1989: 266). Therefore, in analysing a psychiatric text, the first step is to identify how different categories of patients signify as either ‘symbolic life’ or ‘death’. Are they presented as victims or threat? Do they sustain or undermine present political, hierarchical, socio-economic, and epistemic orders? Expressed in medical terms, I queried whether their condition is described or known as resulting from unpredictable circumstances beyond their control, or whether it proceeds from factors somehow inscribed in the patient themselves. The former might be the case if a psychiatric practitioner unequivocally identifies a railway accident or shock from a nearby artillery shell explosion as the cause of post-traumatic symptoms. The latter might happen if a psychiatric practitioner discerns weakness of the will, perhaps as a

result of constitutional ‘inferiority’, in the patient, leading them to make unjustified claims for monetary compensation which are both fiscally and politically irresponsible.

Once these figures were identified, in a second step I drilled down into the specific characteristics of each group, or figure: what are the attributes of patients characterized as threats to Man? By what traits are they known as dangerous? For example, for a hysteria patient, what about their attributed weakness of the will made them so dangerous to the thriving of the sovereign subject? Relatedly, for those crafted as innocent victims, what is their ‘essential limitation’, or trait that is both condition and limitation of their sovereignty? For instance, how does the category of ‘willpower’ function to elevate sovereign Man as reasonable and masterful while simultaneously circumscribing the nature of the existential threat to him in evolutionary terms as a degenerative atrophy of the will?

Following Wynter’s insight regarding the specificity of modern articulations of Man and his Others, it is important in this step to be attuned to the articulation of human subjects according to codes of natural selection and economic accomplishment: how are sovereign figures crafted as sovereign based on their ‘superior’ genetic stock or ‘natural’ intelligence and ability? How are subhuman Others positioned as ‘naturally’ closer to death and destitution due to their ‘dysgenic’ attributes?

The different groups I write about in the following chapters occupy and are assigned different positions in this order. The first two groups, 19th century industrial workers and WWI soldiers, are located near ‘subhuman’ status due to their working-class status and suspected leaning towards socialist politics. The third group, Holocaust survivors, are Jewish. They are produced as ‘mad’, ‘disabled’, or ‘racially inferior’ on account of a perceived psychic flaw located in the ontology of their bodily being, thus inscribed by the unfolding of evolutionary logics. However, it is important to understand that I am making no claim that psychiatric statecraft neatly produces two coherent groups of subjects, Man and inhuman Other, and that all those produced as the latter are equidistant from the status of Man. Nor am I arguing that these assigned

positions are mutually exclusive, permanent, and unchanging. Instead, guided by Wynter's account of the precise functioning of descriptive statements, I argue that these different ways of inscribing human being occur within a framework that defines specific points – the 'nadir' of racialization and Blackness, the naturalization of disability as tragedy, the articulation of human difference through bio-evolutionary categories – while leaving others open to contingency. Methodologically, I query where these different groups are positioned by scientific knowledge, not just through terms immanent to the text, but within a wider discursive field which routinely locates inhuman status in Black or differently racialized Others. I track how groups are known by multiple, perhaps contradictory, attributes, and how these change over time.

II) Trace the 'disciplines of the body' whereby descriptive statements are inscribed.

Man and his inhuman Others are inscribed in a number of sites and through a number of means, including the diagnostic paradigms discussed in the previous section. However, Foucault alerts us that the 'disciplines of the body' play an important part in the process of (psychiatric) subjectivation. This methodological step specifically queries the bodily means of psychiatric statecraft: how were the bodies of patients made 'docile' who, it was believed, had surrendered authority over their thoughts and the movement of their limbs? Through which procedures were they examined, observed, and confined? How were they convinced, through suggestion, deceit, or coercion, to relinquish their symptoms? How were they trained and made fit for labour once again? How were the objectives of this training internalized so that the patient observed and disciplined himself?

Practically, these methods are usually found in descriptions of treatment approaches, a common genre of psychiatric publication in which practitioners describe the details of their methods so that colleagues might emulate them. Another prominent site is the diagnostic encounter, specifically if patients were examined as part of an insurance or compensation claim. These diagnostic settings were often designed in a way so as to elicit truth from the body independently of direction or guidance from the patient.

They are thus sites constructed for the purpose of bodies revealing themselves, and to disclose without deceit the accurate nature of their pathology (or alternatively, to unmask the fraudulent intent of the patient). This step thus excavates and analyses all these technologies of the body in which 'true' and 'authentic' subjects are found and forged, for the purpose of their re-insertion into circuits of power as 'docile' subjects.

III) Analyse how Man and his human Others naturalize hierarchical political orders and ground the sovereign, German state.

This final step tracks how orders and states emerge from articulations regarding the being of Man and his Others. Wynter emphasizes that scientific knowledge must reiterate hegemonic descriptive statements of the human in order to make a truthful assertion, and that it thus naturalizes unequal socio-economic, global orders (2003: 278). Therefore, this step begins by asking how descriptive statements of 'symbolic life' and 'death' attach to specific groups who are already marginalized, and then sustain psy-scientific theories which explain the exclusion, disfranchisement, and brutalization of these groups as a result of the natural order of things. Ashley, in turn, argues that Man provides the constitutive principle of both the sovereign state and its domestic order (1989: 268). This means that if we are able to identify the threats to Man's sovereignty, we can discern why the state must be, how the state must act, and who it must target to serve the interests and security of Man. This step thus proceeds by connecting attributes and invocations of Man to differentiating, territorializing, bordering, and grounding discourses of sovereign statehood. Specifically, it asks how assertions of sovereign subjectivity in certain psychiatric patients support claims to the existence and coherence of a German nation: how do these claims provide the territorial ground for claims to sovereign statehood? And how, through inscription of a sovereign centre, do these assertions allow participants in these discourses to unproblematically 'see' a sovereign German state, as well as to recognize as necessary certain policies?

Finally, as Howell explains, the production of order and statehood proceeds through war-like technologies of martial politics. Therefore, this last methodological step specifically queries by what means those groups recognized and produced as inhuman Others are maintained in a status of debilitation. While recognizing that psychiatric statecraft always operates through a range of practices whereby some, perhaps even most, patients receive excellent or adequate care, part of its function is to re-produce (liberal) orders by exposing to death and destitution, or ‘refusing to let die’ (Puar, 2017), those groups known as dangerous to this order. Martial technologies of statecraft might include treatment practices, such as the ‘Kaufmann cure’ whereby patients were electrocuted until they either relinquished their symptoms or died, the withholding or denial of accident, disability, or compensation payments, as well as the public defamation of a class of patients as psychopathic, thus exposing them to further humiliation and violence. These practices can be identified as martial if they are applied predominantly towards a group positioned near the ‘inhuman’ end of the spectrum of human articulations, and thus serve a function in the stabilization of socio-political and sovereign orders.

2.12 Conclusion

In this chapter, I have outlined a theoretical framework for this thesis, arguing that we must situate psychiatric knowledge and treatment of trauma within networks of order, knowledge, and Man. Psychiatric knowledge, in order to operate within regimes of truth, must apprehend and treat its patients according to descriptive statements of the human grounding our current episteme. By crafting trauma patients as/in relation to these descriptive statements, psychiatric knowledge enacts and sustains orders of Man, thus articulating an order in which the sovereign state must protect and serve a domestic constituency of sovereign subjects. Reading the figure of Man through the work of Richard Ashley and Sylvia Wynter, I have argued that the emergence of the modern episteme must be situated within a historical context of colonization, ‘by-nature’ difference articulated through race, and confinement of the mad. Modern knowledge thus functions to routinely naturalize and enshrine in scientific necessity

the unequal global distribution of vitality, morbidity, and precarity. Yet within this context, there is great variation: the ‘essential limitations’ of Man are highly mobile and constantly subject to contestation, rendering the process of psychiatric statecraft a site of perpetual struggle over the ultimate ‘fixing’ of the meaning of Man. I have indicated how psychiatric knowledge uses both discursive and bodily means of subjection to partake in the labour of psychiatric statecraft, and I have argued that part of this labour must always be understood to proceed in the mode of martiality. In the remainder of the chapter, I translated this theoretical framework into a methodological procedure for analysing psychiatric statecraft.

In the following chapter, I turn to the first empirical case study of this thesis: the struggle over the compensation claims of traumatized German industrial workers in the 1870s and 1880s, and psychiatric practitioners’ debates over the legitimacy of their claims.

III. THE WORKER

'We will forge our weapons in combat.'

- A. Hoffmann, 1891: 172

In 1895, the neurologist Adolf Struempell published an article in which he outlined guidelines for doctors examining cases of suspected accident neurosis. These patients, usually low-income industrial or factory workers, had experienced an accident in their workplace and were now suffering from a range of psychological and physical symptoms they attributed to the incident. Importantly, certain so-called accident neuroses were actionable conditions under German insurance law, and if diagnosed accordingly, worker-patients were eligible for a disability pension. Yet many of these conditions, Struempell warned, did not result from the accident but from the worker's desire for a pension: 'there is no direct correlation between accident and psychological change, the ideas that are now lodged in the patient's mind hail from somewhere else entirely.' Instead, he continued, 'they result from the patient's efforts to acquire a secure source of income, and to work less hard' (1895b: 1166). The correct response to this, Struempell advised, was to nip in the bud any notions in the patient's mind that he was sick and to urge him to return to work. At the same time, if he was convinced his patient was physically fit, the examining doctor should absolutely refrain from noting in his report any support for compensation claims. This would be counterproductive because 'the patients insist more and more on their supposed rights and turn into veritable hypochondriacs and troublemakers, and it becomes impossible to get rid of them' (1895b: 1167).

In this article, Adolf Struempell wades into the psychiatric debate on trauma raging in the first decades after its emergence as a psychiatric diagnosis. Since the 1860s, the railroads and an increasingly industrialized economy had generated a stream of accident survivors with lasting psychological symptoms. While psychiatrists and neurologists initially were unequivocal in linking their patients' conditions to the

accident they had experienced, from the late 1870s, a growing number of practitioners sought to break this diagnostic linkage and to locate the generating cause, as Struempell puts it, ‘somewhere else entirely’. This ‘somewhere else’, for dissenting practitioners, was the workers’ character, which they appraised as work-shy and advantage-seeking, and thereby as capable of generating symptoms which *appeared* like post-accident symptoms, if they only secured them an accident or disability pension.

In this chapter, I relay the first episode of psychiatric statecraft, or the production of sovereign order through inscription of the being of Man, following the first formalized expressions of psychiatric knowledge on trauma in the middle of the 19th century. I outline the emergence of two diagnostic paradigms – one events-based, the other ideas-based, or ideogenic – and the disputes among them. I discuss how each engaged in the securing of a specific version of sovereign German political order, and detail the sovereign figures mobilized by each in this endeavour. I explain how in the context of this diagnostic dispute, welfare withdrawal first emerged as an instrument of martial politics in psychiatric practice, and how its practitioners wielded it as an instrument of government against populations it deemed adversarial: workers.

I begin by situating the emergent workers’ struggle within the multiple ruptures characterizing mid- to late-19th century Germany, and briefly outline the rise of social-Darwinist and degenerationist explanatory models for socio-political conflict. I then proceed to discuss German psychiatric statecraft in relation to traumatized industrial workers.

3.1 Locating ‘the Worker’ as Threat to the Sovereignty of Man

At the time of its formal consolidation in 1871, the German Reich was a nation in upheaval. An accelerating capitalist industrialization was transforming economic and social relations, which until the middle of the 19th century had still been predominantly agrarian. With mining and industrial centres springing up in the Ruhr region and Berlin, former artisans and agricultural workers were drawn towards rapidly

expanding urban metropolises looking for work. Yet while the demand for labour in the emerging metal, manufacturing, mining, and pharmaceutical industries was relentless, the pay was low, and working conditions often dangerous (Guttsman, 1981: 22-23). As a result, the process of urbanization and demographic change unfolding in the late 19th century was characterized by destitution and squalor, with a new pauper class of workers assembling in crowded, inner-city slums. Increasingly rejecting claims to authority and guidance from the Church and the monarchy – the pillars of the established order – workers began to form their own political associations. A number of socialist organizations were founded in the 1860s, which united to establish the Socialist Worker's Party (SAPD) – the predecessor of today's SPD – in 1875. The demands of workers' associations and the Socialist Party ranged from reformism, namely the improvement of working and living conditions as well as meaningful political representation, to outright revolution, calling for the abolition of the monarchy and the establishment of a worker-led, socialist or communist order (Kruse, 2012).

Members of the established order observed these transformations with concern, noting not only the acceleration, mechanization, and electrification of everyday life, but an emergent class which was both destitute and politically discontent, openly challenging the foundations of the present order (Eghigian, 2001: 95). Amplifying discourses of working-class peril, the late 19th century also witnessed the increased mobilization of scientific knowledge to understand and appraise socio-political phenomena. The publication of Charles Darwin's *The Origin of Species* in 1859 had popularized scientific interpretations of the social world, and was widely circulated as a means to translate inter-group alterity and strife into lawlike processes inscribed by a natural scientific order. According to Darwin, variation within species, as the lever activated by natural selection to trigger evolutionary processes, took on a pivotal function in explaining how species had not been formed in a singular act of Creation and had since remained unchanged, but had evolved over time (Adams, 2014: 52). Those members of the species whose traits were best adapted to any given environment thus prevailed in the struggle for survival and passed on their

advantageous traits to their descendants, while those who were less ‘fit’ would eventually die out (*ibid.*).

As Sylvia Wynter (2003) explains, Darwin’s theory sounded a death-knell for the theocentric Creation narrative of Man’s being and place in nature, while simultaneously inaugurating a new narrative which placed humans in a perpetual struggle against one another, waged with the weapons of heredity. In the wake of Darwin’s publications, there ensued a proliferation of socio-biological theorizing appraising human difference, inequality, and oppression as simply the expression of a natural law of selection and evolution (Adams, 2014: 53). While Darwin himself did not abstain from speculating how processes of natural selection had forged a hierarchy of human races (Stepan, 1982), it was Social Darwinists who popularized an application of Darwin’s theories to social and political life, interpreting difference and conflict as the expression of hereditary traits which were competing for supremacy (Adams, 2014: 52-53). Viewed through this lens, inequality and exploitation simply appeared as the manifestation of struggle between groups which were differently well adapted to their environment. Dominance over a less well-adapted adversary thus became not only a political goal, but a biological, evolutionary, and scientific necessity.

Alongside Darwin’s theory of evolution, the French psychiatrist Bénédict August Morel’s theory of degeneration gained widespread currency in the late 19th century. According to this theory, environmental factors could degrade a person’s heredity and thus ‘degenerate’ the health of their immediate descendants. In this Lamarckian model of evolution, natural organisms adapted and changed not over millions of years as in Darwin’s theory, but immediately passed on any negative influence to the next generation. Thus for Morel, physical and psychological ailments acquired in crowded and unsanitary domiciles could be passed on to children, thereby impairing the hereditary ‘stock’ of a collective. This progressive degradation manifested in ‘nervousness’ and ‘neuropathy’ in the first generation, proceeded to intellectual, psychological, and moral ‘deficits’ in the second, progressed to strong psychic defects and suicidality in the third, and finally culminated in ‘congenital idiocy’, bodily

deformation, and infertility in the fourth (Adams 2014: 53). Morel's theory thereby neatly translated much of what was repulsive to a 19th century bourgeois sensibility – poverty, disability, sexual licentiousness, and alcoholism – into clinical symptoms of a physically and morally decaying population. The allure and popularity of Morel's theses in the late 19th and early 20th century were certainly aided by their lending scientific authority to the fear and revulsion felt by representatives of the established order in observing the unruly and offensively impoverished urban working classes.

By biologizing adversarial socio-political relations and translating them into the terms of natural science, degenerationist and social Darwinist discourses thus raised the stakes of resolving the problem posed by the working classes, which increasingly was positioned as a public health emergency and potential crisis precipitated by the natural forces of evolutionary processes. From the mid-century onwards, the fears circulating around the conditions, fate, and revolutionary potential of the working classes were known as the Social Question. The German state attempted to resolve this question through a two-pronged strategy of, in Bismarck's words, 'sugared bread and the stick' (Schmidt and Ostheim, 2007: 126). On the one hand, socialism would be fought with uncompromising severity by means of Anti-Socialist legislation, which was on the books from 1878 to 1888. This legislation forbade all socialist and communist associations, assemblies, and publications, which it enforced through fines, imprisonment, and so-called 'minor states of siege' (*Kleiner Belagerungszustand*) by means of which persons could be compelled to leave an area (Guttsman, 1981: 60). On the other hand, the emperor initiated a series of welfare, pensions, and accident insurance laws in the 1880s which were intended to blunt the sharpest edges of working-class destitution and, by binding workers to the monarchical state, to 'create a conservative class of pensioners in place of a proletariat' (Harkort, quoted by Eghigian, 2001: 26). The first of these laws was the 1884 accident insurance legislation, complemented by health and old-age pension insurance in the following years. This welfare insurance legislation replaced and expanded an existing patchwork of schemes organized on a basis of cooperatives, corporations, municipalities, and churches, and reconfigured welfare on the basis of compulsory, state-sponsored insurance. While pay-outs through these schemes were very low and hardly enabled

an insured person to survive on its disbursement alone, this welfare legislation was one of the first in the world, and in its broad outlines constitutes the basic format of German welfare legislation to this day (Schmidt and Ostheim, 2007: 123-4).

This accident insurance legislation would become an important means by which psychiatric practitioners engaged in psychiatric statecraft. Workers suffering from post-traumatic symptoms which rendered them unable to work had to submit their claim to the insurance bureaucracy, which referred them to a panel of experts, doctors, and psychiatrists for evaluation. This panel determined the extent of the claimant's entitlement and decided whether the employer or the claimant themselves were responsible (Eghigian, 2001: 71-2). As claims were determined by means of a judicial hearing, psychiatrists and examining doctors were not immediately responsible for awarding or denying claims. However, insurance panels made their decisions on the basis of doctor's reports, which led to their assessment and diagnosis accruing extraordinary power.

Psychiatrists and neurologists were not just aware of this power, but actively participated in and shaped debates on the insurance legislation and its impact on the Social Question. Psychiatric practitioners, who often held national conservative and right-wing views, frequently shared the concerns, discussed above, over the impacts of modernity on nervous health. Writing in 1891, the internist Albin Hoffmann argued that 'our current era, with its brisk struggle for survival, its push towards productivity and indulgence, its striving for excitement ... creates the most miraculous foundation for raising nervous weaklings' (1891: 161). Many agreed that workers, as that population which was most exposed to the stresses of modern city life, were most impacted by this. Noting how these larger changes contributed to the increasingly hostile attitude of the working classes, psychiatrist Robert Gaupp noted that '[t]he 70s have changed the worker's soul tremendously. His stance toward his employer, his political views had become different. He now viewed the state with suspicion' (1906: 2234). In this context, many feared that the insurance legislation, instead of convincing workers of the paternalistic beneficence of the state, might actually cultivate the basest instincts of the worker's psyche – sloth, deceit, and

narcissism. As a result, many psychiatric practitioners overtly adopted a principled stance in support of state objectives in the unfolding ‘pensions struggle’, using their power to shift understandings of post-traumatic conditions and its causes, as well as offensively deploying all means at their disposal to discipline workers into responsible, self-reliant subjects.

3.2 Traumatic Neurosis and the Events-Based Paradigm of Post-Traumatic Injury

The struggle over compensation payments for post-traumatic injuries first erupted among survivors of railway accidents. The railway symbolized the double-edged sword of modernity and industrialization like few other innovations of that age. On the one hand, the steam-powered steel colossus promised to collapse geographical distance and time, disbursing goods, people, and services across the globe at an unprecedented speed. Yet on the other hand, this speed appeared ominous: while mid-19th century trains were slow by today’s standards, they soon exceeded the speed of a galloping horse and thereby propelled persons through space faster than at any previous point in history. People worried what the impacts of this propulsion might be on the human organism, and after a series of headline-grabbing railway accidents in France in the 1830s and 40s, rail travel was considered a bona fide health risk by multiple branches of medicine (Fischer-Homberger, 1975: 39-40).

Among the survivors of railway accidents, doctors encountered a number of patients who appeared to have sustained no (or only minimal) perceptible physical injuries or wounds, but who suffered from the delayed onset of physical and psychological symptoms. The neuropathologist Martin Bernhardt describes the case of a railway conductor who, after surviving a train collision in 1874 (from which he walked away with only a superficial head injury) suffered from debilitating symptoms weeks after the accident. Besides pains in the back of the neck, nausea, dizziness, and general weakness, the patient ‘finds the rattling of train wagons and street cars unbearable.’ Attempts to seat the patient on a bus, horse-drawn carriage or train failed – ‘he had to dismount because he was not able to tolerate the vibrations’ (1876: 275). These

symptoms were remarkable as they affected both the patient's physical and mental fitness, could not be traced to a visible injury or wound, and were believed to result directly from the calamities of rail travel. The term 'railway spine', falsely but enduringly attributed to British doctor John Eric Erichsen², gained currency in the 1860s to designate this class of illness. Doctors described railway spine as a neurological condition manifesting after traumatic impact during a railway accident, and the diagnosis soon acquired purchase across Europe and North America. Railway spine would be the first in a series of conditions which form part of the events-based paradigm of post-traumatic injury, meaning that doctors located its aetiology, or cause, directly in the traumatic event. In the case of railway spine, doctors theorized that kinetic shocks can lead to organic changes in the spinal cord (Fischer-Homburger, 1975: 17-19). While there was debate regarding the exact nature of spinal injury leading to railway spine – whether it was compressed, suffered lesions, or was inflamed – there was little disagreement that post-traumatic symptoms could be traced to a pathology of the central nervous system. Over the course of the 1860s and 70s, as clinical encounters between doctors and accident survivors multiplied, the understanding of railway spine evolved to include other types of accidents as possible causes, and practitioners traced the aetiology of symptoms to cerebral functions instead of exclusively the spine. Thus, railway spine became railway brain, *commotio cerebri* (disturbance of the brain), shock, or post-traumatic tremor, and not only rail conductors but builders, miners, smelters, and a wide range of industrial workers were diagnosed with these conditions (see, for example, Fischer, 1870; Fischer, 1871; Struempell, 1888; Seeligmüller, 1882).

This exclusively organic approach to post-traumatic injury was significantly expanded through the work on hysteria of Jean-Martin Charcot. In his famous public demonstrations at the Pitié-Salpêtrière Hospital in Paris, Charcot showed that verbal prompts to hypnotized patients could produce partial paralysis or loss of sensation in areas of the skin – both symptoms associated with railway spine and its diagnostic descendants. It was thus an idea, implanted and mobilized by means of suggestion,

² He rejected the term's implication that only railway accidents produced these conditions, and preferred the term 'spinal concussion' (Fischer Homburger, 1975: 16).

which had the power to hold complete sway over the faculties of the body, not the organic nervous system alone. This insight revolutionized the medical profession's view of hysteria, which was exiled from its erstwhile uterine domicile and now conceptualized as an 'illness caused by representations' (Möbius, 1888). Applying this insight to post-accident patients, Charcot argued that they might have lost control over some of their bodily faculties not because of the kinetic force but the emotional shock of the incident. Specifically, he elaborated, the traumatic event leads to a discharge of affect – shock – and gives rise to speculative ideas about bodily injuries which might have resulted from the accident. For instance, the 'pathogenic idea' that an arm bruised in an accident might become paralyzed acquires authority and materiality through the patient's autosuggestion and causes the arm to actually become paralyzed. However, this occurs not because the patient has sustained damage to their nervous tissue but because the idea of injury has seized control of their limbs. In other words, their symptoms were of a functional, not organic nature (a 'functional' disorder designates a loss or disturbance of nerve function without a known physiological cause) (Fischer-Homberger, 1975: 105-11). Based on these insights, Charcot was able to subsume certain post-accident patients into the hysteria paradigm, and coined the term 'traumatic hysteria' to describe the particular, events-based aetiology of their predicament. He thus introduced the notions of (auto)suggestion and ideogenesis into the discourse on post-traumatic injury and illness, which enabled psychiatric practitioners to stop chasing the organic substrates of post-traumatic illnesses from one nervous passage to another. Instead, they could now explore the rich connections between *psychic* trauma and post-traumatic symptom.

In the newly industrialized German Reich, post-traumatic conditions were much more varied and complex than the paradigms of railway spine and railway brain had been able to account for. While these paradigms were born from the image of bruised, inflamed, and torn spinal tissue in the wreckage of a train collision, neurologists soon learned that many other implements of the industrial age could produce similar results, and often in a much more subtle manner. A builder who had fallen off scaffolding, factory workers whose limbs had been seized by rotating shafts, and even

train conductors who had narrowly missed an oncoming train all displayed symptoms which had previously been attributed to railway spine or railway brain. But in many of these cases, not only were the spine or brain not injured, but there had been no physical shock to the body at all. In order to accommodate this wider set of accidents and aetiologies, German neurologists mobilized Charcot's insights regarding the functional nature of post-traumatic symptoms and their ideogenic progression, and crafted them into the traumatic neurosis diagnosis.

Traumatic neurosis, as its name indicates, rested on assumptions about the importance of the traumatic event and the functional nature of symptoms. In the texts of its predominant theorists, it seized control of the psychological and physical faculties of an accident survivor through an interplay of the shock of the traumatic incident and the troublesome ideas unleashed by the event. The relative importance of each of these factors varied according to each psychiatric practitioner: Hermann Oppenheim, the neurologist most prominently associated with the traumatic neurosis diagnosis, placed the aetiological emphasis squarely onto the psychic shock of the event. He argued that '[p]hysical trauma is only partially responsible for the genesis of the illness', while 'the main part is played by *psychological trauma: the fright, the agitation of the mind*.' He speculated that the shock of the traumatic event disturbed 'memory images' of movement located in the cerebral cortex and was thus able to immobilize and anaesthetize patients who showed no signs of physical injury (1889a: 123-52; emphasis in the original). By contrast, Adolf Struempell, another neurologist who played an important role in establishing the diagnostic paradigm of traumatic neurosis, foregrounded the generative power of the idea. For him, not just the immediate shock of the accident but subsequent fears for the future – 'the uncertainty, the hopes and fears, the disappointments and distrust' – were crucial in materializing and entrenching post-accident symptoms (1888: 15). Yet despite differences in the relative weighting of aetiological factors, Struempell, Oppenheim, and many of their colleagues agreed in those years that patients who had survived an accident physically unscathed could still develop post-traumatic symptoms, and that traumatic neurosis constituted a useful diagnostic tool in apprehending this condition. Further, even while a number of psychiatric practitioners took issue with traumatic neurosis right

from the beginning, they appraised it as a valuable and worthwhile attempt to come to grips with a set of symptoms which were still elusive to the neurological and psychiatric professions – a far cry from future denunciations of this condition (Löwenfeld, 1889; Hoffmann, 1890; Möbius, 1890; Schultze, 1890).

What really set traumatic neurosis apart from related conditions like hysteria, neurasthenia, and hypochondria, and what would attract the ire of so many psychiatrists, was its rootedness, *qua definitionem*, in the traumatic event. Not the patient's wish or inferior constitution produced post-traumatic symptoms, but, as Struempell had argued, '[their] genesis must always be located immediately in some form of prior traumatic incident' (1888: 2-3). This iron-clad association between trauma and post-traumatic symptom made traumatic neurosis an extremely powerful tool in the post-accident insurance claims of industrial workers. Traumatic neurosis was an actionable condition under the accident insurance legislation passed in 1884, meaning that workers diagnosed with it could claim a portion of their previous wages as a disability pension, while a diagnosis of hysteria or hypochondria might not produce the same result. The majority of claimants were industrial workers already living in humble if not squalid conditions, and the loss of their earning power could thrust them into truly destitute circumstances. With this in mind, Oppenheim remarked that the traumatic neurosis diagnosis was crucial for delivering the means to survival to post-traumatic accident survivors: 'The finding [of the condition of traumatic neurosis] is decisive for the fate of a considerable number of unfortunate individuals' (1889c: 449).

As this overview of the first three decades of the events-based paradigm of post-traumatic injury demonstrates, the psychiatric statecraft enacted through diagnoses of railway spine, railway brain, and traumatic neurosis constructed patients as legitimate claimants. Within this paradigm, accident survivors developed post-traumatic symptoms either because of a spinal or cerebral injury, or because the traumatic event had been so discombobulating that it disturbed a patient's psychic equilibrium weeks and months after the incident. All of these approaches concurred that not the patient themselves but the unfortunate events which had befallen them accounted for their

condition. For this reason, the claims (for both treatment and pensions) of post-traumatic patients must be considered reasonable and the patients themselves worthy of support.

Further, the diagnoses of the events-based paradigm suggested that some of the psychological symptoms of post-accident patients, including anxiety, depression, and insomnia, were understandable because they derived from claimants' worries about their financial means to survive. Having to defend their claims in court and against hostile doctors would only worsen these symptoms. As Struempell explains, 'You have to have seen for yourself how patients are sent from one appellate court to another, how new exams are always ordered, new reports requested, to understand the harmful effect this ... must have on the psyche' (1888: 15). Within this paradigm, the arcane bureaucracy of accident insurance claims was not viewed as a necessary evil but rather as a risk or impediment to the patient's recovery. The doctor's role was to support the patient in his encounter with the medical and insurance bureaucracy as best he could, not add to his worries. As the psychiatrist and neurologist Leopold Löwenfeld argued, doctors should consider it their 'duty' to defend their accident patients against any notions 'through which their interests might be harmed' (1889: 685). Oppenheim in particular was outspoken that doctors should act primarily in the interest of patients, not the insurance bureaucracy. He cautioned that under no circumstances should they enter the diagnostic encounter expecting their patients to be malingerers. This prejudicial view, he argued, was not only medically unfounded, as many of the symptoms of traumatic neurosis might appear as the result of simulation if only superficially considered. Even worse, such an approach risked denying a pension to someone urgently in need of one (1889a: 140).

Thus in Oppenheim's view (and those working within the events-based paradigm more generally), the patient appears as a legitimate and worthy claimant of state welfare support. This point of view implied that as industrial workers, patients had suffered a detriment through their heightened exposure to industrial machinery, which harboured increased risk of bodily and psychological injury, and thus deserved the full support of their employers, doctors, insurers, and community members. Many

psychiatrists subscribing to the events-based paradigm considered it their duty to assist patients in quickly securing welfare payments because the chances of recovery from traumatic neurosis itself were slim. Patients were best assisted, these psychiatrists argued, by speedily issuing an unequivocal diagnosis which would allow the welfare and insurance bureaucracies to quickly process their claims. This would spare the patient any additional indignity, and would prevent a deterioration of symptoms. Only if a pension was awarded in a speedy manner could any ‘significant improvement’ in the patient’s status be expected (Oppenheim, 1889a: 144).

How did psychiatric statecraft proceed in this early period of post-traumatic diagnostics? The sovereign figure of Man, while apprehended as a natural organism, was not yet crafted in exclusively bio-evolutionary terminology. Instead, for psychiatric practitioners labouring within the events-based paradigm of post-traumatic injury, the ‘essential limitation’ (Ashley, 1989) of Man was his vulnerability to the destructive forces of industrial modernity. As both condition and limitation of Man’s thriving, industrialization simultaneously enabled increased and accelerated production while threatening Man’s physical and psychic mutilation. As a result, the task for politics was to protect sovereign Man from the most severe excesses of injuring modernity, and to provide support for those already wounded by it. The contingency of this figure was limited to disagreement over modernity’s point of attack onto the body of the worker: while some psychiatrists insisted that it was the kinetic force of physical impact which frayed nervous tissue either in the brain, the spine, or other branches of the central nervous system, others averred that psychic shock alone was sufficient to dislodge a patient’s psychic equilibrium. Psychiatric practice, in this instance, is not martial but summons traumatized workers into the sovereign subjectivity of Man.³ The symptoms, needs, and distress of traumatized industrial workers are cast by psychiatric practitioners as the unfortunate yet inevitable result of forces beyond their control, and any resultant accident insurance or welfare

³ This does not mean that accident survivors who secured a pension did not struggle to make ends meet. As the neurologist Leopold Löwenfeld explained, accident pensions usually covered two thirds of a patient’s former income. This meant that they ‘protected these persons from hunger but failed to offer them a full equivalent of their lost earnings [...] . If the patient’s inability to work persists he cannot hope ever to improve his sad economic condition’ (Löwenfeld, 1889: 663).

claims as reasonable. Psychiatric statecraft thus inscribes a political order in which welfare payments and necessary medical treatment for those maimed by the instruments of modernization appear rational, urgent, and necessary.

3.3 The Simulation Dispute

The traumatic neurosis diagnosis had been controversial from the moment it was first outlined (Seeligmüller, 1882). However, it was only after Oppenheim published his textbook on traumatic neuroses in 1889, viewed as the authoritative text on this condition, that objections reached fever pitch. In what became known as the simulation dispute (*Simulationsstreit*), a number of prominent German neurologists took to task the traumatic neurosis diagnosis (as well as, to a certain extent, Hermann Oppenheim personally) for what they claimed was its openness to abuse through simulation of symptoms and incitement to pension fraud.

Oppenheim had addressed the question of simulation in his 1889 textbook on traumatic neurosis, where he argued that it was not a particularly pressing problem. Traumatic neurosis, he averred, usually presented through a variety of symptoms which, in their interaction and complexity, would be difficult to impersonate convincingly. He had only had ‘occasion to expose malingerers in a small number of cases’ (1889a: 138) and generally contended that some level of simulation in nervous conditions is simply a fact of life, ‘rooted in the nature of the thing itself’ (1889a: 139). Further, he had insisted that a knowledgeable doctor would be familiar with neurotic symptoms which might appear bizarre and erratic to uninformed observers, and he would thus be able to draw a sharp line between simulation and true symptoms of traumatic neurosis. The tendency to suspect malingerers everywhere, he contended, evidenced a ‘tenacious insistence on old ideas’ and was simply out of touch with modern diagnostic techniques (*ibid.*).

A number of doctors took issue with this stance. Neurologist Friedrich Schultze insisted that traumatic neurosis, as theorized by Oppenheim, was open to abuse and

that malingering was widespread. Not only did Oppenheim create diagnostic coherence where there was none, but many patients specifically exaggerated and performed their symptoms in a way that would secure them a pension (1889: 402). The neurologist Adolf Seeligmüller, in a review of Oppenheim's book, decried what he considered the author's *laissez-faire* attitude to simulation. It appeared, he writes, as though Oppenheim was much more concerned with making sure no true sufferer of traumatic neurosis would ever be charged with simulation than with finding the means to expose scammers. This silence on the means by which 'doctors can protect themselves against being cheated by malingerers' was a 'regrettable gap' and 'serious shortcoming' of his book (1889a: 561-62). These initial charges were followed by a remarkable exchange of missives between Oppenheim and Seeligmüller in which they debated whether or not simulating symptoms of traumatic neurosis was facile and whether or not it was possible to devise reliable tests to expose malingerers (Oppenheim, 1889c; Seeligmüller, 1889b; Oppenheim, 1889b). Seeligmüller's texts were laced with such anger, condescension, and at times latent violence ('Oppenheim runs into a skewer', etc. 1889b: 571) that the publisher of the journal in which the text appeared refused to run parts of the article. Seeligmüller's demonization of Oppenheim and his diagnosis was a preview of the diagnostic battles to come and gives an indication of how some psychiatric practitioners viewed the stakes of this encounter: as a battle against enemies of the Reich, and for the survival of the nation.

The simulation dispute became the main topic of debate at the 1890 Medical Congress in Berlin, where both sides again stated their views. Schultze reiterated that traumatic neurosis should not be considered a stand-alone condition but an amalgam of various psychoses and neuroses, in effect arguing for a weakening of the link between the doctor's diagnostic certainty and the patient's entitlement to a pension. Further, he insisted that traumatic neurosis had no objective and typical criteria (as Oppenheim claimed), that simulation was widespread, and that there was no reliable way of exposing it (1890). Oppenheim retorted that the symptoms of traumatic neurosis were, in fact, objective and real, even if they manifested erratically. Further, he chastised doctors who had boasted of having 'cured' patients of their symptoms by confronting them with undeniable evidence of their simulation. These so-called cures

might themselves be simulated, Oppenheim cautioned, as ‘patients whose honour has been questioned repeatedly will indeed simulate – but only their health and cure’ (1890: 510). While in later texts, this Congress is often portrayed as the first defeat of Oppenheim (succeeded by his second defeat in 1916, detailed in the next chapter), numerous doctors in fact openly voiced their support (see summary of Congress by Bruns, 1891: 84). The Congress thus figures as a contentious, and by no means final, first public confrontation between the events-based paradigm of post-traumatic illness, represented by traumatic neurosis, and an emergent, novel diagnostic paradigm.

The simulation dispute brings into view the outlines of a new diagnostic paradigm which cast its patients as a threat, and it constitutes the site in which some of the instruments of a martial politics of psychiatric statecraft are first put forward. In the context of this dispute, the traumatized industrial worker is vacated from sovereign subjectivity and instead crafted as its Other. In the texts of Schultze, Seeligmüller, and their colleagues, he appears as a conman and a cheat. They describe this figure as so cunning in their impersonation of a true sufferer that even a seasoned neurologist would need to summon all his clinical knowledge to expose him as a fraud. The neurologist Johann Hoffmann describes how he was able to expose malingerers who, ‘through clever imitation of the symptom complex, had fooled other doctors not just temporarily, but over a period of years.’ Shockingly, they had been able to ‘simulate the entire ensemble of symptoms which are considered characteristic of traumatic neurosis.’ To persevere in this adversarial diagnostic encounter, doctors required the ‘most precise knowledge of the symptoms [...], a calm demeanour, keen sense of perception, and the presence of mind, if the patient’s mask slips, to apprehend him without mercy’ (1890: 659). These types of patients, doctors argued, had a work-shy character and were motivated to engage in these criminal acts because of the promised spoils of a pension. Struempell explained that for a typical traumatic neurosis patient, once the initial symptoms receded and they are asked to return to work, ‘the contrast between the comfortable life of doing nothing and strenuous work’ causes them to question ‘whether all the after-effects of the accident had really been removed and whether one might not actually be able to justify further claims for an accident

pension' (1895b: 1167). Some authors describe the extreme lengths fraudulent patients went to in order to acquire detailed knowledge of the symptom complex of traumatic neurosis (doctors assumed that this kind of knowledge would not be found on the factory floor, but was the exclusive purview of specialist medical journals). These patients, it was argued, attended court hearings of pension cases, studied medical publications, or were told about symptom complexes by corrupt doctors in order to simulate them convincingly (Schultze, 1890: 510). As a result, they were able to impersonate a true sufferer with baffling accuracy, resulting in their taking advantage of the weaknesses inherent in the events-based paradigm. These doctors felt they had to protect themselves against falling victim to their intricate charades, and that the nation must be secured against their unfounded pensions claims.

The emergence of this new Other-figure to Man clearly presented a threat, and thus called for the use of martial means of psychiatric statecraft. In contrast to the 'legitimate claimant' of the events-based paradigm, who required an empathetic doctor and a speedy awarding of pensions benefits, patients constructed as conmen and cheats had to be resolutely confronted and exposed. Seeligmüller devised a number of such tests throughout his career. In some, he deprived patients of (what he considered) the necessary means to enact their simulation: patients simulating a tremor in the leg, he argued, needed a point of support for their toe. If one placed their foot on an oiled surface, they were denied this support and would have no means to articulate the tremor. A true sufferer's leg, however, would continue to tremble even on this surface (1889b: 579). In another test, Seeligmüller threatened suspected malingerers with an 'American truth serum', thus convincing them to relinquish their made-up symptoms (1882: 54). In 1890, Seeligmüller went as far as calling for an institutional infrastructure to tackle the simulation crisis, encompassing provincial accident hospitals to which suspected malingerers could be sent for observation, as well as the criminal prosecution of pension fraud (1890). This suggestion was resoundingly rejected by his colleagues, who found it inefficient, unrealistic, and cruel (Möbius, 1890: 887; Hoffmann, 1891: 173). Yet in just over two decades' time, this punitive and vindictive attitude to post-traumatic accident survivors would become the norm among German psychiatric practitioners. This transformation would be

enabled by a paradigmatic shift in the assessment of post-traumatic symptoms – from an events-based to an ideogenic, or psychological, model which recognized pathology in the character of the worker him- or herself – of which the 1889-90 simulation dispute was the first expression.

3.4 The Ideogenic Paradigm of Post-Traumatic Injury and the Pathogenic Character of the Worker

In the years following the simulation dispute, there emerged a new diagnostic paradigm of psychiatric statecraft. In contrast to the paradigm it would come to replace, it was entirely martial in character, enacting a form of diagnostic warfare on its patients which would strip them of their status as injured subjects and deny them any means to claim accident insurance or welfare payments to aid their survival. Specifically, this new diagnostic paradigm achieved this by removing any aetiological significance from the traumatic event itself and redistributing it between two interrelated aetiological factors: the ‘desiring wish’ and the character, or type, of the worker.

It is important to note that this development by which one diagnostic paradigm of post-traumatic injury and illness would come to replace another was gradual, rarely total, and did not turn out to be final. Further, the expression of this new diagnostic paradigm was modulated differently across medical texts, with some attributing more importance to one aetiological factor than the other. However, it can be said that generally, the ideogenic paradigm of post-traumatic injury in which the worker him- or herself was considered generative of pathologies acquired near-complete hegemony towards the end of the First World War. This development is outlined in the following chapter. It would remain dominant, and would continue to be mobilized to cast patients as so-called psychopaths and deny them compensation payments, until the late 1950s.

A decisive moment for the coherent expression of this new paradigm was a journal article published in 1895 by Adolf Struempell. As noted above, Struempell had been, together with Oppenheim, most closely associated with the emergent traumatic neurosis diagnosis and the events-based aetiology it gave rise to. Yet in this article, Struempell dismantled traumatic neurosis in its current form and sketched out the basic tenets of a new diagnostic paradigm: one that was entirely ideogenic in character as well as rooted in the character, or type, of the worker.

Struempell begins by discussing the role of ideas, or the psyche, in generating somatic symptoms. He had long been interested in, and had published widely on, the somatically generative role of the psyche. In his inaugural lecture at the University of Leipzig in 1884, Struempell discussed the aetiological significance of ‘psychic stimulation’. Calling attention to everyday somatic expressions of strong emotion like becoming red in the face from anger, going pale from shock, or shaking from fear, he argued that affective stimulation could impact or even override willed motor functions (1884: 19-20). Struempell had made these remarks at a time when most post-traumatic injury was still conceptualized in terms of somatic nervous damage (like *commotio spinalis* or *commotio cerebri* [disturbances of the spinal cord or brain]). However, by insisting that pathological symptoms from affect result only from ‘severe psychic exaltation’ (ibid.) – in other words, a traumatic event – Struempell remained firmly moored in an events-based paradigm. In later contributions, he also remained consistent in tying psychic generation of trauma (through shock or fears for the future resulting from the accident (1888)) to the traumatic event itself. But in 1895, Struempell took a different view, and now traced the origin of the psychic charge to desires harboured in the patients themselves.

He explained that after the accident, the patient would immediately be besieged by anxious questions circulating around the awarding of a pension: “‘Will I receive an accident pension’, ‘how much will I be awarded’, ‘to what extent have I been damaged in my ability to work?’” (1895b: 1137). These types of questions, Struempell noted, prompt patients to introspectively observe their symptoms, which causes them to linger and manifest with exaggerated severity. As these thought processes become

lodged in the mind of the patient, they acquire remarkable power and are able to produce ‘a whole range of apparently objective disorders and subjective sensations’ by means of ‘meddling in and inhibiting all processes of formation of the will’ (ibid.). Hence it is not the accident itself, but the thought processes emerging in its aftermath (which in turn are significantly fuelled by the existence of accident pensions legislation) that produce the symptoms commonly associated with traumatic neurosis. Struempell named these thought processes, in a term that would become iconic, ‘desiring thoughts’ (*Begehrungsvorstellungen*).

Struempell then explained how the character of the worker was in itself aetiologically significant. A number of their group personality traits, he argued, predisposed them to generating and exaggerating symptoms long after any physical grounds for them existed. First of all, Struempell outlined, workers were unreasonable: ‘Initially, this desire for an accident pension emerges in nearly every single worker who has been affected by an accident. Only a small number of them can be said to engage in clear, rational thought’ (1895b: 1137). Further, they were work shy and opportunistic: ‘The idea of acquiring an income without effort and without working is so alluring to them that it halts any other thought processes’ (ibid.). Finally, they were unreasonably entitled: ‘It is common among many workers to think that any accident, regardless of its consequences, should be compensated. Many workers believe that they have a right to compensation after every accident’ (ibid.). These character traits combined to form a recognizable type, mobilized repeatedly by psychiatric practitioners in the coming decades, which was understood to be exceptionally prone to developing symptoms rooted in ‘desiring thoughts’. Not unlike Foucault’s homosexual-as-species, the worker ‘became a personage, a type, a case history’, someone whose entire being was determined by the status attributed to them by the medical profession (Foucault, 1978: 43). As a result, merely the fact of being a worker would soon be sufficient to disqualify a post-accident pension claim because the worker’s character was known to generate pathological desiring thoughts.

Having completed these two moves, Struempell proceeds to dismantle the dominant understanding of the traumatic neurosis diagnosis. The illness he had previously

defined as ‘a nervous condition whose genesis must always be rooted immediately in some form of prior traumatic incident’ (1888: 2-3), he now restricts to only those disorders resulting from physical, or mechanical, impact and producing somatic nervous damage. Because according to Struempell, so many of the symptoms commonly associated with traumatic neurosis – paralysis, anaesthesia of certain areas of the skin, restricted field of vision, accelerated breathing and heart rate – were not in fact produced by the event of the accident but by the desiring thoughts emerging in its aftermath, these conditions were not, strictly speaking, post-traumatic but ‘psychoneurotic’. With the term ‘psychoneurotic’, Struempell indicated those symptoms which were ‘produced by ideas’ and only ‘apparently physical’ (1895b: 1139). All of these symptoms are under the authority of ‘conscious and unconscious innervation of the will,’ meaning that their manifestation ‘certainly does not indicate an organically pathological modification, but has factually been called forth by inner psychic excitation’ (ibid.). This meant that a patient ‘who gave the loudest expressions of pain even upon the mildest pressure’ will make no sound if this pressure is applied while he is distracted, while paralyzed limbs will return to functionality as soon as the doctor’s gaze is averted. These patients are not simulating but are ‘so fully governed by the idea of not-being-able that they do not even apply the correct innervations for the movements demanded by the doctor’ (1895b: 1138). As a result, Struempell contends, a large number of cases which would usually be diagnosed as traumatic neurosis could more usefully be classified as hysteria, neurasthenia, or hypochondria – all conditions identifying the patient’s inner life as causative of his or her condition. Henceforth, he argues, only those cases which are unequivocally the result of a traumatic incident – a collision, fall, or injury resulting from an encounter with industrial machinery – should be considered traumatic neurosis. Specifically, it should be designated as an illness ‘produced by certain traumatic, meaning mechanical, causes’ which materialize ‘not in coarse anatomical, but in finer ... material changes’ to the central nervous system. In other words, with this definition Struempell re-somaticized a certain number of post-traumatic accident conditions, which presented no differently than what had previously been diagnosed as railway spine or railway brain, *commotio cerebri* or *commotio spinalis* (1895b: 1168).

With this aetiological reclassification and somatic provincialization of traumatic neurosis, Struempell succeeded where the charge of simulation had failed. The charge of simulation had been an attempt at securing the Man's Other, figured at the time as the cheating traumatic neurosis patient, by stripping him of his status as legitimate sufferer and denying him access to an accident pension. However, neurological and psychiatric practitioners had not been able to reach a consensus on what tests were reliable in exposing malingerers, or whether simulation of symptoms was even a significant problem. But now, Struempell's aetiological relocation from the event to the desiring thoughts and the character of the worker achieved the same end, but crucially, without making the charge that patients were malingering. This diagnostic model acknowledges that symptoms are genuine but locates their emergence elsewhere – thus voiding any claims to financial entitlement, and producing newly grounded concerns about the security implications of the unregulated worker.

The change of opinion which Struempell had undergone as an individual could be observed among most psychiatric practitioners at the turn of the century. More and more psychiatrists and neurologists came to regard the wishes and character of post-traumatic worker-patients as decisive for the development and persistence of symptoms, as opposed to the traumatic event itself. Again, this development was gradual. In 1901, the neurologist Ludwig Bruns lists Struempell's 'desiring thoughts' as one of a number of psychic aetiological factors, while insisting that the traumatic event was 'obviously' the most significant (1901: 17; 22). Only seven years later, Bruns writes that while a traumatic aetiology of traumatic neurosis is possible, this is extremely rare. In most cases, its causes are entirely psychological: after an accident, patients are prone to introspection and 'hypochondriacal ideas are produced by this fearful attention.' Further, the patient's 'desiring thoughts' of pensions payments lead him or her to regard a pay-out as their inalienable right. And finally, the uncertainty and stress of the 'pension struggle' aggravates and consolidates symptoms. As a result, the patient's post-traumatic symptoms should be regarded 'less as the result of the accident itself than of the circumstances resulting from the employer's liability insurance legislation' (1908: 1136; 1138).

The generative role of ‘desiring thoughts’ became so widely accepted that many, like Bruns, considered the pensions and accident insurance legislation an aetiological factor in its own right. Writing in 1897, the neurologist and psychiatrist Friedrich Jolly recalls a patient he had treated prior to the availability of accident pensions. This patient, who had lost an arm in an industrial accident and subsequently manifested many of the typical symptoms of traumatic neurosis, had no choice but to return to work in order to make a living. But crucially, Jolly observes, this compulsion had had a therapeutic effect, ‘safeguarding him from the dissatisfied, morose, trouble-making [*querulierenden*], and paralyzing sentiment that we observe in so many accident patients.’ This patient, Jolly argues, did not stand to gain from sustaining his symptoms, while patients under the current regime do. As a result, for Jolly, the ‘struggle for compensation and a pension’ plays a significant role in turning fleeting symptoms into aggravated and permanent conditions (1897: 242-43). Others saw an even more direct connection between pensions legislation and post-traumatic symptom. The psychiatrist and neurologist Robert Gaupp argued that ‘the accident legislation has not only economical but extraordinary medical importance.’ He observed that ever since the accident and pensions legislation had been passed, cases of traumatic neurosis developed more frequently and with more severity. For him, this permitted only one possible conclusion: ‘[t]he reason had to be the law itself’ (1906: 233-34). Like Jolly, he recalls that ‘before the accident laws there was the bitter certainty that hard times were ahead and that one would struggle to find work and bread.’ But with the promise of a pension, there is no compulsion to get well (1906: 235).

On the eve of the First World War, the causative effect of pensions legislation was widely accepted. In 1910, the psychiatrist Alfred Hoche writes that ‘[t]his epidemic [of accident neuroses] followed the accident legislation not just temporally, but is also a direct result of it. The law – and of this there can be no doubt – has caused this illness’ (1935: 16). Naturally, as part of this paradigm shift, the traumatic event came to be regarded as entirely irrelevant. As Hermann Engel, medical doctor and forensic specialist of the Imperial Insurance Office in Berlin observed in 1913, the curious ‘neuroses’ emerging after an accident ‘are caused not by the trauma but are a result of the accident legislation’ (1913: 608).

Like the concept of ‘desiring thoughts’, the notion that the worker’s character was especially prone to the ideogenic production of post-traumatic symptoms was widely circulated from the 1890s onwards. Struempell argued that the typical traumatic neurosis patient was characterized by ‘despondency, lack of energy, depression, a tendency towards complaining and trouble-making’ (1895a: 594), thus identifying a lack of self-discipline, drive, and plucky can-do attitude as decisive in failing to resist the onset of symptoms. Willy Hellpach, a physician, psychologist, and politician, explained these character traits as resulting from the living and working conditions of the working classes. He observed that the existential insecurity of workers – their insufficient income, lack of savings, and threat of destitution if they are no longer able to work – as well as the alienation from their labour, meaning they gleaned no joy or fulfilment from it, combined with their quintessential sense of entitlement and ‘primitive thinking’ to predispose them to psychogenic post-traumatic symptoms (1906b: 607). Because the working classes could find no self-fulfilment in their work, Hellpach argued, their psyche produced the necessary symptoms to free them of this obligation. This meant that after an accident, workers tended to ‘cling to’ their compensation entitlement and became fixated on it. Any attempt to distract them would be met with anger and hysterical symptoms. Generally, Hellpach observed, workers were characterized by ‘the fearful refusal to return to work and the attachment to that source of income [the symptom] which makes such a return redundant’ (1906a: 15). Hellpach observed that this attitude was aggravated by the political ideology of Marxism, which, as an eschatological world view promising abundance in exchange for pure belief instead of hard labour, reinforced the working classes’ sense of entitlement. By presenting the salvation of the working classes as an inescapable law of history, Marxism signals to its acolytes: ‘you have nothing and you shall own everything; you have been disinherited but you shall be a dictator; without lifting a finger these things shall come to pass, the law of development itself has destined you for it!’ (1906a: 19). Thus, for Hellpach, the industrial metropolis, the factory floor, and Marxist demagoguery combined to produce potent incentives for the character of the worker to abide by its lowest instincts, and to be governed entirely by a ‘desire for pensions’ and ‘aversion to work’ (1906a: 17).

As psychiatrists increasingly came to understand the worker's 'soul' as sullen, selfish, work shy, and unduly entitled, they became fluent in a vocabulary which cast the worker's status as pariah and security risk in medical terms. For instance, Gaupp explained that the accident insurance legislation had been intended as a generous gesture to alleviate suffering. However, policy makers had not reckoned with the treachery of the working classes – 'the accident pension appeared to him [the worker] not as a magnificent deed in his best interest, but as a pitiful advance payment, offered by the state out of fear.' This legislation had only been passed because '[t]he worker's soul as a psychological entity was insufficiently understood' and it turned out that, scandalously, he felt that there existed a 'general right to a pension' (1906: 2234). From this perspective, the anti-socialist laws of the 1880s and the destitution of the working poor seemed not like instruments of a martial politics of disenfranchisement, but prudent measures based on psychiatric assessment of the worker's character. Offering this population a pension based on their inability to work only heightened their most corrosive (and costly) psychological attributes. A meaningful and effective government of workers required different forms of statecraft.

This form of statecraft envisaged Man and his Other in fundamentally different terms than the events-based paradigm of post-traumatic injury had. While this earlier paradigm had cast worker-patients as legitimate claimants of state support and medical treatment, the new approach subsumed most of its targets under the sign of Otherness to Man. It characterized workers as selfish and entitled, and expected them to nurture their symptoms in order to secure a pension-based life of leisure. Workers, it charged, resisted treatment, lacked the self-discipline and strength of will to overcome their symptoms, and pursued their prize with single-minded and malicious intent. In short, this kind of patient was 'a troublemaker [*Querulant*] ... whose thinking and yearning revolves only around his pension' (Bruns, 1908: 1136). The risk this human Other posed was both fiscal and national, as their pensions were understood to weigh heavily on the state's budgets and their recalcitrance to treatment viewed as corrosive to collective strength⁴. By contrast, Man was understood as the exemplary

⁴ Writing shortly after WWI, the psychiatrist Ewald Stier claimed that the fiscal burden of pensions for 'nervous disorders' had escalated so enormously that they were costing the young Weimar Republic 1 billion

convalescent. This figure, instead of regarding post-traumatic psychological symptoms as a cherished prize, found within him- or herself the vigour and self-discipline to overcome them. Many psychiatrists conceptualized this figure on the basis of a case description by Bruns, who had written about his treatment of an officer who had exhibited post-traumatic symptoms after falling off his horse. However, for this officer, the ‘hypochondriacal idea of not-being-able was overcome by the more valuable idea of returning to his profession.’ This was the case because ‘not only his financial survival but the fulfilment of all hopes which the patient harboured in relation to his advancement and achievement of an excellent place in life depended on it’ (1901: 23). In other words, self-discipline, drive, and an appreciation of the importance of work combined to raise this figure above lowly yearning for a state pension. The fact that an elevated class position was a prerequisite for this ability was not considered a contradiction. ‘Man’, in this paradigm of psychiatric statecraft, was a bourgeois or aristocratic subject seeking self-actualization in the fulfilment of duty. Workers had been shunted outside the realm of sovereign subjectivity, from where they threatened Man’s thriving through their ‘desiring thoughts’ and troublemaking, work-shy character.

The forms of treatment advanced by this modality of statecraft were based on three principles: prophylaxis, immediacy of intervention, and return to work. Doctors stressed that in the clinical encounter, it was urgently necessary to combine the first two of these principles – prophylaxis and immediacy – to counter the generative power of ‘desiring thoughts.’ As Engel explains, ‘[a]s soon as the first desiring thoughts make their appearance one must instruct one’s client [*sic.*] that even if he is awarded the highest damages he will fare worse than if he filled his life with duty and labour’ (1913: 615). Bruns explains that such prophylactic intervention is necessary in order to ‘work against the mounting hypochondriacal ideas and worries about one’s future financial survival.’ Importantly, doctors must avoid making ‘all too bleak statements regarding the severity of the injury and its consequences,’ as this could

marks annually (Lerner, 2001: 141). I have not been able to confirm this figure, nor to locate a detailed breakdown of pensions paid only to traumatic neurosis patients. For overall figures on accident and disability pensions, see Engel, 1913: 6; Thiem, 1919: 4-6.

result in ‘irreparable harm’ (1908: 1150). This intervention must happen immediately, and ideally on the day of the accident itself. If this opportunity is missed and the ‘accident neurosis’ becomes established, it is very difficult to treat ‘because one mostly fails to convince one’s patient to give up his pension’ (Bruns, 1908: 1148-9). Once the first two treatment steps had been completed, doctors advised that patients should return to work as quickly as possible. The dutiful completion of tasks and shouldering of responsibility would function therapeutically, serving to ‘occupy the patient through labour and thereby educating him to regain his confidence and productivity’ (Hoffmann, 1891: 172). The resumption of work was thus elevated to a curative mechanism and was imbued with medical authority and urgency. Like all diagnostic and treatment mechanisms mobilized by the ideogenic paradigm of post-traumatic injury, it produced the self-reliant and economically independent subject as the only psychologically healthy and politically acceptable citizen. A failure to support oneself financially was thus not only a fiscal burden on the state but had a corrosive effect on the entire national community.

The coupling of discourses of medical authority, economic necessity, and national security increasingly found expression in the overt support by many psychiatrists of eugenics. Its terminology and logics, including warnings of increased ‘degeneracy’ among the working classes and the risk this posed to national vigour, make an increased appearance in psychiatric and neurological texts in the years immediately preceding World War I. In 1913, Engel writes that ‘a large portion of the accident neurosis patients is already psychologically inferior, “nervous”, feeble-minded, congenitally weak willed and lethargically hypochondriacal or paranoid before the accident. Another portion has hereditary diseases or shows signs of degeneration (ears, skull, toes, pigment or anomalies of hair growth)’ (1913: 607). In the same document, he approvingly cites a colleague who defines traumatic neurosis in terms of ‘desiring thoughts’ and heredity, namely as the ‘reaction of the degenerate to an accident which entitles him to a pension’ (1913: 609). Some years prior, in 1910, Hoche had described traumatic neurosis as a ‘nervous epidemic’ and a ‘veritable cancerous affliction in the organism or our entire working classes’ (1935: 16), while Hellpach had named ‘biological degeneration’ as one reason why psychiatric

practitioners were finding such a high level of nervousness among the working classes (1906a: 47). But despite their increased visibility, eugenic rationalities and policies only won the support of large sections of the psychiatric profession, politicians, and the public in the wake of the First World War. The following chapter will trace this development in detail.

3.5 Conclusion

This chapter has analysed the conduct of psychiatric statecraft in relation to trauma patients in the late 19th and early 20th centuries in the newly consolidated German Reich. Responding to what was perceived as unprecedented symptoms produced by violent encounters with industrial machinery among the country's newly minted class of industrial workers, neurologists and psychiatrists set out to understand and therapeutically intervene into these quintessentially 'modern' afflictions. In their appraisal of these symptoms' aetiology, expert opinion shifted from locating the cause in the traumatic event itself to the character and 'desiring thoughts' of the worker-patient.

The first diagnostic paradigm of post-traumatic injury positioned the traumatic event itself as decisive, positing that the kinetic impact and/or psychic shock of the incident was so powerful that it produced lasting physical and psychological effects in the patient. Patients diagnosed and treated under this paradigm were understood as legitimate claimants of state accident pensions, and psychiatric practitioners conceptualized their role predominantly as advocates for their patients' wellbeing. Diagnostic consensus around an event-based approach was challenged in the context of the simulation dispute in 1889, when a number of psychiatrists aired their concern that traumatic neurosis, the foremost diagnosis of the events-based paradigm, was prone to abuse through fraudulent pensions claims by malingerers. From the 1890s onwards, conceptualizations of post-traumatic injury shifted decisively towards an ideogenic paradigm which cast the 'desiring thoughts' of a pension payout and the character of the worker as primary causes for the genesis of symptoms. Worker-

patients were now viewed as entitled, irrational ‘troublemakers’ who treated their post-traumatic symptoms as a guarantee for a life-long pension.

This period of psychiatric statecraft was thus characterized by periods of diagnostic consensus and stability interrupted by contestation, with each paradigm inscribing Man in radically different terms: while one side crafted patients as susceptible to injury from novel, machinic perils, the other increasingly recognized worker-patients themselves as the source of danger, their supposed ‘inferiority’ generating symptoms in order to unjustly siphon off fiscal resources. Therefore, in an era increasingly structured by the sedimentation of authority around (social-) Darwinist, biologicistic approaches, many psychiatrists used the tools of their trade to translate the Social Question into the terminology of biological determinism. Yet notably, while diagnostic disputes were conducted vitriolically, the grounds for debate concerning the being of Man remained: even at the height of diagnostic authority of one paradigm, the other could still stake a claim to inscribing Man’s being. While the discursive space for crafting sovereign figures progressively contracted in the early years of the 20th century, it was still possible at this time to inscribe a figure of sovereign Man not based in the ontology of his class or his character. Yet with the rising authority of the ideogenic paradigm, psychiatric statecraft had become martial: under the ideogenic paradigm of post-traumatic injury, effective treatment was equated with pension withdrawal and coercion to return to work. Those unable or unwilling to comply were left without any form of income.

The results of this martial politics of psychiatric statecraft, which primarily targeted worker-patients believed to be socialists, were mixed. While individual accident survivors found it increasingly difficult to claim a disability pension and psychiatric discourse crafted them as selfish and irrational ‘troublemakers’, the popularity of socialism as a political project surged. While the SPD had secured only 7,8% of the vote in parliamentary elections in 1878 – right before the anti-socialist laws had forced their activities underground for a decade – their share climbed to 19,7% in 1890. By 1912, the SPD had 1 million members and won 30% of the votes, allowing them to send the highest number of MPs to the German *Reichstag* (Kruse, 2012).

The next chapter will analyse psychiatric statecraft by means of trauma diagnoses in this period, starting at the outset of the First World War and concluding in the early years of the Weimar Republic. It will detail the martial politics of this form of statecraft in relation to the same ‘adversary’ – socialists, workers, and socialist workers – who were now located predominantly among the infantry’s working-class soldiers exhibiting ‘hysterical’ symptoms after their exposure to the unique horrors of modern, industrialized warfare. By closely following psychiatric discussion of the post-traumatic symptoms of soldier-patients, the chapter will show how the ideogenic paradigm of post-traumatic injury, now expressed through the hysteria diagnosis, conclusively ousted events-based conceptualizations of trauma from the realm of respectable medical opinion. It will show how, over the course of the war, psychiatric statecraft increasingly functioned according to a eugenic rationality and inscribed sovereign subjectivity as an attribute of the physical body.

IV. THE SOLDIER

'It goes without saying that in our army of millions, we will initially see a large number of individuals falling ill who would have become just as ill if they had remained peacefully at home.'

- A. Hoche, 1915: 11

German psychiatrists reported extraordinary events at the outbreak of the First World War. Otto Binswanger, a professor of psychology at the University of Jena, describes attending a rally in the town square on one of the first days of general mobilization: 'Next to me stood a worker whom I personally knew to be a political adversary of the emperor; he joyfully joined in the cheering for the emperor and solemnly shook my hand. We exuberantly sang ... "Deutschland, Deutschland über alles" and silently went our separate ways' (Binswanger, 1914: 15-16). His colleague Robert Sommer made a similar observation, noting that the 'shared experience of danger and the wider national enthusiasm' had 'promoted a spirit of togetherness' (Sommer, 1915: 21). During these heady August days, when news of the declaration of war led to frenzied spontaneous street celebrations and mass volunteer enlistments, the bitter divisions which had characterized German politics since the 1871 unification appeared to have been swept away. The Social Democrats, fierce adversaries of the monarchy for decades, had helped to pass the war credits in parliament, and the emperor had responded by calling a truce. The very same socialists whom the emperor had previously denounced as 'unpatriotic rabble' and 'scoundrels' (Craig, 1964: 250) were now welcomed into his nationalist embrace. Thus when the emperor proclaimed that 'I no longer recognise any parties or affiliations; today we are all German brothers' (Ullrich, 2009: 16-17) from the balcony of his Berlin palace to a roaring crowd, he gave expression to a cresting wave of nationalist sentiment which many Germans would continue to ride for the next few months. Until the advancing German army ground to a halt in October 1914, the war cast aside decades of political strife and inspired calls for reconciliation across the political spectrum. As Alfred Hoche, an arch-conservative psychiatrist, proclaimed, '[o]ur subjective claim to everything

individualistic has shrunk; there is no more right to individual joy, no right to individual grief; the entire people has been transformed into a coherent and fully formed organism of a higher order' (Hoche, 1915: 28-29).

These gestures of reconciliation and dreams of the people as 'coherent and fully formed organism' would be short lived, however, as the hardships of war soon uncovered old political fault lines which had only been superficially concealed by the outbreak of a long-yearned-for war. As the fantasy of a lightning campaign faltered in the mud of eastern France, as casualty numbers mounted and the war revealed itself as one of the inaugural nightmares of the century, (socialist) workers were once again identified as a threat to the thriving and survival of Man, blamed for undermining the war effort, and fomenting revolution.

This chapter will trace psychiatric knowledge and practice during the war and immediate post-war period, analysing how psychiatrists scrambled to secure political order in (what they perceived as) the unfolding catastrophe of defeat, revolution, and the establishment of Germany's first republic in 1919. I will pursue the evolution of the diagnostic dispute between traumatic neurosis and hysteria, or an events-based and an ideogenic paradigm of trauma, begun in the last chapter, and will track how this dispute progressed to tilt ever more decisively towards the latter: at a psychiatric conference in 1916, a majority of psychiatrists enforced a consensus around the hysteria paradigm, thereby enshrining the view that post-traumatic symptoms were usually the product of a 'will to sickness' (*Wille zur Krankheit*) rooted in an inferior character. Along with this privileging of the wish in the pathogenesis of hysteria, German psychiatrists increasingly singled out a given, bodily inferiority – vaguely circumscribed by the term 'constitution' – as the ultimate determinant of psychiatric sickness.

As a result of this enforced consensus, this chapter will identify and trace a constriction in the conduct of psychiatric statecraft: following the manufactured hegemony of hysteria in 1916, psychiatric knowledge could only inscribe Man in terms proffered by a social-Darwinist biology: as 'naturally' equipped with a firm or brittle

will, as ‘constitutionally’ weak or strong, or as ‘selected’ or ‘dysselected’ by evolution (Wynter, 2003: 264). Psychiatric knowledge thereby not only prepared the ground for a eugenic, race-based political order which was to follow in the 1930s, based in an exaltation of those ‘born-to-be’ superior, but restricted the remit of psychiatric statecraft: whereas the knowledgeable production of political order until then had been open-ended and contentious, it now had to be conducted in the terms of a Darwinist biology. It is in this period that we witness German psychiatry pivot towards a practice which is fully martial, appraising patients as political adversaries who must be neutralized for the grave political threat they pose. In addition to the pension withdrawal discussed in the previous chapter, this chapter will scrutinize how the denial of safety from bodily harm – in this case, traumatized soldiers subjected to forms of treatment-torture – functions as a technology of martial politics.

The chapter begins by locating its protagonist – the ‘hysterical’ soldier – in the overall socio-political hierarchy of a German state which venerated its military class, and explains how soldiers, as members of this class, could become the target of a martial politics of psychiatric statecraft. I then review the diagnostic conflict between traumatic neurosis and hysteria and detail its conduct during the early years of the war. I proceed to discuss the 1916 War Congress of Psychiatrists and examine how traumatic neurosis was ousted from legitimate psychiatric discourse, before analysing in detail the mobilization of the hysteria paradigm and its treatment methods during the remaining years of the war. I close with a deliberation of psychiatric statecraft in the post-war, revolutionary period, and draw out its open embrace of eugenics.

4.1 Soldiering against Man – the Production of Working-Class Soldiers as the ‘Enemy Within’

The German Reich, and its Prussian core in particular, were well-known for their militarism and the high esteem in which martial values were held. Afterall, ‘the Prussian army [had] made the Prussian state’ (Craig, 1964: xiv). However, the influence and prestige of the military did not extend to all its members. Like German

society more generally, the army was strictly divided along lines of class, and prestige pooled at the top. The officer corps, which bestowed high status onto its members and wielded considerable political influence, had for centuries been open exclusively to the aristocracy. Consequently, this officer corps (and the higher ranks in general) were a bastion of social conservatism and monarchical support. So much was the army aligned and identified with the German monarchy that Bismarck, after the granting of universal suffrage and the rise of militant socialist movements, considered it 'the last bulwark against revolution' (Craig, 1964: 226).

Even after the officer corps was pressured to open its ranks to the sons of the bourgeoisie in the 1860s, its status as self-styled embodiment of the monarchical state remained intact. Making the announcement that the officer corps would now also admit members of the 'nobility of conviction', Emperor Wilhelm took pains to specify that this would only apply to persons from 'honourable bourgeois families in whom the love for King and Fatherland, a warm heart for the soldier's calling, and Christian morality are planted and nurtured,' thus signalling that neither Jews nor socialists would be welcome (Craig, 1964: 235). As a result, in the decades leading up to the First World War, the officer corps' feudal ethos was strengthened, not lessened, as new members from the upper middle classes sought to emulate what they perceived as existing attitudes (Kocka, 1990: 78-79). Working-class conscripts, by contrast, remained associated with the threat of socialism, which clung to them even after they donned a military uniform. Therefore, working class soldiers did not have to undergo a substantial transformation to be considered a threat to German Man – before the outbreak of the war, they already had been. The widespread sentiments of national unity at the start of the war only provided brief respite, and old divisions soon reappeared as military fortunes waned and casualty numbers mounted.

4.2 Diagnostic Paradigms at War: Hysteria and Traumatic Neurosis at the Outbreak of WWI

October 1914 constituted a turning point in the war, as the German offensive which had overrun Belgium and northern France came to a standstill, and the war of

movement was transformed into a stationary trench war. As the unparalleled horrors of industrialized warfare unfolded around the soldiers – forced to charge repeatedly into machine-gun fire, witnessing the effects of exploding shrapnel on flesh, exposure to hour- if not day-long artillery barrages, poison gas, and more – increasing numbers broke down with what was termed ‘nervous’ symptoms. These symptoms included a staggering range of reactions and disabilities including well-known symptoms associated with WWI to this day, like paralysis and shaking of the limbs, but extended to crying fits, loss of speech, hearing, and sight, facial tics, muscular cramps, changes to the gait (such as walking bent over at the hip), and more. Linking these conditions was the fact that doctors could not link their genesis to a particular physical injury, hence making them ‘nervous’ or ‘functional’ disorders.

Psychiatrists appraised these conditions in the terms familiar to them from previous decades of treating traumatized patients. Thus, as in the previous chapter, two diagnostic paradigms competed for diagnostic and treatment authority over traumatized, or ‘nervous’, soldiers: an events-based paradigm, which privileged the shock of warfare in its explanatory model, and an ideogenic approach, which identified a weakness of the will as the root cause of post-traumatic symptoms. Each of these paradigms contained a different explanation for how precisely these symptoms came about, whether and how they might be prevented, and what kind of treatment they necessitated. As a result, each paradigm also contained and enacted different versions of Man and his Other, each grounding different sovereign German orders.

By the outbreak of WWI, ideogenic approaches to post-traumatic injury were most commonly expressed through the hysteria diagnosis. Simply put, psychiatrists argued that a hysterical symptom manifested because the patient (perhaps unconsciously) desired it thus. The privileging of the wish-tendency had revolutionized psychiatric practice at the turn of the century, which had been dominated by a physiological, somaticist approach in the preceding decades. Instead of tracing every nervous

symptom to an anatomical substrate, younger practitioners at the turn of the century sought to locate these processes in wishes, fears, and desires – in short, the psyche.⁵ The diagnostic paradigm of hysteria was defined by three constitutive elements: the patient's weak willpower, his constitution, and instinct. Psychiatrists conceptualized the first of these, the will, in terms of its ability to keep affect in check. Affects like fear, greed, and selfishness were understood as psychic forces which needed to be strictly regulated. Unsupervised, these affects could deluge the psychic apparatus and sabotage nervous functionality. The conceptualization of the will as a kind of lid on unruly affect was paramount to this model, leading psychiatrists to praise 'affective tolerance' in those who appeared immune to fear (Bonhoeffer, 1922: 5-6) and to denounce the 'affective incontinence' (Gaupp, 1922: 100) in those who succumbed to it. Max Nonne explains how affect translated into a symptom: 'the illness is produced by an unconscious drive for self-preservation which is transmitted by strong affects generated in the unconscious' (Nonne, 1922: 104). This drive, which might be triggered by acute fear for one's life, witnessing the mutilation of comrades, or other distressing events, kicks into a gear those symptoms which will remove the soldier from immediate danger, such as partial paralysis or blindness. As a result, 'these neuroses have an inner purpose [in that their] appearance actually corresponds to the patient's interest' (ibid.). While some psychiatrists conceptualized this process as 'self-preservation' and 'defence', it was more commonly understood in terms of the iconic

⁵ Psychoanalysis, of course, makes similar claims, and its emergence is coeval with the ideogenic approach in mainstream psychiatry. Yet the impact of psychoanalysis on WWI treatment of hysteria and shell shock is often overstated (Rose, 1999a: 19), perhaps as a result of the lasting fame of Freud compared to many of his colleagues who are largely forgotten today (beyond specialist circles). At the time, Freud was both an international celebrity and a pariah in psychiatric circles: by the 1910s, Freud was a giant in the field of psychiatry, and many authors cited in this chapter make references to Freudian concepts and texts. Yet Freud's insistence on the fundamental aetiological importance of sexuality was an embarrassment to his colleagues, and they disavowed it in the strongest terms. Further, as a Jew, Freud faced significant barriers to professional advancement which culminated in his forced exile in 1937.

Yet most significantly, the early-20th-century psychiatric literature on hysteria shows that Freud was only one among many theorists pondering the significance of wish-based, or psychogenic, processes in the production of mental disturbance. For instance, while the rootedness of conscious behaviours in unconscious wishes is considered one of Freud's fundamental contributions, this claim is commonplace among the theorists of hysteria. Struempell's discussion of *Begehrungsvorstellungen*, or 'desiring thoughts', in 1895 shows that a shift in psychiatric thinking toward consideration of the generative effects of unconscious wishes was well underway when Freud published his first tracts. In fact, Bonhoeffer chides Freud in a 1922 article for claiming that he had discovered the aetiological significance of unconscious wishes for hysteria, insisting that he himself had made that discovery in 1911 (1922: 29). In the same year, Nonne cites Freud as one among *many* practitioners he credits with advancing understanding of the wish tendency (1922: 109).

terminology of Karl Bonhoeffer's 'will to sickness' (1911: 373). This 'will to sickness' signified an inclination in the hysteric's will to seek refuge in an illness in order to gain some sort of personal advantage – a pension, or withdrawal from the front. In the context of the 'pension wars' of the previous century, Adolf Struempell had coined the term 'desiring thoughts' (*Begehrungsvorstellungen*) to designate the process by which the prospect of personal gain generates nervous symptoms (Struempell, 1895b). Obviously, this pathological weakness of the will was recognized as detrimental to military discipline, and many psychiatrists noted that the hysteric's 'insufficiency of the will' conflicted with the 'physical and moral demands of military service' (Gaupp, 1915: 362). The loss of control over one's own emotions and nervous apparatus implied by the hysteria paradigm was understood as weakness, cowardice, and abdication of duty and therefore, just as in the 'pension wars' of the previous decades, hysteria was associated with those who put their personal interests above the collective interest. Robert Gaupp speaks of an "exhausted" psyche that flees into illness' (Gaupp, 1915: 361), while Oskar Kohnstamm observes a 'defective health conscience' (quoted in Nonne, 1922: 103).

The concept of constitution was an essential complement to weakness of the will in the diagnostic paradigm of hysteria, as this weakness was understood to be a function of inborn inferiority. German psychiatry at the turn of the century increasingly subscribed to the view that certain individuals were simply born with an innate pathological character weakness which expressed itself in unregulated affect and feeble willpower. As Gaupp put it, 'anxious, sensitive disposition, irritable and nervous temperament, heightened fatiguability from infancy – none of these are an illness, but clear signs of a psychopathic constitution' (Gaupp, 1922: 97). Those with an inherent constitutional weakness were understood to possess lower psychic defences than a healthy individual, meaning that 'the more unstable the entire personality [...] the easier it was for the acute storm of affect to bring about the nervous collapse' (Gaupp, 1922: 72). In the case of nervous soldiers, this psychic model of constitutional weakness enfeebling the will served to explain why someone leading a well-adjusted life as a civilian might collapse during the war. While a psychopathic constitution was 'unremarkable in a peaceful villager, a teacher or scribe

and certainly did not disable him from working', it did cause 'its carrier to break down at the front at once' (Gaupp, 1922: 97). This indicates that psychopathy (discussed in more depth below) did not have the same connotation as it does today, but served as a psychic assessment of being not-quite-up-to the more extreme demands which might be made of a person. Bonhoeffer cautions that '[t]he psychopathic constitution is not divided from the psychic norm by any sharp boundary' and that the 'pathological imbalance between affect and intellect' is a matter of degree (Bonhoeffer, 1914: 1778). However, this did not preclude psychiatrists from using psychopathy as an indictment of character, as it was applied indiscriminately to shirkers, malingerers, hysterics – 'timid and hypochondriacal characters, men with a hostile attitude towards soldierly duties' (Gaupp, 1922: 72-3) – as well as pension claimants and revolutionaries.

The final component in the diagnostic model of hysteria is instinct. German psychiatrists appraised instinct as an archaic, primal, base, and animal urge – 'old inherited connections between body and mind that used to have a biological purpose' (Gaupp, 1918: 9) – which is usually kept in check by reason. Specifically it describes the process by which affect overpowers the will: '[Hysterical disorders] set in when an emotional shock dislodges calm and sober judgement and when resolute behaviour is replaced by an instinctual discharge of inner tensions' (Kraepelin 1992 [1919]: 261).

Discernible from this diagnostic paradigm is a figure of Man characterized by willpower, regulation of affect, and evolutionary 'fitness'. Psychiatric knowledge labouring under this paradigm inscribes a human figure which is threatened less by the horrors of modern warfare than by the inferior constitution of 'psychopathic' individuals. A sovereign figure, for this paradigm, is one which is able to summon its will to domesticate fear and the primal urge for self-preservation in the face of fire. By contrast, his Other is at the whim of affects due to a psychopathic constitution, and thereby loses control over the nervous system. Limited in his abilities due to constitutional weakness, this Other must fall short in the trials imposed on him and the nation at war. Therefore, in the early years of the war, psychiatric knowledge of

hysteria grounds an order led by the born-to-be superior, with Man's Other delegated to a non-essential supporting role.

In stark contrast to the hysteria paradigm, the events-based paradigm of traumatic neurosis foregrounded the impact of the traumatic incident. In his war-time publications, Hermann Oppenheim built on previous conceptualizations of trauma in industrial settings to theorize combat trauma as 'both psychic shock as well as mechanical insults', stressing that 'shock and the brute force of bodily injury can give rise to functional disturbances in the central nervous system' (Oppenheim, 1917: 6). As discussed in the previous chapter, traumatic neurosis was deeply contentious because, as an actionable condition under German insurance law, it allowed survivors of industrial accidents with nervous symptoms to claim a pension. Its numerous opponents attacked both the diagnosis and Oppenheim, its foremost theorist, on the grounds that it fuelled the problem of 'pension hysterics' by giving them the illusion that their symptoms were the result of a traumatic event (instead of the product of their 'desiring wishes' for a pension).

As a neurologist by training, Oppenheim often conceptualized the consequences of traumatic shock in terms of nerve damage and brain function. He argued that 'the brute force of trauma generates a shock wave which protrudes into the central organ', where it causes a disturbance in nervous function (Oppenheim, 1917: 9). One might apprehend this disturbance in terms of a 'malfunction in the central nervous innervation mechanism' following an 'overly strong impulse' – the shock of trauma leads to an 'obstacle in the conduct of motor impulses,' from which a wide array of symptoms including paralysis, shaking, cramps, loss of sight, speech, and hearing can result (Oppenheim, 1915: 20). Put simply, the shock of the trauma causes the nerves to fail, whether it is by misdirecting an impulse or 'losing the memory of how to execute a specific movement' (Oppenheim, 1915: 19). This approach was some steps removed from his first explanations of traumatic neurosis, which assumed that traumatic impact literally led to fissures in nervous tissue. Microscopically locating such nerve injury had proved impossible, however, and Oppenheim now used different models to explain the translation of shock into symptom. Yet he held fast

to the conviction that one ‘should not underestimate the mechanical insult’ and that the ‘fine organization of the nervous structure could be damaged directly and indirectly’ (Oppenheim, 1915: 4). Thus, doubling down on his neurological bias, Oppenheim conceptualized the damage of impact in ‘functional-somatic’ terms (1917: 8).

Traumatic neurosis also differed from hysteria by relegating the importance of the psychopathic constitution. Writing shortly after the outbreak of the war, Oppenheim reports that ‘the severe war traumas can bring forth neuroses (and psychoses) in formerly healthy, non-predisposed persons’ (1915: 6), thus rebutting his opponents’ claim that nervous conditions were predominantly found in the constitutionally inferior. Going one step further, he argues that ‘doctors working at the front had the opportunity to see the nervously ill immediately after their injury and ascertained that their condition was the direct result of psychological and physical trauma. They appear with such speed and primal force that the workings of wishes and desiring ideas must be disqualified’ (Oppenheim, 1915: 25). Oppenheim insisted that the weight of the traumatic event was so significant that even in a ‘constitutionally predisposed’ individual, there would be no disorder without a preceding traumatic event: ‘Even if it were certain that a trauma was only the immediate cause while the seed of the disorder was already dormant inside the individual, this condition would be meaningless without the trauma. Only the trauma renders it [the psychopathic constitution] a reality’ (Oppenheim, 1917: 6).

The figure of Man inscribed by the traumatic neurosis diagnosis differs significantly from hysteria’s fit, affect-regulated sovereign figure. This figure is under threat not from an excess of affect or constitutional inferiority but the traumatic impact of modern technology – industrial machinery (as explored in the previous chapter) or now, during the First World War, the horrors of mechanized warfare. His anatomy is conceived of as mechanistically controlled by an intricate network of nerves which is vulnerable to traumatic impact both from being catapulted out of a trench by artillery explosions, as well as the psychic shock of seeing the mangled bodies of soldier-comrades. Like in the previous chapter, psychiatric knowledge of traumatic neurosis

grounds an order in which those vulnerable to the violent trappings of modernity are given access to social welfare provisions. The state grounded by this figure is, therefore, the welfare state, which accepts that a number of subjects will inevitably become incapacitated as a result of work and war but legislates for a safety net of insurance and pensions payments to compensate for this event.

4.3 The 1916 War Congress of the German Association of Psychiatry

There were only a small number of nervous casualties at the beginning of the war. The turning point, Robert Gaupp recalls, came in December 1914 when, ‘with the start of the great battles in the Champagne, our Western adversaries’ artillery dominance grew into a devastating barrage and the medical trains delivered a larger number of unwounded, nervously injured officers and soldiers to us’ (1918: 4). While each side in the diagnostic debate had a different explanation for this sudden increase in ‘unwounded, nervously injured’ – the hysteria paradigm emphasized the frightening nature of the thundering, ceaseless artillery barrage, while traumatic neurosis deemed the kinetic and acoustic impact of the cannons more significant – neither was able to effectively treat soldier patients. Early in the war, nervous soldiers were withdrawn from the front and ordered to rest. As Karl Poenitz recalls, not only were these patients treated with ‘extraordinary mildness’ and ‘allowed to lie about in the hospitals’, the treatment they received was also ineffective – ‘the symptoms either remained, or suddenly reappeared when they were to be returned to their troops, and the number of hysterics who lay around in the hospital stations at the beginning increased more and more’ (quoted in Lerner, 2003: 57-8). This state of affairs was untenable for many psychiatrists, who not only resented the fact that hysterics were being rewarded and encouraged in their ‘desiring ideas,’ but ‘frequently they were released with very high pensions’ (Gaupp, 1918: 14).

This was the context in which German psychiatrists convened for their annual conference in Munich in 1916. On the first day, some of Germany’s most famous psychiatrists – Oppenheim, Nonne, and Gaupp – gave presentations deliberating the

aetiology of war neuroses. In his presentation, Oppenheim mostly reiterated his known position on traumatic neurosis but made a number of important concessions to the other side which would come to haunt him. For one, he appeared to admit to the importance of a hysterical disposition in the generation of symptoms a number of times, averring that '[i]t is certainly correct that these conditions are encouraged in their genesis by the existence of a hysterical diathesis' (1917: 16-17). Further, he acknowledged the importance of the 'will to improvement' in treatment success and recommended that 'pensions should be as low as possible' to avoid a 'fixation of symptoms' (1917: 36). These were themes directly out of the hysteria playbook, and his opponents pounced on what they perceived as an admission of defeat.

Robert Gaupp, speaking after Oppenheim, ridiculed his somaticist approach by arguing that the use of 'anatomo-physiological terminology' fuels a kind of 'brain mythology' or 'molecular mythology' and clouds understanding of the matter at hand (1917: 118). Doctors should avoid 'translating the clear language of psychology into the helpless stammer of physiology' (1917: 133). He also frequently reminded his audience of the stakes of the diagnostic debate, warning that 'a wild greed for profit' had taken a hold of a significant portion of the population – namely, war hysterics claiming a pension – and that the 'burden of fighting and the misery of dying [weighed desperately] on the fully healthy portion of male Germans' (1917: 150). Gaupp thus presented himself, and by extension the hysteria paradigm, as grounded in disinterested empiricism and opposed to the profit-seeking opportunism enabled by traumatic neurosis.

After the conference's main presentations, a plenary discussion ensued in which the overwhelming majority of speakers denounced Oppenheim and his diagnosis. The advocates of the hysteria diagnosis had been in the majority for a number of years, and their opposition to traumatic neurosis, which had been strong since Oppenheim's first lectures on the topic in the 1880s, had only hardened in the context of the war. The actionable status of traumatic neurosis in insurance claims meant that many German psychiatrists, who were arch-conservative monarchists, viewed it with disdain. This dislike, amplified by anti-Semitism, meant that they stooped low in their

personal attacks on Oppenheim (who was Jewish) and attacked his diagnostic paradigm with ideological vigour. A number of speakers (unfairly) denounced Oppenheim as a crude somaticist, impervious to evidence to the contrary gathered in the war (Friedländer, 1917: 153), and many noted gleefully that he appeared to have retreated from previously held views (Friedländer, 1917: 196). One speaker even suggested that Oppenheim, founder and present president of the Society of German Neurologists, was out of touch with current debates (*ibid.*). By the conference's second day, it became clear that Oppenheim was professionally isolated. In his closing statement, aware that he was outnumbered and had lost his colleagues' support, Oppenheim exclaimed: 'It is inconceivable to me how neurologically and psychiatrically trained doctors can estimate the effect of the tremendous psychic war traumas (without even mentioning the mechanical traumas) as so low that they assume it makes only a fleeting impression on the nervous system' (1917: 33).

The outcome of the Munich Conference, which would reverberate in German psychiatric practice for decades, was essentially three-fold. First and foremost, it signalled the defeat of traumatic neurosis and the undisputed hegemony of the hysteria paradigm for many decades to come. Henceforth, psychiatric knowledge appraised its patients primarily in terms of their 'constitution', or evolutionarily inscribed 'fitness', thereby positioning ingrained hereditary attributes as singularly determinative of psychic fate. Following the 1916 Conference, the discursive constriction theorized by Sylvia Wynter indicative of the modern episteme comes to bear: from this point forward, Man was produced in a 'lawlike manner' as a natural organism, either 'selected' or 'dysselected' by evolution (2003: 268). Second, the Munich Conference heralded the turn of psychiatric practice towards a purely martial form of diagnostics and treatment, appraising patients not as patients but political adversaries who needed to be disciplined and the danger they posed contained. This arch-martial phase of psychiatric statecraft was epitomized by forms of treatment-torture known as 'active treatment', discussed below. Third, the public denunciation and humiliation by his colleagues portended the personal and professional destruction of Oppenheim. After the conference, Oppenheim withdrew from public life and died of a heart attack shortly after.

4.4 War Hysteria – The Evolution of the Diagnostic Paradigm During the Final Years of the War

Following the Munich Conference and the end of diagnostic pluralism, German psychiatric statecraft was able to proceed with single-minded focus. As would become clear in the wartime writing and treatment practice of German psychiatrists, the target of this focus was the establishment of a political order increasingly based on eugenic principles, in which an elite caste of ‘strong-willed’ persons was able to overcome the nervous challenge of modern, industrial warfare and defend against the claims of psychopaths and degenerates. The production of this order proceeded through the inscription of the being of Man and his Others in diagnostic paradigms and treatment approaches. This section will scrutinize the diagnostic elements of this inscription, while the next will analyse forms of treatment.

Over the course of the war, most psychiatrists would come to classify the German (soldier) population along a spectrum ranging from ‘fully human’ and ‘lesser human’ to ‘inhuman’. The normal, fully human subject was conceived of as psychically ‘elastic’ and ‘resilient’, while ‘true neurasthenics’, victims of ‘legitimate shock’, and ‘hysterics’ were classified as progressively lesser humans. It is within this period of the hegemony of the hysteria paradigm that the monstrosity at the far end of the human spectrum begins to take shape: the ‘mentally deceased’ figure of the inhuman.

After 1916, psychiatrists working within the hysteria paradigm came to elaborate a version of the ‘normal’ human which was entirely impervious to psychic trauma. As Gaupp wrote after the war, ‘[t]he war has shown convincingly that man is so elastic that most participants in the war overcame even the most harrowing experiences without permanent damage to their health’ (1922: 82). Psychiatrists thus theorized that Man, as long as he was ‘healthy, able-bodied (*lebenstüchtig*), mentally and physically resilient’ (Binswanger, 1922: 45) at the start of the war, possessed the strength of will to undergo any experience, no matter how distressing, unscathed. In such an individual, Bonhoeffer speculated, there existed ‘defences against severe, distressing emotions which prevent the repercussions of affective impact on the psyche’ (1922:

7). Remarkably, Gaupp took a generous view of the nervous health of the German people, observing that ‘the majority of our people, both in the field and at home, developed a tenacity and decisiveness, a kind of endurance and loyalty in their performance of duty which filled us all with joy and surprise’ (1918: 22). As some psychiatrists had hoped in 1914, the war appeared to strengthen the nervous health of its participants as ‘there was no more time to hypochondriacally observe one’s own nerves and one stood firm’ (ibid.). This exceeded Gaupp’s expectations because these were deeds ‘which one no longer expected from modern nervous humans’ (1922: 87-88). Man was thus construed as possessing ‘extraordinary adaptability’ (Bonhoeffer, 1922: 43) in the face of extreme distress, hardship, and prolonged deprivation. The political order grounded by this form of knowledge was one which enjoined nervous sufferers to overcome their symptoms through their sense of loyalty, self-possession, and duty, and declined to pay them a pension.

‘Lesser’ humans, according to the hysteria paradigm, were those who developed nervous symptoms as a result of exhaustion and shock. While these individuals were not quite so robust as to be able to withstand psychic trauma entirely, they did not have a psychopathic constitution. The definition of a set of nervous conditions apart from hysteria constituted an about-turn for many German psychiatrists, as they had previously insisted that all nervous conditions were rooted in a ‘desiring wish for personal gain (Bonhoeffer, 1922: 7-8). Now, perhaps in response to witnessing the scale and range of nervous suffering during the war, many were at pains to insist that these symptoms were ‘normal expressions of affect’ (Gaupp, 1917: 139) and ‘nothing pathological’ (Gaupp, 1922: 68) – at the end of the day, ‘our nervous system was not made to endure eight consecutive days of machine gun barrage’ (Gaupp, 1918: 10). However, the circumstances under which these conditions could be considered ‘normal’ were strictly circumscribed. The first of these was exhaustion: German psychiatrists acknowledged that ‘following extraordinary exertion and particularly grave experiences’, some soldiers might become ‘sleepless, irritable, prone to tears, troubled by anxious dreams’ (Gaupp, 1918: 8). The condition of nervous exhaustion, known as neurasthenia, was widely established throughout Western psychiatry but was previously decried as an upper-class, luxury (pseudo-) condition. Now, its remit

was extended to include some nervous soldiers because the war had made clear that a number of ‘primitive defences’ which were normally controlled by the will might make an appearance ‘not only in the psychopath and morally weak but also in the psychically exhausted’ – in other words, there can occur a ‘victory of instinct over the idea’ (Bonhoeffer, 1922: 30).

The other, ‘normal’ condition of nervous disorder was shock. Gaupp describes a typical scenario as follows: ‘After leading a charge, after taking the most severe artillery fire, one might see many people who are shaking, are extremely agitated, are laughing or crying convulsively, running around aimlessly, losing their calm and cool. But as soon as the unit resumes its resting position, all that is over’ (1918: 6). The causes for nervous shock were located not in a wish to be safe from bodily harm but in ‘fear in response to exploding shells and mines, seeing mutilated or killed comrades, the collapse of trenches, perceiving an injury or harm to one’s own body through blunt force’⁶ (1918: 9). Since the decisive criterion for distinguishing legitimate shock from hysteria was the patient’s constitution, all efforts had to be made to encourage his will to subdue the symptoms – patients were permitted ‘neither the time nor the opportunity to assimilate themselves into their sickness’ (Binswanger, 1922: 51). If this was successful, a patient would recover from shock very quickly, usually ‘within hours, days or weeks’ (Gaupp, 1922: 74).

Hysterics were located at the far end of the spectrum of ‘lesser’ humans. While their symptoms might look exactly like those of neurasthenics or victims of nervous shock, they were assumed to be the result of a ‘severe psychopathic disposition’ (Gaupp, 1922: 83) if they persisted after a long period of rest or their carriers were from a working-class background. Ernst Kretschmer explained how ‘hysterical habituation’ was distinct from ‘hysterical disorder’: while the latter was an ‘automatic involuntary disruption of the nervous system’, hysterical habituation occurred in those who, as a

⁶ At the 1916 War Congress, Oppenheim noted how curious it was that the proponents of hysteria (and hence a will-based aetiology of post-traumatic symptoms) used the term ‘shock neurosis’: ‘Apparently even on their terms, psychic shock can lead to nervous disorders that they identify neither with hysteria nor with neurasthenia. This means they fully follow in my footsteps, only they are choosing an aetiology with a more tightly circumscribed name.’ (1917: 7).

result of their ‘inferior disposition’, simply did not want to control their symptoms. In these patients, the ‘will to health’ was so atrophied that the capacity for simulation, whether consciously or unconsciously, became implanted in their being (1917: 64-5). The line thus firmly drawn between those who ‘could not and those who would not’ (ibid.), hysteria became the diagnosis of choice for those who presented a threat to German order on account of their inherent inferiority, and crystallized as a foremost instrument in a martial politics of producing working-class trauma patients as political adversaries and national security threat. They might be ‘physically feeble, ... weakened persons’ (Bonhoeffer, 1922: 45), ‘intellectually inferior, frequently even puerile persons’ (Binswanger, 1922: 65), or ‘criminals, degenerates, ... men without love for their country, full of resistance against the demands of military service’ (Gaupp, 1918: 12). As a result of this differentiation within the diagnostic paradigm of hysteria, it was only logical that Kretschmer should ask ‘[t]o what extent is the hysteric’s will criminally liable for his symptoms?’ Comparing the ‘habitual hysteric’ to those ‘psychopaths’ who had ‘perverse drives’, he noted: ‘We find the same excuses based on the weakness of the psychopathic constitution and the strength of the abnormal psychopathic instinct on both sides; and on both sides we find the commanding presence of society’s demand for self-preservation against the ever-expanding harms through the psychopathic individual’s will’ (1917: 89). The defence against hysterics thus became both a matter of national health and national security.

These diagnostic categories were not the result of disinterested medical observation but emerged through and reinforced existing categories of class, gender, sexuality, and race. For instance, the distinction between neurasthenia and hysteria relied on class differences: neurasthenia was an officer’s disease. Specifically, the kind of over-exertion from which officers were believed to acquire their nervous symptoms was an over-exertion of the will – ‘ignoring the warning signs of fatigue’ and refusing to ‘withdraw himself from the damaging attacks on his nervous system’ (Gaupp, 1922: 89), officers apparently were so duty-bound that it made them ill. Not the weak will of the hysteric, but the ‘excessive responsibility, the overexerted will’ was recognized as the cause for breakdown in officers (Gaupp, 1922: 95). Hence it was a characteristic inscribed into the predominantly aristocratic officer caste – the loyal devotion to

emperor and fatherland, the unflinching commitment to a gruelling task regardless of the toll this takes on personal health or even survival – which provided the grounds for the distinction between the two diagnostic subcategories.

Relatedly, the grounding of hysteria in weakness of the will rested on an account of masculinity as mature and competent, since the ‘flight into a hysterical attack’ was understood to be ‘the last escape for those personalities who are underdeveloped and ill-suited to ward off the dangers of day-to-day life, especially children and adolescents, [and] women’. By contrast, for ‘the mature and emotionally well-anchored male, these antiquated defence mechanisms against overwhelming external pressures no longer have a role to play’ (Kraepelin, 1992 [1919]: 260-61).⁷

A similar argument can be made in regard to race, or the means by which Man was whitened and his other racially alienated and darkened. Although racial categories were rarely used overtly by the theorists of hysteria and traumatic neurosis, the status of race as a fundamental category structuring the world views of Germany’s leading psychiatrists is clearly apparent. For instance, in texts reflecting on Germany’s role in the war and its relationship with its neighbours, many psychiatrists shored up the whiteness of Western Man by appealing to white solidarity among Western nations – Binswanger recoiled at the suggestion that the war might be a ‘race war’ because it was fought among people of ‘joint racial stock’ (Binswanger, 1914: 18). Others noted the ‘great difference in cultural standing’ between the Western and the Russian armies, as well as the ignominy of countenancing the deaths of one’s own soldiers at the hands of ‘coloureds, wild animals, rabble, and mercenaries’ (Hoche, 1915: 30-31).

More specifically, the assumptions of racial psychiatry undergirded the hysteria debate. The subdiscipline of racial psychiatry, a thriving area of research across Europe and north America since the late 19th century, furnished the knowledge which was necessary to craft differently racialized populations. Relying both on

⁷ While Man might be unequivocally gendered masculine, his sexuality is more ambiguous. Gaupp discusses cases of sexual deviance in the trenches, noting that ‘the infantry soldier’s masturbation along with its psychic consequences appeared frightening and depressing to some. Homosexual inclinations surfaced even among usually heterosexual men’ (1922: 93). Yet remarkably, he classifies these cases as expressions of neurasthenia, and hence a ‘permissible’ and still ‘normal’ deviation from standards of Man.

concepts of distinct human races and pathological modernity, it argued that Jews, colonized peoples, and white Europeans were differently predisposed to mental disorder. ‘Primitive’ people, its theorists argued, did not have the mental complexity to develop nervous disorders, while Jews were especially prone to it (Adams, 2014: 105). Modernity, as discussed in the previous chapter, was considered corrosive to social order and traditional mores, and racial psychiatry specifically identified the decline of manual labour and agricultural lifestyles as detrimental to the psyche. Consequently, it viewed those populations considered ‘pre-modern’ as highly resistant to mental disorder, while conversely, those groups who were ‘excessively’ modern (like Jews, who worked predominantly in clerical and administrative positions) were particularly prone to it (2014: 109-10). As a result, a degree of nervousness came to be closely associated with whiteness, and could function as a badge of intellectual or creative finesse (2014: 115). While this paradigm racialized black and brown colonized populations as ‘not-modern-enough’ and hence immune to madness, it crafted Jews as excessively modern and hence particularly prone to nervous disorder.

Germany’s leading psychiatrists – not just those working in racial psychiatry – accepted these theories as scientific fact, evidenced for instance by Gaupp’s observation that ‘Poles and Jews seem to fall ill [from hysteria] more frequently than Germans’ (1922: 70), or Emil Kraepelin noting the ‘active involvement of the Jewish race in such upheavals [the revolution].’ Kraepelin, who was the most famous German psychiatrist of the era and remains well known to this day, confidently shared his view that ‘the frequency of psychopathic predisposition in Jews could have played a role [in their prominence among revolutionaries], although it is their harping criticism, their rhetorical and theatrical abilities, and their doggedness and determination which are most important.’ (1992 [1919]: 264). Alfred Hoche, while rejecting any blanket judgement of a higher incidence of ‘nervousness’ among white Europeans, nonetheless praised many tenets of racial psychiatry as important insights: the increase in psychiatric hospitalizations among emancipated former slaves in the United States may, according to Hoche, be the result of alcoholism among a population ‘not yet accustomed to governing itself [*einer noch nicht an die eigene Führung gewöhnten Bevölkerung*], while the importance of race [*‘Rassenzugehörigkeit’*] was proved

to him beyond a doubt by the preponderance for psychiatric illness among the 'Israelite population' (1935 [1910]: 17-19).

While the leaders of the revolution were racially alienated by association with pathological modernity, other parts of the population were cast as primitive and backward. Bonhoeffer, denouncing widespread 'disinclination to work and hedonism' since the end of the war, attributes this to a 'sinking back onto a more primitive mental level' (1922: 27). Gaupp similarly detects a 'barbarization of customs' (1922: 82). Against this background, the racialization of the sovereign figure inscribed by the hysteria paradigm becomes apparent: its sovereignty is guaranteed not only by its evolutionarily 'selected' status, but more specifically by its *racial* differentiation from those groups which were racially 'darkened' or made Other by contemporary knowledgeable discourses. Projecting a racial stratification based on supposedly differential racial ability to contain affect, psychiatric knowledge of hysteria thus claimed willpower as a biological attribute of whiteness, while further affirming the racial 'inferiority' of Jewish, Black, and Brown populations by reference to their inadequate (too high/too low) stress responses.

4.5 The Martial Politics of 'Active Treatment'

In the wake of the enforced hegemony of the hysteria paradigm in 1916, psychiatric statecraft became fully martial. Under the hysteria paradigm, patients were appraised as suffering not from the experience of extreme stress, but as slyly seeking to carve out a form of personal advantage. Psychiatric treatment, in response, now focussed squarely on denying the patient-adversary this victory.

How were these new forms of treatment conceptualized? As noted above, German psychiatrists were frustrated with the kinds of treatment offered to war neurotics and the low rate of treatment success. Indeed, the rest cures administered by 'lying about' in military hospitals had not prevented the fact that 'these patients generally had not been cured, that quite to the contrary ... these conditions worsened in military

hospitals' (Gaupp, 1918: 14). Psychiatrists became determined that 'it was time to clean up the neuroses once and for all' (Nonne, 1922: 105). This shift came in 1915 with the introduction of so-called 'active' treatments by Max Nonne, Fritz Kehrer, Fritz Kaufmann, and others, and these treatment forms became dominant after the 1916 Congress. The term 'active' indicated that these treatments did not rely on the rest-cure model which was predominant in many Western countries at the turn of the century but that they focussed on the removal of symptoms through either suggestion or shock. The suggestive character of treatments did not mean that they were mild, but signalled a range of approaches – hypnosis, pain, torture, electroshock, drill, or coercion – which were mobilized to, in one way or another, convince patients to relinquish their symptoms.

Both treatment approaches, suggestion and shock, relied on certain shared factors for success. The first of these was creating an atmosphere of suggestion in the clinics. From the moment they arrived, psychiatrists advised, soldiers should be made to feel as though their cure was inevitable. Clinics devised a number of strategies to achieve this, including pairing new arrivals with recently cured patients and segregating difficult cases, but most practitioners concurred that crafting a 'positively charged psychic atmosphere' (Kehrer, 1917: 13) was crucial if one wanted 'to breed and maintain a will to victory in the hospital unit' (Nonne, 1922: 107). The second precondition for active treatments was the unquestioned and absolute (military) authority of the psychiatrist. Since the hysteria paradigm hinged on the assumption of the patient's weak or diseased will, treatment success was premised on the disciplinary capacity of the doctor's strong will. Nonne explained that 'the doctor must have the ambition not to tolerate any failures in treatment ... he must be unyielding against the patient and against himself.' By means of his authority, demeanour, and ruthless pursuit of a cure, the doctor must communicate to the patient: 'This man is your superior' (1922: 106-7). Other psychiatrists advised that the character of discipline in a hospital ward should be explicitly military, and that doctors should use their military rank – they were usually officers – to force patients into submission. It was imperative that a soldier learned to obey even in trivial matters (so that the 'movement of the will' becomes automated and thus less susceptible to

corruption) and that the hospital enforced the credo that '[a]s long as the war persists, the individual loses his individual autonomy' (Hellpach, 1915: 1205). If these two preconditions were maintained jointly, hospitals could maintain a salutary balance between a 'tone of the barracks and a Lourdes atmosphere' (Nonne, 1922: 102).

The most famous of the suggestion-based treatments was hypnosis. Pioneered in mainstream German psychiatry by Max Nonne (who had performed a 'miracle' cure of war hysterics through hypnosis on stage at the 1916 Munich Conference), this approach capitalized on the insight that the war neuroses stemmed 'not from bodily but mental origins' (Nonne, 1922: 105). Treatment through hypnosis proceeded by first inducing in the patient a highly suggestible state in which 'the will was absent' before locating those 'forces of the will ... which permit an overcoming of symptoms' (Nonne, 1922: 109). In this suggestible state, the doctor would speak sternly to the patient, encouraging him to regain control of the specific bodily function he had lost due to hysteria. If the doctor was able to convince the patient 'that these symptoms are to a large degree under his own influence and are subordinated to his will', the patient will succeed in 'suppressing and removing' them (Nonne, 1922: 112). Following initial treatment success after the hypnosis session, patients would be submitted to a regimen of several weeks of work, exercise, and military drill, and would be released only after they had performed these tasks 'without complaint' for four to six weeks (Nonne, 1922: 109).

Another form of suggestion-based therapy was feigned surgery, where a patient's symptom was either forcibly or ostensibly removed while he was anaesthetized. One treatment for hysterical loss of hearing involved a patient waking up from 'surgery' with a sound-proof ear cover which would remain in place for at least 24 hours. Once it was removed, the 'palpable transition from not hearing to hearing as the bandages are being removed' leads to a 'significant suggestive effect', which frequently eliminated the symptom (Kehrer, 1917: 12). Another symptom addressed through feigned surgery were permanently cramped and bent limbs. While patients were unconscious, these limbs were stretched and put into a cast, thus demonstrating to

the convalescent once he had awoken that it was indeed possible to relax the hold of this muscle on this limb (Binswanger, 1922: 58).

A large number of treatment approaches were devised on the premise that ‘the symptom had to be made so unpleasant for the patient that he uses all his might to liberate himself from it’ (Kehrer, 1917: 3). These forms of treatment turned the generative capacity of the hysteric’s assumed ‘desiring idea’ to the psychiatrists’ advantage by simply making their present circumstances – the hospital – even more unpleasant than front-line combat. The most notorious of these is Otto Muck’s treatment for hysterical muteness, whereby a metal ball is inserted into the larynx to simulate asphyxiation. Once the patient believes he is suffocating, he starts screaming and thus unwittingly reactivates his vocal cords. As Fritz Kehrer put it, ‘[t]he physical and affective coercion of an emergency innervation precipitates the healthy innervation along with it’ (1917: 3). Other approaches included forced long-term isolation – a ‘truly cruel’ method, according to Nonne (122: 133) – in which the aim was quite explicitly to ‘bore the patient to death’ (Kehrer, 1917: 3). Patients were confined to their beds for weeks at a time, forbidden to speak, read, or interact with each other, the outside world, or even clinical staff.

A third subcategory of suggestive treatment was devised entirely from the assumed curative powers of military discipline. Fritz Kehrer, who developed the method of ‘violent or forced drill’, was so convinced of its effectiveness that he described it as the ‘most immediate, firm, and thorough form of making an impression on the will’ (1917: 8). Specifically, the method proceeded without recourse to the physically violent means of other active treatment approaches and relied entirely on the compelling force of a sternly issued military order: ‘under a steady stream of precisely issued commands, we ask patients to perform a series of the most diverse drill exercises in quick succession, without consideration for the specific kind of hysterical affliction’ (1917: 8).

While the suggestion-based active treatments sought to remove symptoms by convincing the patient – whether through the force of argument, deception, pain, or

trained obedience – to relinquish his symptoms, another genre of active treatment functioned on the basis of the assumed curative powers of shock. As Gaupp explained, shock treatment relied on the simple premise that ‘symptoms which were caused by acute movement of affect, like shock or fear, can also be loosened and removed by acute movements of affect’ (1918: 15). The most (in)famous of these shock treatments was the so-called Kaufmann-cure, named after its creator, psychiatrist Fritz Kaufmann, and sought to achieve the desired ‘acute movements of affect’ by means of administering high voltages of electric shock. In a typical session, the treating psychiatrist would mobilize all the means of suggestive therapy, including telling the patient in advance that he would definitely be cured, issuing strict military orders during the treatment, and calling on him to exercise his will to discipline his symptom. However, the success of the treatment was guaranteed by pain, not suggestion. As Kaufmann explained, ‘the recalcitrant patient can resist hypnosis’ but his method ‘almost invariably forces even the kind of patient who does not incline towards a cure into recovery.’ This was the case because ‘the enormous impression of pain displaces all negative desiring ideas’ (Kaufmann, 1916: 804). Kaufmann did not exaggerate the enormity of pain caused by his treatment: not only did this form of treatment generate more patient protest and resistance than any other (Gaupp, 1918: 16), it also led to a number of patient deaths (Riedesser and Verderber, 1996: 63).

Active treatments also shared the aim of rendering useful a soldier whose weakness of the will and constitutional inferiority risked making him a liability to the war effort: psychiatrists worried that if treated incorrectly (with too much mildness, for instance), these hysterical soldiers not only withheld their soldiering labour power, but were rewarded for their cowardice with comfortable ‘rest cures’. Through active treatment, psychiatrists hoped, these soldiers would be disciplined into offering some form of service to the state. As Gaupp put it, ‘[t]hey should have the will to recovery, the will to give everything they can to serving the Fatherland’ (1918: 18). Aiming to train the will was a more realistic treatment goal than returning soldiers to the frontlines because, as Binswanger observed, ‘these patients were lost for active service’ (1922: 48). In fact, psychiatrists using active treatments noted that most patients developed

symptoms again as soon as they were faced with the prospect of being returned to the front (Gaupp, 1918: 13). But instead of sending cured hysterics home (and risk them being idle and claiming a pension), psychiatrists pushed for a reform during the war which enabled them to release patients into a form of labour which was directly relevant for the war, either in military barracks or civilian industry (Nonne, 1922: 115; Gaupp, 1918: 15). This outcome, psychiatrists proudly noted, served both the individual soldier as well as the state: ‘The treatment of psychoses both during the war and in times of peace serves two purposes: securing the general public and the actual therapy itself’ (Bonhoeffer, 1914: 1779). Between these two aims, however, the former, the ‘self-preservation instinct of the state’, had to take precedence (Nonne, 1922: 115). Putting to work the survivors of electrocution, solitary confinement, and other forms of treatment-torture seemed only adequate to psychiatric practitioners who viewed their patients as subversive of the war effort. Gaupp, never one to mince words, put it this way:

If the best of our people must sacrifice themselves out there on the battlefield so that we may survive and our people may have a future, then we must certainly ensure that the nervous weaklings whom we cannot send out anymore, because their strength and their will have faltered, at least recover at home by means of work and, through their work, contribute as much as possible to our collective endurance.

(Gaupp, 1918: 17)

In sum, all forms of active treatment staged a martial, adversarial encounter between psychiatrist and patient in which the former, in order to attain treatment ‘success’, sought to overpower the atrophied and reluctant will of the soldier-patient. Differently from the previous chapter, where the martial politics of psychiatric statecraft aimed solely for pensions withdrawal for ‘troublemakers’, it increased its arsenal during WWI to include forms of treatment-torture designed with the principal aim of outwitting and overpowering a patient’s ‘will to sickness’. The personal advantage sought by hysterical soldiers, psychiatrists believed, was their removal from the front, and hence the safety of their bodies from mortal danger. And just like pension withdrawal had been conceptualized by a previous generation of psychiatrists

as an effective treatment for wish-based neuroses, wartime psychiatric treatment was premised on denying the patient any sense of bodily inviolability, even in the military psychiatric hospital. We thus find in the psychiatric treatment regime of WWI psychiatry a form of power which is simultaneously disciplinary – the production of ‘docile bodies’ through the imposition of surveillance, command-obedience relationships, and minute training of bodily movements (Foucault, 1995 [1975]) – and biopolitical, regulating the vitality of bodies as a means to control a population. Given the fact that active treatments were unleashed predominantly on working-class soldiers, and the long-standing political discord between the bourgeois-monarchical order and its socialist challengers, the political utility of these treatments must be seen as not only rendering productive individual soldiers, but also to reduce the health and vigour of a potentially revolutionary class (Puar, 2017). The military utility of these treatments was negligible, if not non-existent: some sources put the percentage of soldiers who were deemed unable to return to combat duty at 74%, and those who were sent back nearly invariably relapsed, if not at the garrison, then ultimately in the trenches (Riedesser and Verderber, 1996: 68). It is not clear to what extent, if at all, ‘recovered’ soldiers pressed into military labour were fit to do so. What remains is the appearance of ‘active treatment’ as a means to debilitate and permanently disable a population of traumatized soldiers by means of physical and mental torture.

4.6 Defeat, Revolution, Degeneracy?

As hard as psychiatrists tried to shore up the collective strength of the nation by mercilessly training the will of hysterics, it proved not strong enough to prevent the collapse of 1918. Military defeat ensued after the spring offensive had failed to secure a breakthrough in Entente lines and US forces arrived on the Western front in the summer, while large-scale domestic unrest was imminent after years of rationing and intermittent general strikes. The sailor’s rebellion in Kiel, days before the signing of the Armistice Agreement, was the spark that set alight the November Revolution, leading to the ousting of the emperor and the establishment of the first German republic.

While this revolution failed to decisively remove former elites from power and remained limited in its ambition and achievements (Gallus, 2010), its impact on psychiatric practice was immediate. Longstanding patient grievances about psychiatric abuse now translated into open mutiny, and a number of psychiatrists reported having to run for their lives from former patients seeking vengeance (Lerner, 2003: 213). Psychiatrists found it impossible to enforce the militarist atmosphere of unquestioning obedience which was required for treatment success after the revolution ('Naturally, military drills and exercises disappeared' [Nonne quoted in Lerner, 2003: 210]) and consequently, treatment success bottomed out. Paul Lerner writes of one military hospital in Brandenburg near Berlin where the rate of cures fell from nearly 100 to 8 percent after the war (*ibid.*). But as treatment success rates fell, the number of sudden cures skyrocketed. Some psychiatrists had predicted this, arguing that since the 'primary cause' for these symptoms had been the war, they would dissipate once it ended (Gaupp, 1917: 148). This proved to be correct, and Robert Wollenberg describes how his station 'immediately emptied out, and many paralytics and shakers, who just before were still hobbling around on crutches, at once found their strength again and could suddenly walk around remarkably well' (quoted in Lerner, 2003: 211).

Despite this temporary setback, psychiatrists did not cease to mobilize against 'defectives' whom they viewed as threatening any hopes of a return to order. As self-declared guardians of the nation's nervous health, they took a vivid interest in parsing political events and offering their insights on the causes of and future remedies for (what they viewed as) the unfurling disaster. Applying the central tenets of the hysteria paradigm to Germany's military defeat and revolution, they located three main causes: nervous exhaustion, hystericization, and psychopathy. Through their multi-sited intervention into current events – from the publication of commentary to the 'treatment' of revolutionary leaders – psychiatrists inscribed, more firmly than ever, the tenets of a racially stratified, eugenic order led by those with a strong will and robust constitution.

First of all, psychiatrists argued, nervous exhaustion had created the conditions for Germany's military to disintegrate. Gaupp, writing in early 1919, argues that the attrition, exhaustion, and horrors suffered by the military during the war offered 'fertile ground for the defamatory influences which increasingly came from the home front since 1917' (Gaupp, 1919: 43). Like most German conservatives, Gaupp considered the army blameless in its defeat and traced the causes for its collapse to Bolshevik agitation. However, nervous exhaustion also had a role to play: the 'whispers of radical leftist elements' which were brought in as troop replacements were only able to amplify into revolutionary mutiny because the nervous strength of the army had been decimated by the 'grinding and exhausting effects of the increasingly severe battles' (1919: 44). The war had also wreaked havoc on nervous strength on the home front. Just like with the army, 'the slow grinding down of the collective psyche' was a necessary precondition for the events that followed. As Kraepelin notes, '[t]he masses and leaders lost the calm judgement and determined will which could have protected us from the worst' (1992 [1919]: 260). The home front, psychiatrists argued, had already been in a precarious condition before the revolution because the constitutionally most robust men had been drafted into the war. This left morale in the hands of women, who were emotionally immature, as well as those men who were unsuitable for military service (Kraepelin, 1992 [1919]: 259). Following the armistice, four years of nervous exhaustion manifested in a number of undesirable (and, as Erwin Stransky noted, decidedly un-German) tendencies like 'restless and work-shy behaviour.' All of this, he insisted, is 'nothing but a symptom of the disequilibrium in the psychic-nervous state of the masses of our people' (Stransky, 1920: 274).

Second, Germany's defeat and revolution were also attributed to hystericization. Recalling the structure of the diagnostic paradigm, this designated behaviours which were guided by loss of control over the will and an excess of affect. In the midst of a disintegrating, mid-revolutionary social order, many psychiatrists stressed the instinctual aspects of affect which were unshackled by hysteria. For instance, Hans Brennecke observed that the 'collective soul' of the masses 'expresses its primitive emotional life in unrestrained affect', which it unleashed with 'elemental force'. These

outbursts of mass hysterical emotion are not only dangerous to public order because they ‘trample over and blindly destroy all sense of order, custom, and morality’ but they threaten to debase Germany’s advanced cultural-evolutionary standing. Masses in the throes of hysteria are guided by ‘animal and bestial instinct’ and thus open to ‘strong suggestibility’, ‘naïve egotism’, and seek the ‘fulfilment of utopias they had been led to believe were real’ (1921: 249-50). Attributing hysterical tendencies to the larger population also served as a means to explain why the revolutionary demands had resonated so widely. Stransky argued that hysteria was the factor which led an already exhausted people to lend credence to revolutionary leaders, as it ‘created the susceptibility of large swathes of the population for pathological and ill-conceived ideas which have been revealed in the various coups.’ Had the resolve and judgment of the German people not been tainted by these conditions, Stransky suggested, they would not have allowed themselves to be led by ‘pathologically degenerate persons’ (Stransky, 1920: 274).

This brings us to the third necessary ingredient in generating military and state collapse: the psychopath. Large portions of the German population, psychiatrists argued, were either blameless or afflicted by a temporary disorder, and could thus not be held accountable for the catastrophe which had befallen the country. However, the perfect storm of mass neurasthenia and hysteria had opened the door to psychopaths to wield their nefarious influence, inciting rebellion and fomenting revolution. The figure of the psychopath had been essential to fixing the boundary between hysteria and ‘normal’ nervous exhaustion, but the term was rarely defined. In the history of its use in psychiatric literature, psychopathology had been associated with socially deviant behaviour at least since the writing of Esquirol, a French psychiatrist working in the late 18th and early 19th century. In the late 19th century, ‘psychopathy’ increasingly was made synonymous with deviant, criminal, or dysfunctional behaviour, and was commonly considered to be rooted in ‘congenital degeneration’ (Günther, 2008: 10-11). During WWI, psychiatrists used the term broadly to designate any psychic behaviour they associated with hereditary or constitutional pathology instead of acquired and short-term conditions. They thus included the ‘psychically instable’ (Bonhoeffer, 1919: 725) and persons whose

‘nervous apparatus ... was inherently less firmly constructed ... than a healthy person’s’ (Gaupp, 1918: 10). After the war, the psychopath was named as culprit, instigator, and leader of the revolution.

Psychiatric interest in the psychopathic personality of revolutionary leaders was so strong that there emerged a veritable sub-genre of psychiatric literature appraising this population. Eugen Kahn famously wrote psychiatric assessments of the leaders of the Munich uprising in 1919 after they had been jailed or killed, diagnosing them as ‘fanatical psychopath[s]’, ‘irritable, fanatical, fantastical’, and ‘the prototype of an intellectual hysterical degenerate’ (the latter, of course, was Jewish) (Kahn quoted in Riedesser and Verderber, 1996: 82-84). Brennecke wrote a similar text in which he described the ‘psychopathic personalities’ of revolutionary leaders as comparable to but distinct from hysteria. While they also suffered from ‘defect in the activity of the will and affective insufficiency’, they additionally evidenced an ‘over-pronounced ego complex, ... an inability to appraise and judge situations, as well as lack of objectivity’ (1921: 251). The centrepiece of Brennecke’s study was a psychiatric assessment of eight revolutionaries jailed during the uprisings in Hamburg in the summer of 1919. In these subjects, Brennecke noted both the physical as well as mental signs of degeneracy: ‘Finding: infantile habitus, very sparse body hair. Genitalia almost completely underdeveloped. Several signs of degeneration’ (1921: 255).

Against the background of these political developments, psychiatric statecraft became explicit in naming the types of policy which were necessary for a state to meaningfully serve rational Man. As outlined above, the hysteria paradigm crafted Man as an individual who was able to face down the unique challenges of modernity on account of his evolutionary ‘fitness’, which equipped him with superior affect control and strength of will. Man’s Other, by contrast, was deemed to be afflicted by constitutional weakness, leading to his struggle with ‘affective incontinence’ and his yearning for personal comfort. This led Man’s Other to put narrowly defined self-interest above the well-being of the collective. The war’s ending and subsequent revolution had demonstrated to psychiatrists the disastrous consequences of a weakened and hysterical population being exposed to the nefarious influence of

psychopaths. Clearly, more capable men – Man, in fact – were required to steer the affairs of state.

Therefore, it was at this point that the eugenic logics which had always been inherent in the hysteria paradigm were made plain. Society as viewed through the lens of the hysteria paradigm, in which the war had ‘enacted Darwinian selection of the wrong kind’ (Nonne, 1922: 112) and the ‘racially most valuable men’ (Stransky, 1920: 277) had been killed, needed to be protected from the whims of the hysterics and the excesses of the psychopaths. It called for an oligarchy of Man brought about through eugenicist politics of reproduction, sterilization, and murder – or, as Alfred Hoche, one of the most prolific psychiatric theorists during both the pension wars and the war hysteria debates put it, the ‘destruction of life unworthy of life’ (Binding and Hoche, 2006 [1920]).

Psychiatrists made a number of specific suggestions how this might be achieved. The first was to simply educate the public about the merits of nervous strength and the perils of normalizing psychopathology. Stransky hoped that psychiatrists could become ‘Germany’s appointed leaders’ in ‘teaching the people that the mentally degenerate are as unsuitable as psychic role models as the physically degenerate are as a physical ideal’ (1920: 275). Stransky worried that while physical disability inspired healthy revulsion, the German people were not sufficiently repulsed by what he argued must be included in psychic disability: constitutional hysteria and psychopathy.

The second suggestion was to engage in selective breeding. In Kraepelin’s view, the natural differences in human ability meant that some individuals were more suited to governing than others. Democracy, as the rule of all, would lead to a rule of the mediocre or the weak. If modernity demanded rule by the people, he argued, let it at least be the ‘true’ people:

‘The true people [Volk] is entirely different from that people which, according to the conception of the sovereign state, is competent in the unrestricted choice of the most important aspects of existence. Fortunately, however, true popular rule is entirely impossible.

Invariably the masses submit to individual leaders who by virtue of certain qualities have risen to the top. They are true leaders; those led by them are left with only the appearance of sovereignty. It is not they who decide, but rather the superior leaders who understand how to force the others to follow.’ (1992 [1919]: 268)

From this observation, Kraepelin concludes the necessity for eugenic selection: ‘If our people is to prosper, then its leaders must be its most noble and diligent sons. Popular rule must become the rule of the best. Therefore, it is necessary that, drawing on all our resources, we rear the most superb personalities to guide our destiny in the difficult days to come’ (1992 [1919]: 268).

The third suggestion was to kill the disabled. In a notorious pamphlet which would prove influential in justifying the Nazi disability murders, Alfred Hoche and Karl Binding, a criminologist, argued that certain forms of life had deviated so far from Man that they had forfeited their right to life (2006 [1920]). In this call to ‘approve for destruction the lives unworthy of living’, we find the same argumentative tropes which had been rehearsed by psychiatrists cited throughout this chapter – the contempt for ‘softness’, pity, and empathy, the celebration of ‘robust’ life alongside the denigration of ‘worthless’ life, the appraisal of the quality of a life according to its labour power, and the casting of suspicion on those receiving a pension. Binding and Hoche, like their colleagues, note with distress that ‘we squandered the most worthy lives, the ones filled with the strongest will to live and the strongest vital power’ but go one step further⁸ in naming why exactly this is so outrageous – it is because at the same time, ‘the greatest amount of care is spent on not just absolutely worthless, but negative existences’ housed in ‘idiot institutes’ (2006 [1920]: 27). In this pamphlet, the monstrous figure of the inhuman, ‘mentally deceased’ person, which was already inherent but not explicitly named in the hysteria paradigm, comes fully into view. The authors define such persons as those in whom ‘clear ideas, emotions, or stirrings of the will cannot develop’, in whom ‘there was no possibility to awaken a worldview’, and who could forge ‘no emotional connections with the world around them.’ The

⁸ But they were not the only ones in their profession to do so: See Gaupp, 1926 and Bonhoeffer, 1924.

single most important characteristic of such persons, according to the authors, was the ‘absence of self-awareness’ (2006 [1920]: 57). Binding and Hoche thus conjure up a figure which is monstrous, useless, and dangerous because of the complete absence of the will. Not only is it helpless in the face of modernity’s essential limitations but is unable even to provide for its own subsistence through labour. In the pre-war period of abundant wealth, the authors argue, society may have been able to carry such ‘ballast existence’ (2006 [1920]: 55). This period was now past, however, and it was high time to argue in favour of killing ‘these humans who were the terrible mirror image of real humans’ (2006 [1920]: 32).

4.7 Martial Politics, continued: The Resolution of the Pensions Dispute

While calls for a eugenic programme of selective breeding, sterilization, and mass killings would not be realized for more than a decade, psychiatrists were successful in foreclosing one important means of subsistence for ‘nervous’ war veterans and civilian survivors of industrial accidents: pensions. They thereby enacted a multi-pronged campaign of martial politics against formerly hysterical soldiers – now veterans – which followed on seamlessly from the treatment-torture of the military psychiatric hospitals. While the martial politics of ‘active treatment’ had effected the physical and mental destruction of its working-class soldier-patients, the curtailing of post-war veterans’ and disability pensions ensured that this debilitation remained chronic.

This had been an issue which had continued to occupy psychiatrists throughout the war and beyond. The spectre of a future avalanche of nervous veterans’ pensions claims had haunted the war-time writing of psychiatrists, and as discussed above, denying the eligibility of nervous patients for pensions was a crucial component in diagnostic paradigms and treatment approaches – as Nonne recommended, ‘[a]fter vigorously executed treatment, neurotics should receive very small or perhaps even no pension at all, so that this incentive to illness is also removed’ (1922: 119). This anxiety persisted in the post-war period, when psychiatrists filled endless column

inches in medical journals complaining that nervous pensions claimants were met with too much sympathy and empathy by local doctors, administrators, and courts. Addressing the profession in 1925, psychiatrist Alfred Hauptmann writes: ‘There will be no one among you who has not made the painful experience of witnessing how appeals courts close their ears to the well-meaning explanations of capable experts regarding the true nature of accident hysteria’ (quoted in Riedesser and Verderber, 1996: 97). Even neurologists who should know better, he lamented, were often unaware of the true aetiological factors underlying hysterical symptoms and thus unwittingly misdiagnosed patients. This was unacceptable because, as the experience gathered during the war and revolution had shown, more was at stake than simply an administrative error – the fight against hysteria was a fight against ‘idleness, effeminacy, pensions greed, and any other antisocial attitudes’ (Nonne, 1922: 120).

Therefore, when the 1889 decision which had granted traumatic neurosis actionable status under accident insurance legislation came up for review in 1925, expert opinions submitted by Bonhoeffer, Friedrich Panse, and Ewald Stier unanimously recommended withdrawing this status (Bonhoeffer, 1926; Stier, 1925; Panse, 1926). The Imperial Insurance Office promptly followed suit, and in 1926 officially reversed its more than 35-year-old decision on the compensability of traumatic neurosis. In its justification, the insurance office argued that

If disability from gainful employment of an insured person is only caused by his imagination of being ill or by his more or less conscious desires, then the preceding accident is not the essential cause of the disability. And it is so even if the insured develops the feeling of being ill on the occasion of the accident, if the desires controlling his imagination are directed towards an accident benefit, or if the pathogenic imagination has been intensified by the unfavourable influence of the legal proceeding of compensation. (quoted in Schäffner, 2001: 91)

This decision completed a process first launched in the late 19th century by psychiatrists hostile to the events-based paradigm of trauma: railing against the perils of a diagnosis which, as they viewed it, encouraged the worst in a work-shy and dishonest working class, they embarked on the exploration of the wishful and

constitutionally inferior psyche as the actual root of symptoms. Over the following decades, these views sedimented to gradually consolidate into a widespread psychiatric consensus on the psychogenic and constitution-driven nature of post-accident neuroses. This development was brought to a first apex in the public demolition of Oppenheim's professional standing at the 1916 War Congress, and now finally culminated in the pensions administrative bureaucracy siding with the majority of psychiatric practitioners in denying the existence of any link between traumatic event and post-traumatic symptoms – at least, if the patient was filing a pension claim. The Imperial Insurance Office decision thus constitutes a second significant milestone, further to the 1916 Conference, through which the restriction of discursive space for the psychiatric inscription of Man proceeded. Not only had the main rival diagnostic approach to post-traumatic conditions been professionally delegitimized, but its diagnostic eligibility for pensions claims was now voided. Henceforth, psychiatric knowledge of trauma could only appraise its patients through the framework furnished by the hysteria paradigm: as constituted by relative strength of will battling against the wish-function, both fashioned from the raw material of a 'constitution' handed down via heredity. For decades to come, well into the post-WWII period, psychiatrists diagnosing patients who suffered from symptoms following a traumatic experience considered these symptoms to be rooted in a wish, and the patient's personality psychopathic. The next chapter will turn to the moment this diagnostic hegemony was challenged in the 1960s when Holocaust survivors sought to claim compensation payments from the West-German state.

4.8 Conclusion

This chapter has traced the continuing diagnostic competition between two opposed paradigms of post-traumatic injury, traumatic neurosis and hysteria, during WWI and the immediate post-war period. The struggle between these two approaches, begun in the previous century and traced in the last chapter, intensified in the high-stakes context of war, which saw large numbers of 'nervous' casualties incapacitated by an unprecedented array of symptoms.

The chapter first outlines the diagnostic competition in the early years of the war: psychiatrists working under the traumatic neurosis paradigm argued that the kinetic force and psychological shock of artillery shell explosions disturbed ‘movement images’ (Oppenheim, 1915) in the brain, ultimately leading to functional nervous disorders. Adherents of the hysteria paradigm, in contrast, suggested that nervous soldiers became incapacitated on account of their insufficient control of affects, which surged in high-stress situations and paralyzed the nervous system. They averred that the weakness of the will of afflicted soldiers, rooted in a constitutional ‘inferiority’, meant that their psyche was governed by base desires for personal safety, and was unable to privilege forms of behaviour which served the greater, collective good. I proceed to trace the culmination of the diagnostic conflict at the 1916 War Congress, during which the adherents of the hysteria paradigm established their approach as the only legitimate appraisal ‘nervous’ casualties, and effectively ousted traumatic neurosis from the realm of professional acceptance and respectability. I then lay out psychiatric diagnostic and treatment practice in the final years of the war, conducted under the diagnostic authority of the hysteria paradigm. I track how psychiatrists classified ‘nervous’ soldiers into distinct groups of casualties based on their class background, with officers usually deemed neurasthenic, or exhausted, while working-class recruits were diagnosed as ‘criminals’, ‘degenerates’, and ‘psychopaths’. I discuss new forms of ‘active’ treatment to which these soldiers were subjected, and which were designed with the aim of overpowering an adversarial will. As a result, these treatments were degrading, violent, coercive, and sometimes lethal. I then analyse how psychiatrists intervened into post-war, revolutionary politics by treating revolutionary leaders and offering their interpretation of current events. Psychiatric knowledge and practice during this era functioned to ground political radicalism and socialism in psychopathy, or hereditary defect. In the final sections of the chapter, I outline psychiatry’s full embrace of a politics of eugenics, enacted through a series of publications recommending the reproductive supervision, sterilization, and murder of the ‘mentally defective’ and ‘mentally deceased’.

I argue that psychiatric statecraft, over the course of the war, atrophies from a multi-sited and heterogeneous process inscribing competing sovereign figures to a

monological practice in which Man is produced in a tightly circumscribed discursive space. A shift in the knowledgeable production of order has occurred in which not multiple, but only a single version of Man is able to ground German order – namely an individual characterized by strength of will and robust constitution. The competing inscription of order offered by traumatic neurosis, in which the state must serve and assist a subject injured by modernity, is thoroughly delegitimized during this period. I also aver that psychiatric practice becomes fully martial during this period, appraising its patients as political adversaries who had to be contained and subdued, not treated. I suggest that further to pensions withdrawal, active treatment also functioned as a biopolitical method of martial population governance which produced soldiers as permanently disabled.

The following chapter details the next diagnostic conflict over post-traumatic conditions in German psychiatry, which erupted only after a decades-long and uncontested reign of the hysteria paradigm, stretching from the 1920s, across the twelve-year Nazi period, long into the post-WWII era. Turning to the trauma of Holocaust survivors, it will scrutinize the enduringly martial character of psychiatric statecraft in its treatment of a population it continued to view as ‘inhuman’ long after the end of the war, and it will parse the late challenge offered to this psychiatric dogma by reforming psychiatrists in the late 1950s.

V. The Holocaust Survivor

*'O Buchenwald I cannot e'er forget you,
for you're my destiny.'*

- H. Leopoldi and F. Löhner-Beda, cited in Leopoldi, 2019: 54

We find the case of 'Frau R.' in a written psychiatric expert assessment, the kind which was commonly commissioned in the context of compensation claims filed by Holocaust survivors under post-war, West-German restitution legislation (Niederland, 1980: 180-197). In the assessment, William Niederland, the examining psychiatrist, presents Frau R.'s case history: Frau R. was detained at Auschwitz and Bergen-Belsen concentration camps for a number of years and emerged as one of only two survivors from her family. She received emergency medical treatment in Sweden and subsequently emigrated to the United States. But Frau R. was not cured: years later, she still suffered from severe anxiety and panic attacks. Sometimes she is overwhelmed by an acute fear of death, which she describes as a feeling 'as though she will die, *must* die.' Frau R. is fearful of going outside and is unable to work.

Niederland includes in his report the outcome of two previous psychiatric assessments. These doctors, who had examined Frau R. when she first filed her compensation claim in the late 1950s, denied any relationship of causality between her persecution and the subsequent, disabling symptoms. One doctor diagnosed her with a 'severe case of hysteria', while another judged her symptoms to be the 'constitutionally induced reactions of a psychopathic personality.' Her claim was rejected.

The case of Frau R. is far from exceptional. For a large number of Holocaust survivors, applications for a health damages pension (the only form of 'compensation' available to most survivors) based on the chronic psychological aftereffects of persecution were rejected. This usually happened with reference to their constitution.

Like in the previous chapter, psychiatric recourse to a claimant's constitution served to sever any links between experience and symptom, and charged that sooner or later, the patient would have developed these conditions anyways. They were simply *wired* that way.

In this chapter, I argue that the treatment of Holocaust survivors by post-war, West German psychiatrists was the expression of an enduring biologicistic scientific paradigm in which Man was produced as a natural organism selected by evolution. Since the Psychiatric War Congress in 1916 and the Imperial Insurance Office revision of pensions eligibility criteria in 1926, psychiatric discourse and practice on trauma had crafted sovereign subjectivity as a resilient organism which, no matter how severe the emotional shock or strain, is always able to return to health, work to earn a living, and sustain itself and its community. As part of this process, psychiatric discourse also interpreted any subject's failure to thrive and work as an expression of a biological, organic fault. This paradigm had endured throughout the years of the Weimar Republic and the Third Reich, and it had survived unscathed and authoritative into the post-WWII era. As a result, German psychiatrists predominantly ruled that if Holocaust survivors still suffered from debilitating panic attacks a decade after liberation, their constitution was to blame.

A significant portion of Jewish claimants were denied a pension by the post-war, West-German restitution bureaucracy, after having undergone a year-long, frequently humiliating and dehumanizing application process in which they had to, once again, submit to the gaze of German medical authority which recognized them as subhuman. German psychiatry thus participated and enacted a form of statecraft in which Jews, for years after the demise of the Third Reich, continued to be identified as threats to German, sovereign Man on account of their biological 'inferiority' and resulting character traits which were viewed to constitute an unacceptable strain on German fiscal stability and societal cohesion.

German psychiatric statecraft in the immediate post-war years thus proceeded in the restrictive fashion theorized by Sylvia Wynter (2003): it produced as sovereign subject

an economically successful, constitutionally ‘normal’ citizen who had recovered from the hardships of war and looked into the future with optimism, while producing traumatized Jewish restitution claimants as threats to the German people. In the process of undergoing a restitution claim, Jewish applicants were cast as biologically deficient, greedy, and intent on thwarting Germany’s recent economic and political recovery (i.e., its return to the fold of Western, liberal states). By thus applying its Darwinian and Malthusian criteria for the formation of sovereign subjectivity (Wynter, 2003: 321), this gesture repeatedly inscribed *as people* those Germans who had quickly overcome the hardships of war, were constitutionally healthy, and who were now labouring to build a new country. As a result, psychiatric statecraft in the first 15 years after the defeat of the Nazi state continued to inscribe a racist, eugenic epistemic and political order in which belonging was premised on biological properties.

Further, it was a form of statecraft which performed the same sovereign exclusions as the preceding, fascist, state, forcibly cleaving Jews (as well as others it recognized as biologically ‘deficient’) from the sovereign body politic, labelling them a threat to German thriving, and submitting them to various forms of martial violence and exclusion. Certainly, these sovereign exclusions were different in scale and kind from the industrial machinery of genocide enacted by the Nazi state. However, what the treatment of Holocaust survivors at the hands of the post-war compensation bureaucracy demonstrates is that Jews were produced by dominant epistemic and political processes as foreign and inimical to the nation, and that they were subjected to a martial politics of post-genocidal debilitation (Mbembe, 2003; Puar, 2017; Howell, 2018). As one (dissident) German psychiatrist noted, in many ways, Jews in post-war Germany ‘remained in the concentration camp’ (Matussek, 1961: 542).

This chapter will track not only the enduring nature of this paradigm, but a challenge to it mounted by a group of reforming psychiatrists in the late 1950s. These psychiatrists argued that considering the totality of Nazi terror, the question of constitution was secondary to understanding the destruction visited upon its victims. These survivors, who were often mere shadows of their former selves, enveloped by

constant fear and debilitating grief, were not damaged because their psychic structure was inherently weak or because they were driven by base desires for material advancement. Instead, these reformist psychiatrists argued, Holocaust survivors were traumatized because Nazi persecution had engulfed them in death worlds over several years, stripped them of all attributes of human individuality and dignity, killed their families, and sundered their communities. It shattered their sense of longevity, bodily security, and trust in a meaningful metaphysical order. Reforming psychiatrists thus constructed the human not as natural organism, but as a complex being embedded in multiple networks of kinship, sociality, and reciprocal moral and ethical codes. If these networks are destroyed, Man is no longer Man, but part of the living dead.

Yet notably, these reforming psychiatrists didn't part ways with the dominant psychiatric paradigm of trauma completely. Instead of rejecting standard psychiatric treatment of trauma as little more than governance of the poor which enforced their return to work, they left many of its tenets intact. Where the dominant paradigm argued that the body recovers quickly from shock, and that any lasting conditions are the expression of advantage-seeking behaviour, reformist psychiatrists agreed: for them, most accident survivors who dared claim an accident pension were 'pension neurotics' who must be firmly opposed with all tools of the psychiatric trade (i.e., exposing their claims as fraudulent).

Further, the political order inscribed by this cohort of psychiatric practitioners did not simply enfold Jewish survivors into a newly constituted sovereign German 'we'. Instead, these psychiatrists enlisted their Jewish patients in a complex process in which their meaningful and effective compensation by the German state served as evidence that Germany had been transformed: from a 'rogue' state unleashing war and mass murder to a rule-of-law-based state which responsibly shouldered its historical responsibility. The compensation process, therefore, was mobilized by psychiatric practice to authorize a rebirth of the German nation. Compensation, they appeared to suggest, if carried out earnestly and authentically, enabled Germans to distance themselves from a shameful past and to express pride in their nation once again. Differently from the race-based political order inscribed by their psychiatric

competitors, the biggest threat to Man in this order was no longer biological ‘degeneration’. Instead, the German state grounded by this reformed psychiatric practice had to defend itself against those who threatened Germany’s transformation into a law-abiding, liberal, and democratic state by failing to atone for its past.

This chapter will trace German psychiatry’s progression from the biologicistic to the revised paradigm of trauma. I will begin by looking back to the last chapter, explaining how the paradigm of hysteria, ‘pension neurosis’, and ‘will to sickness’ could survive more or less unchanged into the post-WWII era. I will then analyse how post-war, West German psychiatric practice enacted a martial politics of post-genocidal debilitation in its treatment of Jewish Holocaust survivors, once again excising them from a German nation understood primarily in racist, biologicistic terms. I will close by outlining the challenge by reformist German psychiatrists to this practice, and by exploring in detail what type of Man and sovereign state these new approaches constructed.

5.1 Old Trauma, New Trauma: The Persistence of the Biologicistic Paradigm of Man into the Post-War Era

As I laid out in the last chapter, the psychiatric dispute over the causes of psychological trauma was considered settled at the end of the First World War. Those practitioners who had argued that the seeds of this illness always lay in the mind – its ‘will to sickness’, ‘insufficient will to health’, its yearning for stability and security – had carried the day. Hermann Oppenheim, their main opponent and principal advocate of the view that shock and severe distress could, in fact, impart lasting damage on the human mind, was dead, and his opinions were now considered roundly disproved. The long reign of what would later be called ‘the ruling paradigm’ was formally enshrined when, in 1926, the Imperial Insurance Office, which is the administrative body charged with adjudicating the pensions claims of employees arising from accidents, stripped traumatic neurosis of its status as actionable condition. It thus followed leading psychiatric opinion in recognizing traumatic

neurosis not as a ‘mechanical result of trauma’ but as an ‘effect of the expectation of a pension’ (Bonhoeffer, 1926: 181).

The last chapter also outlined how German psychiatric opinion fully embraced eugenic principles by the end of the war, and that many, over the coming years, would advocate for various form of reproductive intervention to confront a rising tide of ‘degeneracy’. This was not unrelated to the embrace of hysteria: eugenics advocacy and the unfettered dominance of the hysteria paradigm (i.e., trauma as an expression of ‘will to sickness’) were two sides of the same coin, and were both an expression of a psychiatric inscription of Man as biological organism. Man, in this paradigm, had a strong constitution and quickly recovered from mental strain. As a result, it became a widely accepted truism that ‘the mental limit of a what man can endure is infinite’ (Hoff, cited in Venzlaff, 1958: 70). German psychiatry was firm in its conviction that, no matter what horrors humans experienced, as long as they were constitutionally healthy, they would soon recover. Only ‘psychopaths’, ‘troublemakers’, and ‘pension neurotics’ – attributes inscribed in a person’s constitution – still complained of trauma months or years after a distressing incident. Therefore, denying pensions to ‘psychopaths’ and advocating for reproductive intervention against ‘degeneracy’ were complementary fields of both psychiatric-medical activity and psychiatric-political defence of the German nation.

The scientists of the Weimar Republic remained restricted in the application of their race-biologically based scientific principles to diagnosing patients. Yet this changed with the coming to power of the Nazis, who shared the same scientific convictions and were swift to enact them through policy. The *Gesetz zur Verhütung erbkranken Nachwuchses* (Law for the Prevention of Hereditarily Diseased Offspring) was passed on July 14th, 1933 and entered into force in January of the following year. Henceforth, persons with a number of mental illnesses and forms of bodily ‘deformity’ and disability were subjected to enforced sterilization. The discipline of psychiatry and its institutional site, the asylum, eagerly complied, enabling the sterilization of approximately 360,000 individuals (300,000 until the start of the war) (Blasius, 2015). Through its ideological prominence and attendant administrative effort, sterilization,

in fact, became psychiatry's foremost and primary occupation, relegating any efforts to engage patients in therapy or treatment to the status of irrelevance (Blasius, 2015: 161).

Policies and practices of eugenically crafting a purified German race escalated with the start of the war: from 1939, German psychiatry entered its extermination phase, first rounding up and gassing its patients, and in later years systematically starving them to death. Hitler's *Ermächtigungsschreiben* (Writ of Authorization) from September 1939 instructed doctors and psychiatrists to perform 'mercy killings' of those deemed incurably ill (i.e., cognitively or physically disabled). This writ set in motion the creation of a set of agencies and boards of psychiatric experts tasked with identifying patients and bringing them to suitable (psychiatric) locations from which they could be transferred to designated killing sites. This programme, known as T4 due to its headquarters' location in Berlin's Tiergartenstrasse 4, officially operated from November 1940 until the summer of 1941, and killed 71,088 patients. Notably, this method served as a blueprint for killing technologies in the death camps, where the process of rounding up, 'efficiently' murdering, making available to science, and subsequently cremating those deemed a threat to public health mirrored the means by which Germany's disabled were exterminated (Loose, n.d.; Bock, 1991; Kaiser et al., 1992; Aly, 2013).

Unofficially, the policy of killing psychiatric patients continued until the end of the war, albeit by other means. The informal perpetuation of the T4 programme meant that patients were no longer sent to designated killing sites but were abandoned to starvation or given injections of unsuitable medication to expedite their demise (Blasius, 2015: 175 - 81). This phase of German psychiatry of extermination is known as 'wild euthanasia', as psychiatrists used the T4 infrastructure to identify, catalogue, and abandon patients to lethality. More than 200,000 psychiatric patients were killed in this manner before the end of the war.

While murdering 'degenerates' in the asylums, German psychiatry also assisted in the Nazi war of aggression and extermination by enacting forms of 'active treatment' on

Wehrmacht soldiers suffering psychic breakdown. Relatively restricted in the application of more painful and coercive measures during the early years of the war, psychiatrists once again began treating ‘war neurotics’ with electric shock in 1942 when psychiatric casualties mounted following a turning point in the war (Riedesser and Verderber, 1996: 144-46). Unshakeable in their belief that not war, but a deficient ‘will to health’ was the source of these conditions, psychiatrists constructed an inescapable arsenal of coercion and threat around the neurotic soldier: if electric shocks didn’t cure them, they could be sent to a penal battalion on the eastern front – an especially dangerous assignment that few were expected to survive – or, as a last resort, to a concentration camp (Riedesser and Verderber, 1996: 155-57). Psychiatrists also provided expert psychiatric assessments of soldiers charged with *Wehrkraftzersetzung*, or undermining military force. While one military psychiatrist admitted that he had some qualms about sending to his execution ‘an otherwise valuable young man’, this was necessary if one wished to ‘avoid the irruption of cowardice and to uphold the fighting spirit’ (cited in Goltermann, 2009: 187). German military courts sentenced to death and executed around 33,000 of their own soldiers for crimes including desertion and undermining military force (Welch, 1999).

Regardless of the brutality of their methods, at the end of the war, German psychiatrists felt vindicated in their scientific convictions: according to their own appraisals as well as in comparison to other warring nations, German psychiatric casualty numbers had remained low (Goltermann, 2009: 165-7). It appeared as though their assessment of the psychogenic nature of traumatic symptoms had been correct, and their treatment methods effective. Therefore, when Karl Bonhoeffer – a figure familiar from previous chapters – deliberated in a 1947 article whether the experience of two world wars had added to or amended psychiatric knowledge, he concluded: no. As the quick recovery of the civilian population from Allied bombing, as well as the resilience of soldiers had demonstrated, the pre-war assumption of the ‘extraordinary robustness and adaptability of the healthy [human] brain’ had been correct (Bonhoeffer, 1947: 2)⁹. German psychiatry thus emerged from the Second

⁹ This article is frequently cited to demonstrate that Bonhoeffer, noting the extreme nature of Nazi persecution, revised his view that experiences could never cause lasting psychological damage (see, for

World War with much the same opinions and diagnostic and treatment approaches with which it had entered into it. It held firm to the dogma of the healthy human's (i.e., Man's) infinite capacity for recovery from trauma, and the essentially pathological nature of long-term, chronic post-traumatic conditions.

5.2. Restitution Legislation and Practice: Holocaust Survivors and Martial Psychiatric Statecraft

Yet contrary to these initial assessments, the years of war, persecution, and genocide had left their mark. Not only did German soldiers turn out to be less resilient than expected (Goltermann, 2009: 212), but survivors of Nazi atrocity across the continent still complained of massive psychic impairments years after the end of the war (more on this below). First the *Länder*, or regions, under Allied occupation, followed by the West German federal government, passed a series of laws enabling various (if not all) victims of Nazi persecution to file claims for restitution and compensation. Holocaust survivors suffering from long-term psychological health damages became eligible under the *Bundesentschädigungsgesetz* (Federal Compensation Law, BEG), which was passed in 1953. This law entitled those claimants to a health damages pension whose earning capacity had been reduced by at least 25% as a direct result of Nazi persecution. The law explicitly included psychological health damages and stated that a 'likely' causative relation between persecution and health damages was sufficient to entitle claimants to a pension (Pross, 1988: 134). After numerous revisions and amendments, a final version of the compensation law – aptly named *Schlussgesetz*, or 'final law' – was passed in 1965 to set a final deadline for submitting or resubmitting claims.

How would a survivor go about submitting a claim? After filing their paperwork, claimants had to undergo an extensive medical exam in which psychiatrists and, if

example, Pross 1988: 152). This is only true to a point: while he concedes that 'torture in the concentration camps' could push the psyche beyond what it was able to endure, he mentioned neither Jews, race-based persecution, nor extermination (1947: 3). In their imprecision and vagueness, together with the oddly restrictive reference to 'torture', Bonhoeffer's comments can be read as applying only to non-Jewish, German political prisoners.

necessary, other medical specialists, catalogued all their health complaints. Claimants living in Germany were sent to doctors selected by the compensation bureaucracy, while those living abroad were examined by so-called 'Vertrauensärzte', usually Jewish German émigrés, appointed by the German embassy. These doctors then produced a written expert opinion in which they first determined the total extent of the claimant's impairment (expressed as a percentage of reduced earning capacity) before specifying the extent to which this reduction was the direct result of persecution. Thus, while the final decision lay with the local German compensation office, these expert opinions carried great weight: if a doctor diagnosed a persecution-based 25% impairment, the claimant was eligible for a pension (Pross, 1988: 134-5).

The rate of rejections was high: up until 1965, 30% of health pension claims made from abroad, and 50% of domestic claims, ended in a negative decision. Data from 1966 shows that one third of successful claims had only been approved after a successful appeal in court. Taken together, up to 55% of claims (both rejected at the initial stage and later approved in court, as well as outright rejected) were unsuccessful (Pross, 1988: 144). By contrast, traumatized returning German POWs seeking to claim a veterans' pension – disbursed via a different legal mechanism than Holocaust survivors – were often diagnosed with hunger dystrophy, an organic degenerative disorder which had also been found in many camp survivors, even if their symptoms had no identifiable organic base. This allowed doctors to circumvent the assumptions of the ruling paradigm and give these patients' symptoms a 'reality' and an organic basis which post-traumatic symptoms alone did not possess. This often allowed their pensions claims to be approved (Goltermann, 2009: 212).

German psychiatrists contributed to this staggering rate of rejections among Holocaust survivors by continuing to operate within the framework of the 'ruling paradigm'. Surveying published expert opinion in post-war compensation claims, one repeatedly encounters the concepts and terminology which had been enshrined as psychiatric dogma since 1916. Take, for instance, the *Begehrungsneurosen*, or neuroses based on a desiring wish. A 1953 expert opinion deemed Jakob B., a German Jewish man suffering from heart disease, severe depression, and anxiety following his

detention in a Gestapo prison and Theresienstadt concentration camp, a pension neurotic. Jakob B. was repeatedly hit over the head with a truncheon in the Gestapo prison, leading to recurring dizzy spells. Years later, he still could not shake the feeling of being persecuted, and perceived every passing glance as an indictment. Uncomfortable in crowds, he now only left the house at night. But the examining doctor noted with disapproval that Jakob B. had failed to undergo psychotherapeutic treatment which had been recommended by a previous specialist (which Jakob B. claimed he couldn't afford). 'Herr B. appears to have no interest' in getting better, he wrote. 'If he did, he would have been forced to stand on his own two feet again, and would no longer have been able to live at the public's expense' (Dr. U., quoted in March, 1955: 176-7).

The same is true for 'abnormal reactions', or psychosomatic conditions which fail to subside shortly after the distressing event. Hermine P., a German Jewish woman, filed a health damages pension claim for a number of chronic symptoms she traced back to her abuse in a Gestapo prison. Unable to remember what exactly happened during her detention, Hermine P. only submitted that she was unable to walk following her release, and that she spent the remaining years of the war in hiding. At the time of her claim, Hermine P. suffered from seizures accompanied by heart palpitations, heart disease, as well as joint and muscle rheumatism. Finding no organic causes for her condition, the examining doctor concluded that Hermine P. was exhibiting an 'abnormal mental reaction'. This sort of neurosis does not constitute an illness, he argued, but its symptoms 'only appear because there is an affective or auto-suggestive expectation' of them (Ärztlicher Dienst, quoted in March, 1953: 154).

Another hallmark of rejecting doctors' expert opinions is their suspicion of typically 'hysterical' symptoms, such as purportedly demonstrative, calculated, or exaggerated behaviour. One claimant, Frau C., said that she was beaten with a rifle butt after she fell asleep at her workstation in a munitions factory, where she was held as a forced labourer. The guard forbade her to utter any sound, threatening that the beating would continue until she absorbed it in total silence. In his written expert opinion, the examining doctor noted that Frau C. emitted strange cries – sighs, belches, and

barking sounds – whenever she recalled distressing events in the camps. To him, they underscored his impression of a ‘contrived affectation’ and a playing up of symptoms, and he denied her claim (quoted in Niederland, 1980: 120-22).

But the underlying theme in all of these assessments is their inevitable recourse to ‘Anlage’, or constitution. Sometimes, the invocation of constitution is implicit, as in the cases above. As the previous chapter set out, German psychiatry understood many psychological processes – the ‘will to sickness’, ‘desiring wishes’ – to be mere expressions of pre-determined hereditary, constitutional ‘inferiority’. Conditions like hysteria were thus naturally subsumed within the remit of constitutionally determined pathology (Niederland, 1980: 194). But more frequently, the reference to a patient’s constitution in examining doctors’ written reports was explicit: it appears with unnerving consistency, serving as the grounds for rejection in the context of countless accounts of harrowing experiences. Whether it is the chronic fear and insomnia of an Auschwitz survivor, the death from heart disease of a dentist forced into exile after the Gestapo rampaged through his apartment, or the inability to countenance loud noises or the sight of uniformed men of a Polish woman who witnessed the shooting of her parents and siblings by the SS; the response is the same: ‘endogenous mood disorder’, ‘constitutional psychasthenia’, ‘weak disposition’ – in short, ‘Anlage’ (von Baeyer et al., 1967: 52-55; 202-05; Niederland, 1980-55; 220).

The recourse to constitution in assessing psychological responses to distressing events was not only inscribed in psychiatric convention but was repeatedly affirmed as standard medical practice by government publications. In a text commissioned by the German Ministry of Labour in 1960, the authors – five high-ranking psychiatrists and medical experts – reiterate the core principle of the ruling paradigm, namely that in the case of so-called accident neuroses, not the ‘damaging event’ but the promise of a pension is the generative cause of symptoms. While they acknowledge ‘extreme’ cases, such as concentration camp detention and Nazi persecution, where such symptoms might persist, they frame such instances as extremely rare (Bodechtel et al., 1964: 6). The well-known ‘Kretschmer Gutachten’, an expert opinion solicited in the context of a 1955 court case and subsequently distributed by the compensation

administration among its branch doctors, warns against awarding pensions to ‘pension neurotics’ because this ‘financial windfall would destroy their will to health’ (Bodechtel et al., 1964: 7). The ‘Ammermüller-Wilden’, a standard 1950s reference work for psychiatrists and administrators working on compensation cases, illustrates the ‘lawlike manner’ (Wynter, 2003: 268) with which seemingly any set of symptoms could be traced back to a claimant’s constitution. In case after case, claimants are judged to have carried the source of their demise within themselves. We learn of a Jewish WWI veteran, addicted to opioids following a combat injury, who makes a claim following three years of concentration camp detention and subsequent chronic exhaustion, nerve damage, and coronary disorder. His claim is rejected on the grounds of his ‘mental abnormality’ and pre-existing ‘openness’ to substance abuse (Ammermüller and Wilden, 1953: 263-4). We also encounter a forcibly sterilized Romany man who suffers from generalized amnesia, abdominal pains, and heart disease since his procedure. The experts find that ‘these kinds of psychological reactions are frequently observed in mentally unstable persons’, and reject his claim (1953: 275). The claim of a Jewish man who developed diabetes after years of harassment and abuse is rejected with reference to the ‘known disposition among Jews’ for diabetes (1953: 229-31).

The notion of constitution thus held enormous power. It called forth a body whose organic fate was pre-inscribed by nature: whether it thrived or succumbed to sickness was not a function of the abuse and distress it underwent in its lifetime, but of a destiny encoded in its materiality. According to Wilhelm Jacob, a doctor speaking at a conference organized by reforming medical practitioners in 1969, the concept of ‘Anlage’, while notoriously imprecise, was commonly understood to signify ‘*Erbanlage*’, or *hereditary* constitution (Jacob, 1969: 29; my emphasis)¹⁰. Its use by rejecting doctors, Jacob notes, is remarkable for the ‘magical appeal’ and

¹⁰ See also Eissler’s discussion of ‘Anlage’, which he links explicitly with the racial persecution of Jews: ‘Survivors who are currently being examined had, in the final instance, been condemned to torture and suffering on account of their “constitution”. The selective trait was supposedly a racial one, which is associated with constitution, something one is born with, in our thinking. One might think that society would protect persons who have been made to suffer for their “constitution” in this way. How can those seeking compensation [*Wiedergutmachung*] now fail to experience it as anything but an insult when their current suffering is cast as constitutionally grounded?’ (1963: 289).

‘pseudoscientific function’ they attribute to it. Despite its vagueness, it is wielded by these doctors with great confidence and authority in order to ensnare within the net of law-like, biological certainty any failure to absorb distressing events with stoicism.

What were the effects of this practice, and how did it function as psychiatric statecraft? The most immediate impact of denying a pension was financial: many claimants were poor, as ‘the health damages pension was the restitution for those of humble means, who could not make a claim for the loss of material assets but only for the loss of their health’ (Pross, 1988: 133). Compensation legislation did not entitle survivors to restitution payments on the basis of their persecution alone, but merely compensated either stolen assets or a reduced earning capacity. In addition, many claimants were unable to work or were irregularly employed, and thus required a pension to meet mere subsistence needs. Often their symptoms were so debilitating that they could only work in controlled environments like their home or in the presence of a family member. Many were susceptible to panic attacks, insomnia, an inability to concentrate, and a fear of crowds and loud noises, meaning they couldn’t withstand the demands of most forms of wage labour. In some cases, Holocaust survivors were employed as unskilled laborers in empathetic environments – American Jewish hospitals, for example – which accommodated their disability and frequent periods of absence (see, for instance, Niederland, 1980: 16; 68; 117).

But the harm of a denied pension only constituted the end point in a year-long painful application process. Emigrated Holocaust survivors were understandably reluctant to re-engage with the nation that had murdered their relatives, and were weary of once again submitting to the procedures and judgement of the German medico-scientific apparatus. Many feared the diagnostic encounter with German doctors whose opinions and actions during the Nazi era they could only guess, and who wielded so much power over the outcome of their application (Paul, 1967b: 127). Diagnostic encounters were often hostile, and frequently resulted in breakdowns and walk-outs on the part of the applicants (Jacob, 1967: 68). The written reports of rejecting doctors not only lacked kindness and empathy, but often actively downplayed the extent of Nazi persecution (Niederland, 1980: 216-17). Kurt Eissler, a German Jewish émigré

and psychoanalyst, writes at length about the cruelty of the application process, noting that rejecting doctors ‘are not interested in the slightest in understanding the felt experiences of survivors’ (Eissler, 1963: 286). Instead, they interpret every symptom through the lens of constitutional disposition, and are thus entirely caught up in reproducing reality not *as it is* but as *it must be* according to the ‘ruling paradigm’. It is obscene, argues Eissler, to hear the accounts of these survivors (‘the trials of Job were lesser’ [1963: 287]) and continue to insist that their own constitution brought about their interminable suffering. The title of Eissler’s article aptly sums up the absurdity and callousness of German compensation practice: ‘The murder of how many of one’s children must a person bear without symptoms in order to still be considered to have a normal constitution?’ (1963). The answer, of course, is that there was no such number. No event was sufficiently horrifying to qualify as the cause for a person’s lasting distress.

Applications took many years to process (20% of claimants died before a decision had been reached [Pross, 1988: 144]) and were experienced as dehumanizing by survivors. On those grounds, a number of reforming psychiatrists considered the compensation process an extension of the persecution experienced by Jews under the Third Reich. Paul Matussek, a psychologist and neurologist at the Max-Planck-Institute in Munich, noted that Jewish survivors continued to be exposed to constant stressors because they lived in a society which had not accepted its monumental historical guilt. For that reason, former ‘concentration camp inmates are, to a certain extent, still in the camp’ (Matussek, 1961: 542). For Eissler, the treatment of survivors constituted ‘renewed abuse’ (Eissler, 1963: 265; see also Venzlaff, 1967a: 170).

How was this possible in a state that was legally and constitutionally distinct from the Third Reich? For one, there continued to be widespread and overt anti-Semitism among the German public, especially in the years immediately after the war (Herzog, 2017: 98). Jewish Germans were accosted in public and Jewish cemeteries were desecrated (Pross, 1988: 21). According to one poll conducted in 1947, 61% of Germans openly espoused anti-Semitic views (Herzog, 2017: 254). In addition, many Germans were openly hostile to Jewish demands for compensation, both in the

general public and at the highest levels of government. There was a widespread sentiment that Germans had suffered enough, that Jewish survivors were making claims in excess of the injustice they had endured, and that they were taking advantage of Germany's post-war economic resurgence (Pross, 1988: 21; Herzog, 2017: 95). Fritz Schäffer, Germany's first post-war finance minister and the government official overseeing the compensation and restitution process, openly stoked fears that reparation payments would devalue German currency and thus put German economic recovery at risk (Pross, 1988: 98).

Within the Adenauer administration, compensation was handled as though it were a necessary evil – undesired but unavoidable if Germany wished to regain respectability among Western states. On the one hand, this was certainly correct, and simply reflected the facts of West Germany's post-war geostrategic position. The 1952 transition agreement, which set out the conditions under which West Germany's occupied status would be lifted, stipulated that Germany must issue coherent and comprehensive compensation legislation at the federal level to aid the victims of Nazi crimes (Pross, 1988: 53). The US government in particular was a driving force in Germany's negotiations with different Jewish survivors' organizations, and German officials felt that it was expedient to conclude these negotiations to the satisfaction of American interests (Pross, 1988: 59; 66). But on the other, German aversion to compensation was rooted in the vitriolic anti-Semitism of some of its highest-ranking officials. In internal government correspondence, one finds references to the 'massive Jewish influence' in the United States and praise for the 'manly' resistance to Jewish claims shown by German officials in negotiations (Pross, 1988, 60; 71). Most egregiously, Schäffer's main assistant, Ernst Féaux de la Croix, wrote in his 1985 memoir that reparations were often deemed 'the price that American Jewry exacted of its president for allowing him to take the Federal Republic as a partner into the community of Western nations' (Herzog, 2017: 96). Adenauer himself, in a speech given in parliament in 1951, framed compensation as a moral requirement taken on graciously by the German people despite their opposition to Hitler's crimes: 'In its overwhelming majority, the German people despised the crimes perpetrated towards the Jews, and did not participate in them. [...] However, unspeakable crimes have

been committed in the name of the German people, which oblige it to offer moral and material compensation' (quoted in Pross, 1988: 56-57).

In 1965, when reforms to compensation legislation were being debated (including a means for previously denied applicants to resubmit their claims, in acknowledgement of the fact that medical opinion had shifted in recent years), many politicians reacted irritably. Adenauer's successor, Chancellor Erhard, was keen to draw a line under the post-war era and expressed his opposition to such reforms, rejecting 'those efforts that seek to derive eternal guilt [for Germany] from the barbarism of the past' (Pross, 1988: 110). Former finance minister Schäffer also reacted with indignation, asking 'what, at this point, are we still supposed to compensate?' It had been a mistake, he argued, 'that we had not drawn a line right at the beginning [during the negotiations].' Germany had shown weakness, and was now fated to 'keep the other side happy' (quoted in Pross, 1988: 119). A number of German newspapers echoed Schäffer's concerns and worried that Germany was being taken advantage of. An editorial in the *Deutsche Zeitung* scornfully wrote that while German soldiers didn't willingly go to war, 'they now had to pay the enormous taxes for all kinds of compensation requirements that are completely unconnected to German misdeeds' (quoted in Pross, 1988: 119).

Psychiatric statecraft in the immediate post-WWII era thus continued to enact and ground a racial state in which Jewish survivors of the Holocaust were produced as 'subhuman' threats to Man. It inscribed a political order in which (gentile) Germans appeared as pragmatic, disciplined, and economically successful in their recovery and reconstruction efforts, while Jewish survivors seeking compensation were constructed as jealously guarding old injuries in order to capitalize on them, and hence to undermine German thriving. Constitution functioned in this iteration of psychiatric practice to both signify the racially inferior body that was prone to disease and failure, as well as to give expression to an enduring anti-Semitic panic of 'Jewish interests' conspiring against German success. Through recourse to constitution, psychiatry produced the Jewish body as succumbing to stressors that a 'normal' body would be able to sustain. Psychiatric statecraft thus performed the inscriptions, partitions, and divisions of human being required for the production of German sovereignty: on the

one hand, it inscribed hard-working Germans, shouldering responsibility for the crimes of a past regime they considered themselves the victims of. On the other, it crafted ‘world Jewry’, slyly mobilizing its powerful allies to extract endless financial commitments from Germany and thus parasitically siphoning off the fruits of German ingenuity and productivity.

This signifies the enduring power of an epistemic order in which Man must be produced according to social Darwinist, biologicistic criteria as either ‘eugenically selected’ or ‘dysselected’ (Wynter, 2003: 315). The restrictive terms in which Man could be inscribed by psychiatric knowledge on trauma had been set in 1916 and 1926, as detailed in the last chapter, and continued unabated throughout the Nazi era, long into the post-war period. Traumatized Jewish compensation claimants were appraised by psychiatric practitioners in terms of the relative weakness or strength of their constitution, thereby privileging an inborn trait as decisive in creating susceptibility to long-term post-traumatic symptoms.

This produced a state which, while constitutionally and legally distinct from the Third Reich, continued to perform its sovereign exclusions. These exclusions targeted, first and foremost, Jewish survivors, who were identified as constitutionally (i.e., racially) inferior and hence a threat to German Man. But the sovereign exclusions enacted by German psychiatry extended to other victims of the Nazis, such as Sinti and Roma, the disabled, and homosexuals, who remained ineligible for compensation and whose status as racially inferior pariahs under the Nazis was affirmed by psychiatric practice (Herzog, 2007: 64; Könné, 2018; Hockerts, 2013).

Every aspect of psychiatric involvement in the compensation process – the abusive and humiliating psychiatric exam, the unsympathetic and dehumanizing written expert assessments, the year-long languishing in the arcane bureaucracy of the compensation administration system and the frequent negative outcome leading to a withholding of welfare payments – must thus be understood as enacting a martial politics of post-genocidal debilitation. The previous two chapters laid out how a martial politics of psychiatric statecraft governed worker-patients through a host of

measures aimed at causing the attrition of their long-term health and vitality, including through forms of treatment-torture and the denial of welfare entitlements. Yet this present iteration of martial politics, while wielding the same instrument – welfare withdrawal – differs in its modality and application.

Most importantly, the targets of this politics were not only the victims of trauma but survivors of genocide, and hence a group so ruined by the persecution visited upon them that one reforming psychiatrist characterized them as ‘walking corpses’ (Niederland, 1981: 421). He used this language to describe how survivors often appeared as husks of their former selves, perpetually anxious, isolated, relentlessly cycling through reels of memory of abuse, and subject to returning bouts of overwhelming terror. To withhold welfare from this population, and to subject it to degrading and drawn-out examinations and pensions applications processes, functioned quite simply to extend previously inflicted suffering by other means, and to extinguish any hope of future improvement. In a sense, as Matussek had noted, by barring recovery from psychic devastation, and by once again administering hostile German authority over them, psychiatric practice returned survivors to the camp (1961: 542). While this ‘return’ to the camps did not entail the physical detention of survivors, it renewed and made chronic the degradation, humiliation, and abandonment first called forth by Nazi persecution.

How might one appraise the biopolitical modality with which German state and psychiatric authorities governed Jewish survivors? To recall the discussion in the Introduction and Theory and Methodology Chapter (1 and 2), Foucault’s foundational mapping of biopolitics has been productively extended and amended by a number of scholars (Agamben, 1998; Mbembe, 2003; Puar, 2017). Of these, I have found the work of Achille Mbembe and Jasbir Puar especially generative in parsing the biopolitical logic at work in German psychiatric power-knowledge. Both foreground the insufficiency of the original Foucaultian topography of let live/die, make live/die in getting to grips with the specific formations of sovereignty in a colonial space. For Mbembe, sovereignty in the colony is expressed not only through the modality of biopolitics, or the power to ‘make life live’, but through the

‘subjugation of life to the power of death’ (2003: 39). This ‘necropolitics’ finds expression in a series of different instruments, which jointly function to convert previously functional social and political communities into ‘death-worlds’, or spaces in which social and spatial relations have been severely disrupted (2003: 40). For Puar, sovereign right in the colony is characterized by its propensity to maim and subsequently suspend populations between life and death. By withholding death and ‘refusing to let die’ populations under colonial occupation, colonizers seek to arrogate for themselves international legitimacy through claims to uphold international humanitarian law, while aggressively degrading the bodily integrity and physical infrastructure of its targets (2017: 129; 139-40).

I maintain that German post-WWII compensation bureaucracy and psychiatric knowledge, by ‘returning’ Holocaust survivors to the camps, enacted a related form of biopower, namely a martial politics of post-genocidal debilitation. Its characteristics are as follows: first, it translated the genocidal and colonial methods of extermination used by the Nazis (Pergher et al., 2013) into an entirely legal procedure for the dehumanization of a population still deemed ‘racially’ inferior after the defeat and dissolution of the Third Reich. Second, it no longer sought the death of Jewish persons but subjected them to a necropolitical ‘formation of terror’ (Mbembe, 2003: 23) which extended the ‘social death’ suffered by Jews in the camps – their loss of home, loss of bodily integrity, and loss of political rights – into the post-war period by obstructing their recovery and withholding essential treatment and welfare (Mbembe, 2003: 23; 20-21). By maintaining active the psychic experience of the ‘death-worlds’ in the camps, German psychiatrists quite literally ‘confer[red] on them [the survivors] the status of *living dead*’ (Mbembe, 2003: 40, original emphasis; note the congruence of terminology used by Mbembe and Nederland). Third, the withholding of treatment and essential welfare payments also functioned to debilitate survivors, denying any return or rapprochement to psychic normality and maintaining survivors in perpetual psychic states of near- or actual terror (Puar, 2017). By extending these states into chronic forms of being, this form of psychiatric power unfolds in the temporality of the endemic, described by Lauren Berlant as ‘slow death’ (2007). Sovereign right administered as ‘slow death’ neither makes live nor die, but extends

life 'laterally', which in the case of Holocaust survivors means subjecting it to chronic ill health and disability through the withdrawal of necessary care, protections, and welfare payments (2007: 28). Fourth, this martial politics of post-genocidal debilitation was not only the *expression* of an enduringly racist and anti-Semitic formation of power-knowledge, but an *instrument* wielded by the German government to regain international credibility. As noted above, this politics operated in a geopolitical context in which Germany had to appear to atone for its crimes and to abjure from the racial politics of its predecessor state. By passing compensation legislation under which even formerly unpropertied victims were eligible, yet withholding payments on the grounds of a constitution-based (and hence racist and eugenic) psychiatric paradigm, the West-German state was able to secure international recognition and (re)-integration within a Western, liberal order while continuing to violently degrade a population many of its citizens still viewed as 'subhuman'.

5.3 Challenging the 'Ruling Paradigm': New Approaches to Trauma in Post-War West German Psychiatry

The authority of the so-called 'ruling paradigm' remained nearly unchallenged in Germany for more than a decade after the liberation of the camps. Immediately following the war, German scientists directed their attention not towards Jewish Holocaust survivors, but towards the psychological ailments of returning soldiers, prisoners of war, and from 1949 onwards, of so-called *Spätheimkehrer*, or soldiers who had been imprisoned in Russian POW camps (Goltermann, 2009: 199-216; Pross, 1988: 149). But outside Germany, particularly in countries which had been occupied and were treating (returning) survivors on their own soil, medical and psychiatric practitioners observed a number of conditions which appeared to be specific to former camp detainees. In the immediate post-war period, these were the ailments of bodies ravaged by years of malnutrition, untreated infectious diseases, physical abuse, and other conditions resulting from camp detention (von Baeyer, 1969: 177). However, even after survivors were released from hospital, they continued to suffer from amnesia, depressive and anxious states, as well as chronic headaches and dizzy

spells. These conditions were so consistent across groups of survivors that doctors coined a number of syndromes to give them coherence, including ‘asthenia of the deported’, ‘concentration camp syndrome’, premature aging, and ‘neurosis of the repatriated’ (ibid.).

While German reformist psychiatrists later praised this research as the ‘preliminary labour for a psychopathology of persecution-based harm’ (von Baeyer et al., 1964: 99), it initially found little resonance in German psychiatric circles (Pross, 1988: 151). Throughout most of the 1950s, German psychiatric research on trauma had remained focused on the after-effects of POW detention of (gentile) Germans, and its expertise in compensation cases, as explored in the previous section, remained locked into the gospel of a constitution-based aetiology of post-traumatic symptoms. A small crack in this façade of psy-scientific consensus appeared in 1952, when a court adjudicating a Holocaust survivors’ pension claim sided with the expert opinion of a junior psychiatrist, Ulrich Venzlaff, who had diagnosed a persecution-based neurosis, over the expert opinion of Ernst Kretschmer, a leading psychiatrist who had diagnosed a pension neurosis. While this ruling caused ripples across the German psychiatric community and compensation bureaucracy, it hardly presented a sea change in the treatment of Holocaust survivors. Quite the opposite: despite the court ruling in line with Venzlaff’s statement, the compensation administration distributed Kretschmer’s text among its branches, turning it into one of the most widely cited touchstones in post-war German compensation commentary (see above; Pross, 1988: 156).

The first publications by German psychiatrists seeking to reform the ruling paradigm were published in 1958 and 1959. Wilhelm Ritter von Baeyer in Heidelberg, Kurt Kolle in Munich, and Ulrich Venzlaff in Göttingen, as well as German Jewish émigré doctors in the United States including Hans Strauss, William Niederland, and Kurt Eissler began chipping away at the dominance and unquestioned status of German compensation practice through publications, conferences, as well as their own practice as experts in compensation cases. The shared thrust of these new approaches was twofold: to reject the law-like character of ‘Anlage’, or constitution, in producing post-traumatic symptoms, and to highlight the reactive nature of camp survivors’

conditions. The names they gave these new conditions reflect this: reactive personality change (Venzlaff), experience-based personality damage (von Baeyer), break in the continuity of life (Kolle), reactive depression from uprootedness (Strauss), and Holocaust syndrome (Niederland). Many of them foregrounded the view that Nazi persecution of Jews had been unique in the totality of terror and abandonment to which it had exposed its victims (and which continued to envelop survivors), and noted that these survivors were wholly altered by the trials they had undergone.

The reforming psychiatrists used a number of tactics and mechanisms to overturn the ruling paradigm. First among these was to reject the biologism of the old approach. This approach, complained Niederland, saw the survivor not as a holistic person constituted by both bodily and mental processes, but as simply a ‘sum of organs and organ systems.’ What is more, he argued, if Holocaust survivors really suffered from a weak constitution, they never would have survived the concentrations camps, which ruthlessly eliminated the weak (Niederland, 1980: 7; 60-61).

Second of all, reforming psychiatrists dismissed the notion that the ability of the human psyche to recover from stress is limitless. Instead, they argued that certain experiences were so extreme and destructive that they literally broke humans: they sundered their connection with the world and ‘twisted’ their personality (Venzlaff, 1958: 73), ‘smashed’ their sense of existential security (von Baeyer, 1961: 536), and ‘murdered’ their soul (Niederland, 1980: 234). In making these observations, practitioners noted the exceptional and unique character of Nazi persecution of the Jews. Eissler argued that, as opposed to political and religious prisoners who could in some cases draw inner strength from being persecuted for their convictions, this had been denied to Jews because their persecution was race-based (1963: 265). The dehumanizing force of hunger and the collapse of a rule-based, ethical order, along with the divide-and-rule-based *Kapo* system of detainee surveillance, meant that any semblance of community support was impossible – everyone was ‘desperately and ferociously alone’ (Niederland, 1964: 463). Most perniciously, however, Jews observed what was happening to their peers and family members, and thus lived in constant anticipation of death. In the camps, they occupied the lowest rung in the

hierarchy of detainees, and were subjected to the cruellest and most brutal treatment (Kolle, 1958: 152). It was thus the totality and inescapability of terror in the camps, as well as the complete abandonment to destruction that characterized Jewish experience and set them apart from others. Paul Matussek, in a study of hundreds of concentration camp survivors, found that not a single one of them had emerged from camp detention without lasting psychological damage (Matussek, 1961: 539).

After liberation, Jews were once again set apart from other detainees because they were unable to return to families, friends, and communities. Many were the sole survivors of extensive families, and Jewish communities had been eviscerated across the European continent. Psychiatrists emphasized that recovery often depended on the ability of a survivor to return to a nurturing environment, where their suffering was taken seriously and their survival was celebrated (Venzlaff, 1967b: 100; Trautmann, 1961: 550; Eitinger, 1964). In contrast to soldiers and POWs, for instance, Holocaust survivors ‘were not sheltered, upon their return, by a protective community or caring institutions’ (Cremerius, 1960b: 37). For many Holocaust survivors, alone in a foreign country or subjected to continued anti-Semitism in Germany, this was impossible.

Thirdly, reforming psychiatrists rejected the claim, frequently made in the expert assessments of rejecting psychiatrists, that those who had been detained for a comparatively brief period of time, had emigrated, or had been in hiding, did not sustain lasting psychological damage. For example, Nederland writes about the case of a German Jewish man whose claim was rejected because his four-week-long detention in Dachau concentration camp was deemed too short to produce a lasting persecution-based neurosis (Nederland, 1980: 199). This decision, Nederland argues, failed to take into account both the incisive effects of persecution prior to the man’s detention, as well as the catastrophic impact of *any* period of time spent in a camp. Nederland describes how this man, who had run a successful dental surgery until 1933, was ‘ostracized, shunned, and expelled’ practically overnight as he lost his professional standing and respected status in the community, his friends and family emigrated, and was incessantly harassed whenever he set foot outside. During the

pogroms in November 1938, the Gestapo stormed his flat, beat him, destroyed his possessions, and interned him at Dachau. 'Upon his return', writes his widow, 'he appeared completely changed, hardly spoke, and was constantly afraid' (Niederland, 1980: 206; see also von Baeyer, 1961: 537).

In order to understand what happened to this man, writes Niederland, it is not enough to consider only the duration of his detention. One had to recognize how, immediately after coming to power, the Nazis subjected all Jews to complete social ostracism, economic ruin, and personal humiliation. Venzlaff called this form of persecution 'Ächtung', a German word that has no precise translation but designates both an expulsion from the community and the denial of human worth. 'Ächtung', argues Venzlaff, is something all Jews under Nazi rule experienced, and constitutes 'a carefully coordinated and detailed campaign of degradation' including the undermining of material existence, the expulsion from public life, the shattering of social status, the stripping away of legal rights and protection, incessant baiting with anti-Semitic propaganda, and the threat of mob violence, arbitrary arrests, raids, and interrogation. These factors combined to rupture an individual's self-worth and to fatally undermine their sense of security (Venzlaff, 1967a: 160). All in all, even before the onset of mass deportations, Jewish life in Germany had to be considered unliveable, and its effects deeply damaging.

The same was true for survivors who had been able to emigrate or survived in hiding. Older émigrés especially, who had been established in their careers, had accrued status, and had been well-respected and admired members of their community before 1933, found it very difficult to adjust to a new life abroad. They had been uprooted and completely severed from their former lives, a condition one does not overcome so easily. But additionally, as Jews, they were never just émigrés but usually survivors, embarking on a new life in the knowledge of the death they had escaped and the dead they left behind (von Baeyer, 1969: 181; von Baeyer et al., 1964: 105). Reforming psychiatrists grappling with these conditions coined terms to describe the particularity of a trauma that breaks up the continuity of life, shatters it, and denies any means to reassemble the pieces: Hans Strauss named these conditions 'depression from

uprootedness' (*Entwurzelungsdepression*), and Kurt Kolle spoke of a 'break in the continuity of life' (*vollständiger Bruch der Lebenslinie*) (Kolle, 1958: 158; Strauss, 1960; Strauss, 1957). Regarding those who had survived in hiding, the accounts of numerous survivors who had spent months, in some cases years, wedged behind a piece of furniture, encased in a manure-filled trough, or sheltering in a ditch in the woods made clear that the harm they suffered was comparable to camp detainees (Niederland, 1980: 23-48; 65-75; 156-167; Cremerius, 1960a). They, too, lived in constant fear and expectation of death, as patrols were never far and those in hiding could expect to either be shot on sight or be immediately deported. Their lives were in the hands of others, who at any moment could decide the risk they were taking was too great and deny them continued shelter. Restlessness, malnutrition, lack of outlets for interpersonal conflict and a complete absence of privacy combined to produce anxious, apathetic conditions in survivors in later years (Venzlaff, 1967a: 163-4; Herberg, 1967b: 338-9).

Lastly, reforming psychiatrists repudiated the notion that Holocaust survivors suffered from 'pensions neuroses', or the idea that not their experiences of persecution but the promise of a payout was fuelling their continued suffering. They argued that this type of thinking was outdated and showed that rejecting psychiatrists had not been keeping up with the latest research. By the late 1950s, there was an established branch of psychiatric and medical research into the long-term psychological and psychosomatic effects of camp detention, which, the reforming psychiatrists argued, German rejecting psychiatrists were simply not abreast of (Niederland, 1980: 62). Further, they noted that the long-term psychological effects of Nazi persecution of the Jews were unique and unprecedented, and it was wrong to read their symptoms entirely through the lens of a paradigm that predated the Holocaust (Cremerius, 1960b: 35). Put simply, according to these psychiatrists, the Holocaust was an unprecedented event, and thus called for an unprecedented diagnostic and treatment approach¹¹.

¹¹ Note also the following statements from reforming psychiatrists: Venzlaff explained that it had become necessary to revise the ruling paradigm because 'our century has witnessed humans falling prey to the excesses of war imprisonment and racial and political persecution to an extent that had thus far seemed unthinkable in the civilized world' (1967b; see also Venzlaff, 1958: 85). In a similar vein, Niederland argued

Despite attacking the ruling paradigm on so many fronts, however, reforming psychiatrists had no intention of overturning it completely. Quite the opposite: most reforming psychiatrists agreed with the basic premise of the pensions neurosis diagnosis, namely that the expectation of a pension or an insurance payout could be a powerful generator of symptoms. 'I am not opposed in principle to the ruling paradigm', Kolle clarified to his readers. Not only had he examined thousands of compensation cases according to the guidelines set out by Bonhoeffer and Kretschmer, he explained, but he was 'also opposed to resorting to nebulous psychologism when we are plainly dealing with a wish-based reaction' (Kolle, 1958: 156). Like Kolle, many reforming psychiatrists agreed that the ruling paradigm had been correct in its appraisal of 'accident neurotics' and 'war hysterics' as opportunists who continued to cling to symptoms years after their exposure to stress had ended. These people, reforming psychiatrists concurred, were driven by the hope for material gain, not the aftereffects of trauma (Venzlaff, 1958: 25; March, 1955: 180; von Baeyer et al., 1964: 24). Further, reforming psychiatrists agreed that pensions neurotics constituted a threat that needed to be countered if one wished to avoid opening the 'floodgates' of illegal pension and compensation claims (von Baeyer et al., 1964: 341; Venzlaff, 1959: 289). Liberally using terminology like 'psychopathy', 'will to sickness', and 'troublemakers' to describe pension claimants, numerous reforming psychiatrists avowed that there were gain-seeking pensions neurotics even among Holocaust survivors, and contended that it was one of the tasks of competent assessment practice in examination cases to identify and weed out these claimants (von Baeyer et al., 1964: 119; Kolle, 1958: 151; Paul, 1967a: 78-9).

By aligning themselves with the basic tenets of the ruling paradigm, reforming psychiatrists also re-affirmed and reproduced its exclusions. This concerned, first and foremost, the workers and soldiers whose post-traumatic conditions they dismissed as the wish-based reactions of work-shy and cowardly pensions neurotics. Secondly, this concerned the disabled. Kolle, for instance, endorsed sterilizations if these were

that 'the classical edifice of clinical psychiatry was erected by people who neither knew of such things [race-based persecution and extermination], nor had to know about them' (quoted in Paul, 1967b: 125).

based on 'eugenic' indications, thus consigning multiple forms of disability to inhuman status (1958: 153). It was thus on the basis of this curious compromise that reforming psychiatrists set out to understand the psychological harm inflicted on Holocaust survivors. Many of the guiding assumptions of the ruling paradigm – the wish-based, advantage-seeking nature of many post-traumatic symptoms and its dehumanization of disability – were left intact, as was the principle that if post-traumatic conditions were coupled in any way with financial advantage, they had to be viewed with the greatest suspicion. The enduring symptoms of Holocaust survivors were positioned as the exception to this rule, with the justification that their persecution had been so ruthlessly genocidal and so unprecedented that the existing model of human conduct under stress had to be revised.

How did the reforming psychiatrists construct the human in their revised model of post-traumatic stress? Clearly, this cohort of psychiatrists had moved on from conceptualizing the human as nothing but a natural organism with certain evolutionarily determined, pre-inscribed characteristics. They theorized a human who was harmed by the destruction of his community, indeed a being that required the sociality of friends, family, and familiars in order not to fall apart. They inscribed a human who required a sense of longevity and security, and one who was crushed by the expectancy of approaching death and the totality of terror that engulfed him in the camps. They also theorized a human who was constituted by the dignity and self-worth which are bestowed by a profession, a caring responsibility, or a recognized status within a community. They astutely described how Nazi terror attacked all groundings of a person's sense of self, from the pride they took in a job, to a name, to basic personal hygiene, all of which were denied by persecution and camp detention.

Based on these observations, how did reforming psychiatrists inscribe the being of Man? One might argue that this form of psychiatric statecraft functioned simply by renouncing the importance previously attributed to hereditary attributes, and instead appraised the human only in terms of his need for sociality, security, and dignity. Yet

I would hesitate to argue that Jewish Holocaust survivors were simply inscribed into a post-fascist sovereign 'we' by 'reformed' psychiatric practitioners.

The poet and writer Max Czollek notes that in the early years of the Federal Republic, Jews were assigned a particular role in the anxious production of a collective German identity. This role entailed proving, through their presence, that Germany had atoned for its past: 'For where Jews live, so this thinking went, there can be no National Socialism' (2020: 171). To this day, notes Czollek, Jews in Germany are enlisted in a complex, multi-sited, and ongoing project of certifying German transformation. Their role in this production is different from non-Western migrants, who, through recurrent admonishments to 'integrate', are cleaved from the sovereign 'we'. Jewish communities, by contrast, are neither subsumed into sovereign being nor cast out, but made to function as evidence, collateral, and security, in the enduring re-signification of German statehood. Writes Czollek,

The reference to Germans is important because it signifies the locality from where the yearning for redemption is first made comprehensible. *Who* would like to believe of themselves that they are no longer Nazis? For *whom* is this redemption subsequently the reason why they can fly flags during the football world cup again? In the shared yearning for normality and positive national pride, the German collective practically constitutes itself. (2020: 170; emphasis in the original)

Guided by Czollek's discussion, I suggest that the psychiatric statecraft enacted by reforming psychiatrists functioned in precisely this way: the figure it inscribed in its diagnostic practice did not ground sovereign German order alone. Instead, this figure (requiring sociality, security, and dignity) must be recognized as an auxiliary figure, harnessed to German sovereign Man to vouch for his reformed being, yet not co-extensive with it. Implicitly, this figure always remains a *Jewish* figure, and is once again made to function as an 'other major Other figure' (Wynter, 2003: 307). It only functions in concert with sovereign German being, which, in a post-Holocaust context, relies on the supporting role of Jewish communities to certify its reconstituted, post-fascist self. To illustrate this point, note the following statement

from reforming psychiatrist Hans-Joachim Herberg: ‘Having passed this law counts among the most significant achievements of the Federal Republic. The transformation from exemplary rogue state [*Unrechtsstaat*] to a state upholding the rule of law [*Rechtsstaat*] could not be expressed more plainly by any other law’ (Herberg, 1967a: 17). For Herberg, the enactment of genuine and meaningful compensation is the threshold which Germany must cross in order to be transformed from pariah to legitimate, sovereign subject.

Yet as Czollek notes, the enlistment of Jewish communities in forging the German national collective functions not only to vouch for the veracity of the undergone change, but re-authorizes expressions of national pride. As Martin Hirsch, Chairman of the Committee on Reforms to Compensation Legislation, exclaimed at a parliamentary hearing in 1963: ‘I want to be proud again to call myself German. As long as we have this material debt [to Holocaust survivors] and are not willing to pay, I cannot be proud’ (quoted in Pross, 1988: 118).

Psychiatric statecraft enacted by reforming psychiatrists thus inscribed a new, reformed, and redeemed German nation, authorized and made whole again by Jewish Holocaust survivors receiving ‘proper’ compensation for the harms inflicted by its predecessor state. The sovereign figure thus inscribed was no longer rendered insecure by the biological ‘inferiority’ of its peers and adversaries, but by a failure to atone for the past. This, the architects of this order knew, would cast Germany back into ‘roguishness’. A new type of sovereign state was thus required: not defending against the monstrous inhumanity of a racialized, disabled ‘subhuman’, but to guard against the ‘roguishness’ of failing to acknowledge and atone for past atrocity¹². Thus for reforming psychiatrists, contrition and compensation for crimes of the past, secured by enlisting Jewish participation in the forging of German sovereign being, grounded the means for a rebirth of the German nation, and authorized a resurgence of German nationalism.

¹² To be clear, I intend neither to malign the therapeutic labour of reforming psychiatrists (which I read as rooted in a genuine empathy for their patients) nor to relativize the moral and legal necessity of these compensations. What I wish to foreground instead is the particular role assigned to Jewish survivors in this process, and its imbrication with a resurgence in national pride.

5.4 Conclusion

This chapter has traced the evolution of German psychiatric knowledge in the post-WWII era, tracking the (late) challenge by reforming psychiatrists to a constitution-based and biologicistic paradigm of trauma which had remained hegemonic since the end of WWI. This paradigm had produced traumatized Jewish Holocaust survivors who submitted applications for a health damages pension as biologically deficient, succumbing to the pre-inscribed fate of their inferior constitution by failing to recover from severe stress. Expressing a continued, virulent anti-Semitism, these Holocaust survivors were cast as greedy and intent on thwarting German post-war recovery by draining its newly reclaimed economic wealth. In this martial politics of post-genocidal debilitation, Jews were treated as though they had ‘remained in the concentration camp’ (Matussek, 1961: 547). Thus, for over a decade after the demise of the Third Reich, there endured a racist, eugenic epistemic and political order which inscribed Jews as threats and outsiders to the German nation.

The reign of the ruling paradigm was challenged by a group of reforming psychiatrists from the late 1950s onwards. They rejected the biologism of the dominant approach to trauma, and instead constructed Man as a being constituted through sociality, security, and mutual recognition of dignity and status. However, they upheld many of the tenets of the ruling paradigm, reiterating its exclusion of accident survivors and traumatized soldiers as well as its denigration of disability. The new psychiatric construction of Man thus did not hail the advent of a post-sovereign order, or a political community that dispenses with the continuous construction of fear-inducing others to shore up the sovereignty and legitimacy of a singular sovereign subject. These ‘inhuman’ others remained, primarily in the shape of those unwilling to work and/or die for the state as wage labourers or soldiers.

Instead, in this revised, post-fascist iteration of psychiatric statecraft, the act of compensating the victims of the Holocaust took on singular importance. Only through this act of contrition could Germany undergo a transformation from ‘rogue’ state to ‘rule-of-law-based’ state. Jewish survivors were enlisted by reforming

psychiatrists to authorize, and to certify as genuine, this transformation. By thus domesticating and rendering manageable a monstrous past, Germans were invited to once again express pride in their resurgent nation.

VI. CONCLUSION

'We can only suspect that the conditions that once before gave birth to the Holocaust have not been radically transformed. If there was something in our social order which made the Holocaust possible in 1941, we cannot be sure that it has been eliminated since then.'

- Z. Bauman, 1989: 87

'Home is where you all are.'

- S. Dede Ayivi, 2019: 194

6.1 'Perpetual Mourning'

This thesis opened with a text by Robert Gaupp, in which he warned fellow psychiatrists of the risks to German national security posed by the 'pathological disposition' of hysterics (1915: 361). I will end (or rather, open the ending) by reflecting on the words of another practitioner of psychiatric statecraft, albeit someone vehemently opposed to Gaupp's position. Consider this passage from Kurt Eissler's (1963) article, which I discussed in the previous chapter. Eissler, of course, was one of the dissenting, émigré German-Jewish psychiatrists seeking to topple the diagnostic orthodoxy of the hysteria paradigm. Contemplating the plight of a Holocaust survivor whom he had examined in the context of a dispute over a health damages pension, Eissler writes:

His wife tells me that they sometimes start to speak of their children, but quickly break off. They have come to an agreement with one another to no longer mention the past. The burden of the past weighs on both of them, and this past is unacceptable. People in this situation are now confronted with two options, either they act out the affect or they repress it. If B. and his wife lived their lives as dictated by their affects (*affektadäquat*), they would fall into perpetual mourning; if B. repressed the affect and shifted his worries onto something insignificant, then he would be able to continue living his life, although it would be somewhat paralyzed. (1963: 272)

Eissler's account offers a window onto psychiatric knowledge in what is probably one of its least harmful incarnations. Eissler and other reformist psychiatrists sought to reduce harm and strove to aid survivors in securing access to pensions. Many of them proceeded with empathy and from a posture of kindness towards patients. Yet I have argued throughout this thesis that psychiatric knowledge is highly effective and productive in ways that have little to do with its success as a medical practice. In this final chapter, I review and reflect on the effective and productive labour performed by psychiatric knowledge across 100 years of psychiatric statecraft, beginning shortly after the formation of the German Reich in 1871 and extending into the era when Eissler was writing in the 1960s. I begin by reviewing findings of this thesis and discuss its contributions. I then offer two extensions of its analytic work, one geographic and one temporal. In the geographic extension, I provide a brief overview of psychiatric statecraft outside of Germany in other European and North American contexts. In the temporal extension, I review recent formations of psychiatric statecraft in Germany in the context of the adjudication of asylum claims.

6.2 One Hundred Years of Psychiatric Statecraft - A Short Review of Findings

I will briefly recall the findings of this thesis by grouping them under three headings: Man, order, and statecraft.

6.2.1 Man

Across three empirical chapters, I found that psychiatrists produced patients as different versions of Man and his human Others by elaborating diagnostic paradigms and treatment approaches to explain and ameliorate different symptoms of post-traumatic injury. Broadly, these figurations fell into two groups: they were either grounded in an events-based aetiology, meaning that patients were understood to suffer the psychological effects of violence or severe misfortune which had befallen them, or they were based in a wish- and constitution-based explanatory model. This

latter approach held that not the traumatic event per se, but the patient's interior psychic processes – a desire for material advancement, leisure, or physical integrity – which themselves were regulated by a pre-inscribed resilience, will power, or bodily disposition, called forth the symptoms in question.

The versions of Man and his human Others based in the former, events-based model included the 'legitimate claimant' (in the 1880s, discussed in chapter 3) and the 'war neurotic' (1910s, chapter 4). Grounded in the traumatic neurosis diagnosis, these figures of Man conceived of him as a figure woven through and constituted by an intricate architecture of nervous networks which was susceptible to disruption from mechanical and physical shock. Man, configured in this way, was understood as vulnerable to the monstrous machinery unleashed by industrial modernity, whether it was the machinery assembled on the factory floor or the 'storms of steel' raining down on the First World War soldier. The 'Holocaust survivor', produced by the diagnostic paradigm of various reactive syndromes in the late 1950s and 60s (chapter 5), was similarly vulnerable to the forces of modernity, in this case the genocidal violence of the Nazi state. These reactive syndromes, while also events-based like their diagnostic predecessor of traumatic neurosis, conceived of the injury of trauma to proceed not via the disruption of nervous networks, but as the result of the destruction of life worlds, kinship networks, and personal dignity. For each of these figures, therefore, it was the wider socio-political and economic forces in which they found themselves – the transformations wrought by industrial modernity, such as the machinery of production, warfare, and mass death – that constituted their 'essential limitation' (Ashley, 1989: 266). It was against these instances that a sovereign, German state serving these version of Man would have to erect defences.

These three figures had in common an emergence from a diagnostic paradigm which formulated an iron-clad association between traumatic incident and post-traumatic symptom, and they each offered different explanatory models for the genesis of symptoms, from the erasure of movement images in the brain produced by shock (traumatic neurosis, chapters 3 and 4), to a wish-based origin (as seen in early theorizations of traumatic neurosis, chapter 3). Decisive for these figures and

paradigms was that the resulting claims of patients, whether it was for an insurance payout, a removal from the trenches, or a health-damages pension, were understood as legitimate, and doctors understood their role as assisting patients in order to alleviate suffering and to help them speedily receive financial or other forms of assistance.

Sovereign subjectivity grounded in the competing, wish- or constitution-based aetiology of traumatic injury was characterized by strength of will rooted in a robust bodily disposition. According to this paradigm, psychic integrity was prone to collapse not from external stressors, but from inbuilt, given, constitutionally determined weaknesses. Everyone, psychiatrists following this paradigm argued, was prone to stressors, and in some cases these were extreme: the compulsion to work and the duty to defend the fatherland, according to these psychiatrists, were simply facts of life which humans were differently able to bear. Danger arose not from these facts of life per se – psychiatrists assumed that these were either necessary or unchangeable – but from a person's inability to master them. If a person was so feebly constituted as to falter in the face of the demands their nation imposed on them, they argued, they became a burden on this community – siphoning off financial, military, and moral resources for their personal care which were more urgently required by the collective of 'deserving' Germans.

Across the three empirical chapters, I traced how psychiatry produced a series of human Others to a sovereign subjectivity grounded in strong will and constitution: these included the 'conman' and the 'troublemaker' in the 1880s and 90s (both discussed in chapter 3), the 'war hysteric', 'revolutionary psychopath', and 'mentally deceased inhuman' during the First World War and the subsequent revolutionary, civil war period (chapter 4), and finally, 'the Jew' in the post-World War II period (chapter 5). Psychiatric knowledge characterized each of these figures as motivated by selfish desires and a callous abdication of responsibility – their lack of will power meant that whenever they found themselves in a challenging situation, be it a frightening incident on the production line, a brush with death on the battle field, or deprivation in a concentration camp, instead of summoning their inner strength and

pushing through, they succumbed to a ‘will to sickness’ and produced whichever symptoms were necessary to reap the ‘benefits’ (i.e., pension or compensation payments) of their condition. Crucially, for all these figures, psychiatric knowledge located a brittle ‘will to health’ in a body inscribed with pre-given characteristics and vulnerabilities. As a result, in this formation of psychiatric knowledge, sovereign subjectivity was characterized as ‘healthy, able-bodied (*lebenstüchtig*), mentally and physically resilient’ subjectivity (Binswanger, 1922: 45), and thus ultimately an attribute of the physical body.

6.2.2 Order

Different political orders emerged based on the attributes of these figures of Man and his human Others. How did this happen? As I explained above, each of these figures achieves clarity and coherence through an ‘essential limitation’, or ‘specific limitation on his knowing and doing’ emerging from his epistemic condition (Ashley, 1989: 266). For the first set of figures, this was industrial modernity, while the second set of figures was most vulnerable to their own, evolutionarily inscribed psychic weakness. As Ashley argues, the sovereign state emerges to respond and protect against the threats arising from each contingently discovered and known ‘essential limitation’.

The first of these was the welfare state, premised on Man’s vulnerability to injury from the abuses of industrial, mechanized, and genocidal modernity. In this order, responding to the ‘essential limitations’ of Man meant that those injured while performing necessary duties for the maintenance and security of the state – as worker or as soldier – were caught in a social safety net which would allow them to survive, even if their ability to work was curtailed. This order recognized that modernity harboured unprecedented destructive forces which Man could not be expected to master through his strength alone, and it sought to provide the means by which he would be sheltered from its most extreme excesses. I traced the production of this order in chapters 3 and 4, where the provision of accident insurance, welfare legislation, and rest cures for soldiers diagnosed with traumatic neurosis served both

to meet the most urgent needs of accident survivors and traumatized soldiers, as well as, in the case of Bismarck's social welfare legislation, blunt the appeal of the Socialist Party to workers living in destitute circumstances.

The second order based on the psychiatric production of Man was the Darwinian state premised on notions of bodily disposition, constitutional health or 'inferiority', and 'racial' fitness. Analysed in chapters 4 and 5, this order reflected a politics which located political subjectivity in a healthy body and enacted a defence of society against all those it recognized as deficient. The highest imperative in this order was to shield Man from the effects of his Others' inferiority: their dishonesty and aversion to work, their malingering and insufficient patriotic fighting spirit, their unpatriotic revolutionary fervour, and their 'racial' inferiority, which they mobilized to conspire against German interests and to stake a claim to its new-found, post-war prosperity. This order engaged in a martial politics of diagnostic and treatment warfare against its subjects, at times conceptualizing the clinical encounter as a form of battle in order to train the 'weak will' of patients, deny them a 'flight into illness', withdraw their means of subsistence, and thus to coerce them into economically productive subjectivity.

The third order was the post-fascist, post-Holocaust state. This order, as I argue at the close of chapter 5, was grounded in the complex interplay of not one, but two sovereign figures. On the one hand, there was 'the Holocaust survivor', or the figure crafted by reformist psychiatric knowledge: grounded in an events-based paradigm, it was produced as vulnerable to injury from the unspeakable violence of the camps. Yet this figure did not ground sovereign German order alone. Instead, it served as an auxiliary figure, harnessed to (gentile) German Man in order to vouch for the latter's reformed being. This auxiliary figure was held close to, but was never allowed to join with, (gentile) German sovereign subjectivity because it was required as a point of reference. Through its presence and well-being, it functioned to certify that Germany had, in fact, been transformed from a rogue-state (*Unrechtsstaat*) to a rule-of-law-based state (*Rechtsstaat*). 'The Holocaust survivor' was thereby once again crafted as an 'other major Other figure' (Wynter, 2003: 307), and ultimately was made to remain 'the Jew'. This process inscribes a new, reformed, and redeemed German nation, with the

wounds inflicted on itself by its genocidal past healed by demonstrating that Holocaust survivors received dignified treatment and meaningful compensation. The ‘essential limitation’ of this (second) figure lies in failing to atone for the past, thereby calling on the sovereign state to defend against the risk of falling back into ‘roguishness’ by neglecting the burdens placed on it by history.

6.2.3 Statecraft

Finally, I observed and tracked the shifting ways in which psychiatric practice, embedded in networks of power-knowledge-Man, constitutes statecraft. In the theory chapter, I discussed how Ashley’s and Wynter’s theorizations of order both complemented, but at times appeared to contradict each other. Specifically, while Ashley argued that statecraft is a process which is subject to relentless contestation and competing inscriptions of sovereign Man, Wynter argues that epistemic orders are, in fact, so constrained that the characteristics of Man and his Others are severely circumscribed. In the modern order, she argues, Man must be produced as a natural organism selected by evolution, and his other as such an organism that was ‘dysselected’ by evolution. While for Ashley, the production of order is open to a play of determinations, Wynter cautions that the grounding of order in paradigms of Man is rigid, and allows for little variation (Wynter, 2003; Ashley, 1989). This thesis’ survey of 100 years of psychiatric statecraft has shown that these two approaches complement each other.

There were numerous instances of contestation over the true meaning of sovereign Man. During the simulation dispute in 1889/90 (chapter 3), psychiatrists debated whether traumatized industrial workers were victims of the sweeping changes restructuring forms of labour, or whether they were con artists abusing the beneficence of the German state and its psychiatrists to extract a pension which would allow them a life of leisure. At the 1916 War Congress (chapter 4), proponents of traumatic neurosis and hysteria, or an events-based and a wish- and constitution-based aetiology of post-traumatic injury, clashed over their competing interpretations

of sovereign subjectivity. While one side held that modern, mechanized warfare understandably shattered the psychic equilibrium of soldiers, the other insisted that a constitutionally healthy subject would be able to mobilize his will to discipline his fears. Again, in the late 1950s (chapter 5), reformist psychiatrists challenged post-war West-German psychiatric dogma and debated whether the claims of Holocaust survivors were based in a desire for a pension, were a form of abnormal hysterical reaction, and ultimately functioned as a way to destabilize the post-war order, or whether these survivors were more usefully understood as ‘walking corpses’ (Niederland, 1981: 421), so ravaged by the horrors visited upon their families and communities that they could never hope to return to life as normal. In all of these diagnostic disputes, we can observe statecraft as the unresolved struggle over the interpretation of figures of sovereign Man. As Ashley writes, Man ultimately constitutes a “form” ... that leaves open the question of “content” (1989: 266), and psychiatrists clashed repeatedly to inscribe their interpretation of his being as the only true version.

However, remarkably, for several decades, the wish- and constitution-based paradigm of post-traumatic injury was practically hegemonic. From the 1916 Medical Congress onwards, enshrined into law in the 1926 decision by the Imperial Insurance Office to remove traumatic neurosis from the list of actionable conditions, brought to its murderous conclusion by the racist and eugenic policies of mass death by the Nazi state, and still enacted by post-war German psychiatrists recognizing in Jewish compensation claimants only ‘psychopaths’ and ‘hysterics’, the aetiology of post-traumatic symptoms was located squarely in the fitness of a subject conceptualized purely as a natural organism. The compulsion of this formation of power-knowledge-Man was so strong that every form of political deviance was recognized as a bodily, ‘racial’, or evolutionary characteristic: war hysterics and post-WWI revolutionaries were described as ‘physically feeble [and] ... weakened persons’ who were ‘intellectually inferior’ (Bonhoeffer, 1922: 45; 65), or even as ‘criminals, degenerates’ (Gaupp, 1918: 12). This culminated in the full-fledged racist and eugenic Nazi state, but remarkably, persisted, nearly unchallenged, for more than a decade into the post-war order. With a paradigm of Man as natural organism with evolutionarily selected

criteria, German political order continued to function as a race-based and racist order, working across medical and administrative sites to defend post-war German recovery against a ‘world Jewry’ intent on its destruction. As Wynter argues, in the modern episteme, differences between humans are inscribed at the level of bodily ontology and ‘enforced at the level of social reality by the lawlikely instituted relation of socioeconomic dominance/subordination between them’ (2003: 310). With Man known to be made, by nature, as equipped with certain abilities and weaknesses, socio-political orders which perpetuate the marginalization of those known as ‘weak’ appear just, rational, and necessary.

6.3 Talking About a Contribution: Psychiatric Statecraft, German History, and Martial Politics

6.3.1 Psychiatric Statecraft

The central contribution of this thesis is an account of psychiatric knowledge and practice as a political ordering process which constitutes sovereign states and hierarchical orders. Psychiatric knowledge, I argue, makes a statement about the being of Man, and thereby partakes in the inscription and production of political orders. This is a contribution to critical IR literatures on psychiatry (Howell, 2011; Howell, 2012 among others), which have previously undertaken pioneering work in demonstrating how psychiatric knowledge is not a resource of knowledge, providing interpretive and predictive models for the behaviour of international actors, but an object of knowledge. Psychiatry partakes in political ordering processes and must therefore be scrutinized as an effective and powerful political actor.

Yet this rich literature has thus far remained silent on how psychiatric knowledge produces the sovereign state. For critical scholars of psychiatric power, Foucault’s stated intention of ‘leaving the problem of the State ... to one side’ in his investigations of psychiatric power may have foreclosed this line of enquiry (2006: 40). This thesis takes the Foucaultian tools of subjectivation, power-knowledge,

discipline, and the episteme to think beyond this apprehension, and to track how psychiatric knowledge and practice do, in fact, constitute stately orders.

In the theory chapter, I argued that psychiatric statecraft should be understood as the production of sovereign, political order by means of psychiatric knowledge and treatment, which proceeds through the inscription of figures of sovereign Man and his human Others. These figures function to authorize specific orders of power-knowledge-Man, giving the appearance of truth and necessity to those knowledgeable statements and forms of politics which are in alignment with the sovereign subjectivity of Man. I specified that psychiatric statecraft operates through bodily and discursive means of subjection (Foucault, 1995 [1975]; Foucault, 1994), and that it forms part of a martial politics whereby certain groups are constituted as a threat to the wellbeing of Man and are subjected to forms of debilitation (Puar, 2017; Howell, 2018).

Appraising psychiatric knowledge and practice thereby offers, first and foremost, an analytic of psychiatric diagnostic paradigms as containing statements about Man as sovereign being. The vast archives of the discipline of psychiatry thus appear in a different light: they contain not only a nosology of mental abnormality, an account of diagnostic technologies and discussion of treatment approaches, but a description, different across place and time, of what constitutes sovereign subjectivity. Like any modern discourse, psychiatry delineates this sovereign subjectivity by identifying an essential limitation, and by placing frightful, unwelcome, and perceived-to-be threatening attributes into a realm of exteriority. Seen from this vantage point, psychiatry comes into view as a modern, knowledgeable discourse which partakes in answering (what Wynter frames as) the Heideggerian question ‘as to the who, and the what we are’ (2003: 264). It claims an active stake in the epistemological ordering processes whereby the world as we know it comes into being.

Two things are of note here. First, if we treat psychiatric knowledge as a modern knowledgeable discourse which brings the world into being through inscription of Man as a sovereign, ordering presence, we are able to turn to the archives of psychiatry

as a scholarly resource for political inquiry in much the same way as archives of parliamentary proceedings, diplomatic negotiations, security policy, immigration legislation, and other texts which have served for this purpose. The archives of psychiatric knowledge thus constitute an archive of political knowledge and contain histories of statecraft.

Second, an appreciation of psychiatric knowledge as statecraft can also offer an account of how, at a particular place and time, the sovereign presence which is inscribed to resolve ambiguity and authorize political arrangements, is conceptualized. If we follow Foucault (1965; 2003; 2006), Rose (1996; 1998), and Howell (2011; 2012) in their argument about psychiatry playing a fundamental role in securing modern and contemporary orders, a vast field of research opens up to analysis of how psychiatry has inscribed sovereign subjectivities, and thereby functioned as a form of statecraft, across multiple settings. For instance, what role did psychiatric knowledge play in inscribing the sovereign subjectivity which authorized the ‘Scramble for Africa’ in the 1880s? How did it craft a ‘civilized Man’ who considered it his duty to take on the ‘burden’ of colonization? What sovereign figure authorized the large-scale economic restructuring of Roosevelt’s New Deal? Did psychiatry assist in producing a ‘deserving Man’ of labour power and productivity, and which exclusions did it perform around Blackness and disability? Further, how did the dissident psychiatric knowledge of Frantz Fanon and other anti-colonial thinkers inscribe a sovereign subjectivity which was premised on the ousting of the colonizer, and thus necessitated decolonization as a form of subjectivization?

Psychiatric knowledge and practice thus appears as a rich, multi-faceted, pervasive, and highly effective form of *political* practice with the potential of being directly embroiled in, and decisively impacting, the most contentious political confrontations of an era.

6.3.2 The Figure of Man in Psychiatric Statecraft

Reading psychiatric statecraft through the blended registers of Ashley's (1989) and Wynter's (2003) theoretical accounts opens up a number of analytical pathways for (IR) scholarship on the inscription of political orders.

Psychiatric statecraft, as I demonstrated throughout this thesis, is a dynamic process, proceeding at varying levels of openness to contestation across history. An analytical framework which contains both Ashley's rendering of radical instability in the inscription of sovereign figures, as well as Wynter's caution regarding its epistemic limits, is alert to the shifting dynamics in knowledgeable practices. On the one hand, it registers practices of epistemic plurality, when multiple knowledgeable discourses compete to offer a definitive account of Man as sovereign being. In a discursive field constituted in this way, this analytical framework will trace radically opposing accounts of what constitutes Man's essential limitation, ranging in this thesis from vulnerability to injury from machines, machine gun fire, and the extreme dehumanization of the camps, to vulnerability from the degradation of 'racial stock' through the procreation of persons with a constitutional weakness of the will. On the other hand, by coupling Ashley's Kantian Man with Wynter's account of the colonality of Being, in which Man is overrepresented as all humans while in fact only designating those on the privileged side of a global 'Color Line' (2003: 210), such an analytic framework can also theorize periods of sovereign statecraft in which possibilities for the inscription of Man are severely limited. It is able to map knowledgeable configurations which only permit sovereign subjectivity to be formulated within the confines of biologized race and evolutionary hierarchy.

Such an analytical framework could produce rich accounts of sovereign statecraft in a multiplicity of settings. For instance, while my reading has focused exclusively on German sovereign statecraft, a further study might investigate how such statecraft, through psychiatric knowledge and other knowledgeable practices, proceeded in countries with different histories. How did sovereign psychiatric statecraft proceed in countries like the United States and Britain, which are often invoked as a foil to

Germany's 20th century political trajectory, and who premise much of their political authority and legitimacy on their opposition to fascism? A blended account of sovereign statecraft might track the discursive contestations over sovereign Man's being in these proto-'Western' countries, and analyse which phases of instability and radical restriction they underwent. It might investigate to what extent, over the course of the late 19th to the mid-20th century, (psy-)scientific discourse in these liberal, Western states contributed to an order in which political subjectivity was restricted to a small subset of the population. Further, it would also bring into view, as this thesis has done, alternative periodizations of sovereign order to the ones inscribed by the dates of warfare, state formation, and state collapse. Such a framework is thus able to delineate the formation of political order called forth by shifting dynamics in sovereign statecraft, providing an alternative view of late-19th and 20th century political ordering dynamics.

Further, the empirical field laid out in this thesis has brought into view the multiple axes through which an outside, or 'exteriority' (Da Silva, 2015: 97) of Man, can be articulated. I showed that discourses of race commingled with discourses of ability, class background, and political radicalism to inscribe otherness to sovereign Man into the ontology of his physical body. This brings into sharp relief the necessity to analyse the multiple registers through which an outside to order has historically, as well as presently, been delineated. IR has recently begun to re-examine the constitutive role of race and coloniality in the establishment of the discipline, as well as its abiding influence in contemporary theoretical formations (Krishna, 2001; Jones, 2006; Jones, 2008; Henderson, 2013; Thompson, 2013; Anievas et al., 2014; Vitalis, 2015; Rutazibwa, 2016; Nisancioglu, 2019; Sabaratnam, 2020). This essential scholarly labour might productively be extended by querying how disability – figured as 'feeble-mindedness', 'idiocy', and bodily 'deformation' – functioned jointly with discourses of race to frame exclusions to rational, sovereign national and international actors. Howell (2018) and Puar (2007) have written pioneering studies on the structuring role of disability in international politics, but a huge field of investigation into the history of statecraft, disciplinary formation, and international thought remains. For instance, how did discourses of madness/sanity, ability/disability, competence/idiocy, and

bodily integrity/disfigurement inform theorizations of stately order vs. disorder (in the work of Hobbes, Locke, Rousseau, Kant, and others), as well as theorizations of international order vs. disorder (in the writing of Morgenthau, Hertz, Waltz, Mearsheimer, Keohane, Wendt, and others)? How does (international) political theory mobilize bodily dysfunction and neurological alterity to invoke and inscribe risk, disorder, and danger?

Finally, the repeated enfolding of forms of political alterity (working-class background and political radicalism) into discourses of biological inferiority by psychiatric knowledge foregrounds the importance of comprehending the complexity of such essentializing discourse. In this thesis, I usually subsumed these discourses under the rubric of 'Darwinian' discourse, or pertaining to 'racial', 'bodily', or 'national' fitness. Yet what became apparent is that we lack the theoretical vocabulary to precisely name the totality of biologization I have traced in this thesis. At present, we are only able to identify and name individual discourses of scientific dehumanization: scientific racism locates human inferiority in a racial ontology, while eugenic discourse calls for the gradual elimination of the disabled. The biologization of class and political radicalism evokes discourses of degeneration. Yet adequately theorizing the simultaneous and imbricated articulation of these various, biologized discourses of dehumanization remains an urgent and incomplete scholarly endeavour (but note the work of Hoad, 2000; Somerville, 2000; Weber, 2016).

6.3.3 Martial Politics

A third aim of this thesis has been to foreground the martial character of psychiatric knowledge and practice. Throughout the period under investigation in this thesis, I noted instances where psychiatrists treated patients not as patients but as political adversaries. Their bodily inferiority, psychiatrists often argued, imperilled national security and indeed the nation's survival. I therefore mobilized Alison Howell's concept of martial politics (2018) to apprehend how psychiatric practice often

proceeded as a form of warfare, waged by psychiatric practitioners against those placed in their care. Yet I also amended and extended Howell's concept in two ways:

First, I employed the concept for a reading of psychiatric statecraft in Germany, not the United States, from where Howell draws her empirical material. A reading of martial politics in late-19th through mid-20th century Germany is noteworthy because on the one hand, German history provides the example of a martial politics taken to its extreme: for Foucault, Nazi Germany was the site in which the 'race war' of 19th century biopolitics culminated in the attempted extermination of several groups identified as an 'inferior' races (2002: 258-59). It will therefore surprise no one that I argue that Germany, over the course of its 20th century history, functioned in a martial mode. Yet in this thesis I showed how martial politics enabled a form of normalized marginalization based on the claim of bodily inferiority which predated by many decades, and in turn outlasted, the Nazi state. If a martial politics in German history was so entrenched beyond the twelve years from 1933-45, it of course begs the question of whether, and to what extent, German politics continue in a martial mode. To this day, the discipline of psychiatry continues to be involved in the adjudication of various entitlement claims, from disability pensions to the granting of asylum (which I discuss below). The martiality, i.e. the production by psychiatry of its patients as political adversaries who present a threat to public health and security, thus presents an urgent field of future inquiry.

Second, I amended Howell's reading of martial politics with the notions of debility (Puar, 2007) and necropolitics (Mbembe, 2003). As a result, a martial politics comes into view which materializes not in the spectacular visual registers of National Guard troops deployed in inner-city streets (as Howell describes in her discussion, 2018), but through the slow and endemic attrition of vitality of those deemed other to Man. The withdrawal of state support, first and foremost unemployment and disability benefits as well as accident insurance payments, thus appears as an instrument of martial politics – a technology in a war of attrition, deployed to control a population cast as politically adversarial, which is thereby kept in a state of perpetual struggle for the barest means of subsistence. I argue that in the context of post-WWII Germany, the

treatment of Holocaust survivors took on a necropolitical quality and proceeded in a manner I term ‘post-genocidal debilitation’. This form of power functioned to withhold essential care and pension payments from Holocaust survivors and to extend the psychic suffering produced by camp detention long after their liberation. The resulting suspension between life and death of survivors, I suggest, permitted post-fascist Germany to occupy a paradoxical stance: to perpetuate the anti-Semitic persecution of an enduring and unreconstructed race-based episteme on the one hand, while seeking to shed its international pariah status by (appearing to) enact meaningful compensation on the other.

Amending the concept of martial politics with the notions of debility and necropolitics brings into view the fact that different forms of medical, psychiatric practice, but also other knowledges labouring in support of administrative bureaucracies, routinely operate to expose poor, racialized, disabled, and otherwise vulnerable populations to destitution, which proceeds as the apparently objective and disinterested result of medical necessity and policy imperatives. As I have also foregrounded repeatedly in this thesis, a martial politics of abandonment through the withdrawal of benefit payments must be considered as existing on a continuum with more directly lethal measures of warfare. There was no radical break, either in medical-psychiatric paradigms or clinical personnel, between the phase of psychiatric practice which withheld pensions from WWI veterans, and which later sent the disabled to their death. After the war, psychiatry reverted back easily from providing the medical expertise which might send a soldier to his execution for ‘undermining military strength’, to waging psychiatric warfare by withdrawing health damages pensions from Holocaust survivors.

For the study of warfare, security, as well as governmentality, the analysis offered in this thesis shows that violent forms of governance must not proceed through entirely military technologies. A technology of security can be effective through the mechanisms of a benefits administration, and it is able to produce effects which are best understood as the willed enactment of reduced vitality: debility, precarity, and destitution. Even a governmentalized apparatus routinely casts out populations

deemed incapable of self-governance, and it enacts this exclusion, *inter alia*, through a martial politics of welfare withdrawal.

Regarding the study of biopolitics, the analysis of the treatment of Holocaust survivors offered in this thesis demonstrates that forms of power first traced in a colonial setting – like debilitation (Puar, 2017) and ‘social death’ (Mbembe, 2003) – may be found, albeit in modified form, in post-WWII, liberal-democratic Germany. The defeat and dissolution of the Nazi State, and the foundation of a new German state grounded in a constitutional order professing the inalienable dignity of Man, were insufficient in forestalling techniques whereby the psychic terror of Holocaust survivors was wilfully extended by psychiatric expertise. It raises a number of important questions: for one, to what extent does the Foucaultian suggestion of the culmination of a biopolitical ‘race-war’ (2002: 60; 260) in Nazi Germany occlude the extension, by other means, of this politics into the post-war era? Foucault, of course, is at pains to explicate that he understands biopolitics and its attendant translation of political relations into a politics of enmity as long predating, and thus exceeding, the temporal confines of the Nazi State. However, his analysis of biologized ‘race war’ concludes there (its enactment as Soviet class warfare is a different matter), thereby – at the very least – leaving open the question as to how it unfolds in the aftermath of Nazism. This has lent support to the widespread notion that ‘biologized social doctrines ... were radically discredited by the genocidal racism of the Nazi regime’ (Dillon and Reid, 2009: 48) – an assumption cast into doubt by the material presented in this thesis. Second, the debilitation enacted by the psychiatric profession on Holocaust survivors raises questions regarding the relationship between coloniality, the Nazi state, and liberal democracy. To what extent does the bio- and necropolitical seizure of life inform, overlap, and mirror each other in these three spaces? To what extent is it possible to sharply demarcate the management of life and death between these three forms of rule and often distinct territorial spaces?

6.3.4 German History

A final aim of this thesis has been to offer a small contribution to recent efforts in German historiography, advanced predominantly from post-colonial theorists and historians, to situate the history of (state) violence in modern Germany (late 19th until mid-20th century) within epistemic and political formations which naturalize and call for the mass death of ‘inhuman’, racialized, and disabled subjects.

This thesis, of course, deals directly with neither German colonialism nor the Holocaust. Nevertheless, my contribution to this scholarship, I would argue, is the excavation of a form of power-knowledge within the mainstream of German scientific knowledge production – the discipline of psychiatry – which, for nearly five decades, naturalized the appraisal of human subjects along stratified and hierarchical lines of ‘racial’ fitness. While it is no secret that the late 19th century witnessed a rise in so-called ‘race science’ and attendant enthusiasm for phrenology, degeneration theory, and the biologization of deviance (Stepan, 1982; Grosse, 2000; Somerville, 2000), and that, in the wake of the First World War, scientists in Western states were swept up in the zealous pursuit of a eugenic society (Adams, 1990; Pernick, 1996; Mitchell and Snyder, 2003; Lombardo, 2011), this thesis establishes two things: one, the near-hegemonic status of this paradigm in German psychiatric circles from 1916 up until the late 1950s, thus exceeding by far the temporal boundaries of the Third Reich, and two, its translation into and mobilization as a form of political subjectivity, again beyond its more familiar situatedness in the Nazi era. I will briefly elaborate on each of these.

Regarding the hegemony of a psychiatric paradigm grounded in notions of ‘racial’ fitness, this thesis makes evident how, with the rise of the hysteria paradigm grounded in a wish- and constitution-based aetiology in the 1880s, political deviance became a function of bodily, ‘constitutional’ inferiority. The failure of the industrial worker to recover from the shock of a workplace accident was framed not as the result of lingering distress, but a function of a bodily ontology produced, by nature, as brittle

and prone to malfunction (chapter 3). I also demonstrated how, in the years leading up to the First World War, the language of ‘degeneracy’ and heredity became commonplace in psychiatric texts on hysteria (chapter 3). I tracked how this interpretation of hysteria, initially contested (and, of course, in retrospect, nearly erased from the historical memory of hysteria, which associates it almost entirely with the work of Charcot and Freud), became increasingly dominant in the early years of the 20th century, and was finally enshrined as dogma, first, at the 1916 Medical Congress, and finally, through the 1926 Imperial Insurance Office decision to void the actionable status of traumatic neurosis (chapter 4). From this point forward, it was standard psychiatric practice in Germany to appraise any long-term, chronic symptoms of post-traumatic stress in racialized and/or working-class subjects as an expression of their given, inferior constitution. I proceeded to highlight how the lionization of willpower and ‘racial’ fitness inherent in the hysteria paradigm translated seamlessly into the endorsement, immediately following the First World War, of eugenic policies by Germany’s leading psychiatrists to cull (what Binding and Hoche termed) ‘lives unworthy of living’ (Binding and Hoche, 2006 [1920]) (chapter 4). I then outlined how a paradigm of hysteria appraising its patients in Darwinian terms, as either ‘selected’ or ‘dysselected’ by evolution (Wynter, 2003: 325) survived, without interruption, long into the post-WWII period (chapter 5). I showed how the administrative and psychiatric compensation apparatus in which psychiatric knowledge of trauma played such a fundamental part frequently appraised Jewish claimants as predisposed to breakdown, independent of the persecution they had suffered.

Regarding the translation of ‘racial’ fitness into political subjectivity, this thesis demonstrates how psychiatrists linked ‘inferior’ constitution with a form of ‘inhuman’ Otherness which needed to be cast out from the national collective. I excavated the roots of a constitution-based paradigm of hysteria with Adolf Struempell’s (1895b) coining of the notion of *Begehrungsvorstellung*, or ‘desiring thoughts’, which identifies the character of the worker as aetiologically significant. According to this approach, workers, as a ‘type’ (Foucault, 1978), were work shy, opportunistic, and unreasonably entitled, and thus more inclined than other groups to developing desiring thoughts

for an accident pension after a workplace incident (chapter 3). This view rapidly gained acceptance among German psychiatrists, and already in the early years of the 20th century, the hysteria paradigm was routinely deployed to implant specific levels of bodily ‘fitness’ and ‘weakness’ into identifiable and circumscribable groups of political constituents. It became commonplace for psychiatrists to characterize workers as unduly entitled, and they warned of the risks they posed to national cohesion and fiscal stability.

The production of ‘fit’ vs. ‘inferior’ subjects by means of the hysteria paradigm fully came into its own during the First World War (chapter 4). This period witnessed the rise of the figure of the ‘psychopath’, described as any person whose ‘nervous apparatus ... [was] inherently less firmly constructed ... than a healthy person’s’ (Gaupp, 1918: 10). This figure was liberally deployed to characterize all those (working class subjects) who could or would no longer fight: they were diagnosed as hysterics with an ‘inferior disposition’ (Kretschmer, 1917: 64-65), as ‘physically feeble, ... weakened persons’ (Bonhoeffer, 1922: 45), as ‘intellectually inferior, frequently even puerile persons’ (Binswanger, 1922: 65), or as ‘criminals, degenerates ... men without love for their country, full of resistance against the demands of military service’ (Gaupp, 1918: 12). These soldiers were not characterized as injured, but as inferior ‘types’ endangering military success and the nation as a whole through the weakness of their psychic and physical build.

I also noted in this chapter (4) the alignment of hysteria practitioners with the views of ‘racial’ psychiatry, which more directly (and in more familiar terms) expressed the terms of a racial Darwinist scientific paradigm, inscribing differential proneness to mental stress into different ‘racial’ groups.

As the war drew to a close, the hysteria paradigm functioned to cast the political deviance of revolutionary leaders as a result of their being ‘pathologically degenerate persons’ (Stransky, 1920: 274), and the hated instigators of revolutionary movements in Munich, Berlin, Hamburg, and elsewhere were promptly diagnosed as ‘fanatical psychopaths’, ‘hysterical degenerates’, and ‘psychopathic personalities’ (Eugen Kahn

quoted in Riedesser and Verderber, 1996: 82-84; Brennecke, 1921: 251). By this point, through the help of the hysteria paradigm, political adversaries had become biological foes.

I then proceeded to trace how, in the aftermath of the war, the weak, ill, and disabled were increasingly framed as threats to the 'racial' fitness of the German *Volk* and a risk to its recovery from the war. Psychiatrists agonized that the war had 'enacted Darwinian selection of the wrong kind' (Nonne, 1922: 112), and that the 'racially most valuable men' had been killed (Stransky, 1920: 277). Binding and Hoche decried the care and resources lavished on the 'mentally deceased' and called for the 'mercy killing' of 'ballast existence' (2006 [1920]: 14; 27).

After WWII, and following the liberation of the camps (chapter 5), Jews continued to be cast as adversarial, 'racially' inferior threats to German recovery and reconstruction. Survivors applying for a health damages pension under post-war compensation legislation were widely portrayed by psychiatric professionals as 'psychopathic personalit[ies]' (Niederland, 1980: 180-97), and various symptoms of distress were reduced to 'endogenous mood disorder[s]' or were rejected with reference to the 'known disposition among Jews' for such conditions (von Baeyer et al., 1967: 52-55; 202-05; Ammermüller and Wilden, 1953: 229-31). This practice aligned neatly with the Adenauer administration's apparent distaste in having to compensate Jewish survivors if Germany wished to regain respectable status among other Western states. I noted the egregious and repeated expressions of anti-Semitism from leading members of Adenauer's cabinet, as well as the wider hostility among the German public towards compensation of the victims of Nazism.

How do these historical linkages and trajectories contribute to post-colonial scholarship tracing the roots of the Holocaust to German colonialism? This thesis does so by rejecting a *Sonderweg*-narrative of German history, which locates the roots of Nazism in a deficit of liberalism in the 19th century (Wehler, 1988; Fischer, 1961). Instead, it situates the Holocaust as the most extreme expression of a formation of power-knowledge which was constituted, in part, by scientific discourse and practice

that produced human subjects on a Darwinian scale of ‘racial’ fitness and attributed political subjectivity only to those groups who were placed at the pinnacle of this stratified order: gentle, white, economically productive, and able-bodied persons. I demonstrate that this formation of power-knowledge was already fully formed on the eve of the First World War, and widely accepted throughout the German psychiatric community. I also trace its persistence far beyond the conclusion of the Third Reich, which, while certainly the ‘most murderous...and most racist’ (Foucault, 2002: 258) was not the only Western, or even German, state governed by Darwinian criteria of ‘racial’ fitness. Further, I demonstrate how political subjectivity located in notions of ‘healthy’ and ‘robust’ constitution served to interpellate as inferior and dangerous a wide set of human subjects, extending from people racialized as Jewish or Black, to the urban working poor, political ‘radicals’, and the disabled. Thus, to borrow and modify Jürgen Zimmerer’s formulation (2003: 63-64), psy-scientific production of humans as natural organisms ‘selected’ or ‘dysselected’ by evolution made ‘conceivable’ a wide range of martial political technologies, from the withdrawal of the means to survive from the working poor, to the protracted ‘treatment’-torture of traumatized, working-class soldiers, to the criminalization and routing by paramilitary units of socialist and communist revolutionaries, to the genocides of the Herero and Nama, the disabled, and the Jews.

6.4 Looking Forward: Transnational and Present Formations of Psychiatric Statecraft

Whenever I presented this research at conferences, workshops, or in seminars, two questions were raised without exception: to what extent was psychiatric practice in other European states and North America comparable to the German case? And how does German psychiatry operate today? In this final section of the Conclusion, I will sketch out some transnational formations of psychiatric statecraft from the mid-19th to mid-20th century, and subsequently outline one site where psychiatric knowledge presently still functions as an adjudicator over access to essential entitlements – namely the processing of asylum claims in Germany.

6.4.1 Psychiatric Statecraft beyond Germany: Transnational Production of an Other to Man

I noted above that I consider this thesis to be part of a broader effort to discredit a *Sonderweg*-reading of German history, an aim it pursues by situating the genocidal violence of the Nazi state as the most extreme expression of a formation of power-knowledge which cast sovereign subjectivity as a function of bodily ‘fitness’, and inscribed various forms of political deviance, psychic breakdown, and cultural as well as phenotypal otherness as a form ‘racial’, or constitutional, inferiority. While it was beyond the scope of my research to demonstrate the prevalence of this formation of power-knowledge beyond Germany, this section will consider incidental evidence to this effect which I encountered in the archives.

As I outlined in the third chapter, the debate around the traumatic neurosis diagnosis did not originate in Germany. From John Eric Erichsen in England via Jean-Martin Charcot in France, among many others, European and North American psychiatrists and neurologists in the mid- to late 19th century participated jointly in formulating various explanatory models for the psychological effects of extreme distress. Similarly, the debate I tracked through all three empirical chapters regarding the appraisal of post-accident patients – were they suffering from long-term effects of psychological distress, or were their symptoms wish-based and rooted in an inferior constitution – had taken place in all European and North American states. The concern that post-accident symptoms were fuelled, first and foremost, by the prospect of material gain was echoed throughout the international psychiatric community, and most states adjusted their accident insurance and corporate liability legislation to reflect this worry (His, 1926). Following consultation with psychiatric experts, a number of states including England, Denmark, Sweden, Spain, Hungary, the United States, and Canada elected to offer one-off compensation payments to sufferers of chronic psychological post-accident conditions, grounded in the conviction that indefinite pension payments would stifle the patient’s will to recovery. As the Swiss psychiatrist Wilhelm His observed, these one-off payments ‘have proven useful precisely because they are not a form of compensation, but a remedy – namely the only available and the only

effective remedy [for traumatic neurosis] at this moment' (1926: 184) – precisely because they forced the patient to return to waged labour.

This North American and European consensus on the appraisal of post-accident neuroses extended into the post-WWII period and, to a certain extent, the present. At the first international conferences on the various long-term health damages of concentration camp survivors in the 1950s (organized by survivors themselves, and without German officials in attendance), there was still widespread support for the notion of a 'pensions neurosis'. Speakers at a conference in Copenhagen in 1954 discussed the claims of survivors in relation to pensions neuroses, noting that while they did not consider it an appropriate diagnosis for camp survivors, the diagnostic paradigm was legitimate (Michel, 1955: 42-45, 66). Yet even after the multiple challenges to psychiatric orthodoxy by Holocaust survivors and Vietnam veterans, which led to the formulation of the PTSD diagnosis and its inclusion in the *DSM-iii* (Diagnostic and Statistical Manual of Mental Disorders – the 'bible' of psychiatric practice), the whiff of undeserved entitlement continued to cling to trauma patients whenever their diagnosis was linked to financial compensation. Historian Dagmar Herzog writes that the *DSM-iii* was subjected to wholesale overhaul during the course of the 1970s, with the aim of standardizing diagnoses and placing the diagnostic process on more secure and 'objective' scientific footing. As part of this effort, contributing psychiatrists sought to remove the question of aetiology from the description of disorders, and instead introduced a checklist of symptoms. PTSD, however, became the sole exception to this rule, and the question of aetiology is still enshrined in its diagnostic process (2017: 91). Relatedly, psychiatrist Bessel van der Kolk notes that a common explanation given for the lack of treatment success of Prozac in combat veterans – a drug proven to be highly effective in the treatment of other groups of trauma patients – is that these veterans receive disability benefits (2014: 66). The assumption underpinning this explanation is, of course, familiar from this thesis: these veterans, it is assumed, continue to produce the psychological symptoms necessary to receive pension payments, and thus (unconsciously?) override the curative effects of Prozac. In this explanation, the 19th century ghost of 'desiring thoughts' makes a 21st century comeback.

This also regards the production of ‘inhuman’ subjects by psychiatric and other forms of scientific knowledge. If, following David Mitchell and Sharon Snyder (2003), the term ‘eugenics’ designates a project of systematic exclusion of those individuals and groups identified as ‘defective’ based on a cognitive and/or physical disability, the rise of eugenics in Western scientific knowledge and practice must be considered a ‘truly trans-Atlantic affair’ (2003: 845). Mitchell and Snyder trace the roots of the modern eugenics movement to France, where the physician Edouard Séguin laid the foundations for the institutionalization and permanent segregation of ‘fools and simpletons’ by campaigning for separate educational programmes which aimed to ‘train’ persons to overcome their ‘idiocy’, itself understood to root in an inherent ‘defect of self control’ (2003: 853). Institutions which segregated and ‘trained’ the mentally and physically disabled proliferated across Europe and North America from the middle of the 19th century onwards, thereby enacting in practice what the founder of the eugenics movement, British scientist Francis Galton, called for through a programme of selective breeding – namely the permanent removal of disabled bodies from society (2003: 855).

Mitchell and Snyder also track how a transnational eugenics research network, encompassing ‘national academic conferences, academic appointments, programmes, majors and departments at more than 80 universities in the USA, and global publication opportunities across Europe and North America’ (2003: 847), gradually escalated its rhetoric in the early years of the 20th century, shifting from justifying segregation and institutionalization as a means to training ‘defectives’, to uttering as a ‘whispered possibility’ more extreme measures, including permanent confinement, barring from immigration, sterilization and even extermination, to counter what was increasingly viewed as a social menace and a threat to national health and stability (2003: 856).

Mitchell and Snyder are at pains to point out that, while the eugenic movement was brought to its genocidal pinnacle with the systematic mass murder of the disabled in Nazi Germany, ‘Germany came late to the scientific sphere of eugenics’ (2003: 847). In the late 19th and early 20th centuries, several US states had passed eugenic

legislation: Connecticut became the first state in 1896 to pass marriage restriction laws for the ‘feeble-minded’ and bills for compulsory sterilization were first passed in Indiana in 1907 (soon followed by many others)(Lombardo, 2011: 95-117). Therefore, what Nazi Germany enacted through the *Gesetz zur Verhinderung erbkranken Nachwuchses* (Law for the Prevention of Hereditarily Diseased Offspring) and the T4 programme (chapter 5) had a precedent in ‘successful’ eugenics campaigns elsewhere: ‘German scientists picked up legislative tactics, sterilisation policies and practices, and the co-opting of institutions as research domains well after the success of this kind of scientific empire building had occurred in France, Britain, the USA, Canada and elsewhere’ (Mitchell and Snyder, 2003: 847).

Neither did eugenics end with the conclusion of WWII: forms of ‘passive’ euthanasia (where patients were purposefully exposed to pathogens) were practiced in US psychiatric institutions until the middle of the century (Black, 2003), and California pursued the sterilization of ‘feeble-minded’ psychiatric patients with particular vigour, performing 20,000 procedures (one third of the nation’s total) up until the 1960s (Lombardo, 2011: 95-117). Anne Lovell and Robert and Françoise Castel noted in 1979 that ‘the extremes to which eugenic ideas were carried by the Nazis are not at variance with, but rather a logical extension of, the principles and practices of the eugenics movement,’ and insist that ‘the dream of using technological manipulation to stamp out “moral disease” is still alive in contemporary American Psychiatry’ (Castel et al., 1982: 46; 48). As a result, the construction of epistemic foundations to establish and carry out an international eugenics movement extend far beyond Germany: ‘Eugenics bound much of Europe, the United States and Canada in a concerted movement to rid disabilities from their own national spaces.’ As such, it constituted ‘a cultural traffic in the cultivation of a shared distaste toward “deviance” and unacceptable human variations’ (Mitchell and Snyder, 2003: 856).

6.4.2 An Abiding Form of Martial Politics? German Psychiatry and Asylum Claims, 1990-2018

Following German reunification in 1990, a wave of racist violence swept the country. Predominantly (but not exclusively) in the ‘new’ federal states of East Germany, foreign contractors were chased in the streets, refugee accommodation set ablaze, and immigrants murdered in their homes. In the East-German cities of Hoyerswerda and Rostock-Lichtenhagen, locals joined neo-Nazi mobs outside of refugee and contractor housing to applaud them as they smashed windows and hurled Molotov cocktails (Schmidt, 2002: 24-28), while in the West-German towns of Mölln and Solingen, neo-Nazis murdered eight persons of Turkish descent, all members of the same family, by setting fire to their houses at night (Herbert, 2017: 1171-80). These events were only the most notorious in an escalating number of attacks on persons considered ‘not German’ in the recently re-unified German state (Langer, 1993: 59-74).

First, the German government reacted to these attacks with indifference. Chancellor Helmut Kohl twice declined to attend memorial services for the victims of Mölln and Solingen, claiming he wanted to avoid ‘condolences tourism’ (Prantl, 2013). Shortly afterwards, it set to work redrafting existing asylum legislation: the so-called ‘Asylum Compromise’ of 1993 restricted the right to asylum with reference to the ‘increasing financial and social burden’ imposed by asylum seekers (Korzilius and Rabbata, 2004: A-3398). Clearly, asylum seekers were the first group to emerge as undesirables in newly unified Germany, and alongside mob violence and legislative reform, psychiatric knowledge was mobilized as an additional instrument in countering the threat they were said to pose.

The ‘Asylum Compromise’ significantly narrowed the grounds on which asylum seekers could make their claim, and the numbers of both applications made and granted decreased sharply after 1993 (Korzilius and Rabbata, 2004: A-3398). For those whose asylum claims had been denied, a trauma-related diagnosis (like PTSD or enduring personality change following a catastrophic event) could provide

protection from imminent deportation. This was the case because the new legislation specified that deportees had to be fit to travel, and PTSD, by rendering those suffering from it suicidal, was recognized as a condition which undermined this fitness (*Das ärztliche Attest*, 2015: 9-10).

This arrangement led to a scenario familiar from the struggles of workers, soldiers, and Holocaust survivors in that doctors, by diagnosing a specific trauma-related condition, held extraordinary power in the adjudication of their claims. In another continuation of historical constellations, psychiatric medical assessments soon became the subject of heated political controversy. In the late 1990s in Berlin, the municipal administration accused doctors of diagnosing asylum seekers from Bosnia-Herzegovina with PTSD only to prevent their deportation. Senator of the Interior Eckart Werthebach ordered that all claimants had to submit to a second medical exam by police doctors, who often found no evidence of trauma-related conditions (Korzilius and Rabbata, 2004: 3401). While Berlin's municipal administration reached a compromise with doctors after the protests of a number of medical professional associations, Cologne's administration withdrew responsibility for medical assessments in asylum cases from the health authorities in 2003 and instead permitted immigration offices to contract their own doctors. This led to a decline in cases recognized as PTSD by the immigration offices from 90 to 60 percent (Korzilius and Rabbata, 2004: 3400). This dynamic is in evidence across the country, with asylum seekers who mount a challenge to their deportation order by means of a PTSD diagnosis ordered to submit to a second exam by doctors contracted by the immigration offices, who usually certify fitness to travel (Eisenreich, 2018).

In 2016, following the entry of 890,000 asylum seekers the previous year and in the context of resurgent far-right anti-immigrant rhetoric, the German government further restricted the fundamental right to asylum and passed a series of measures to expedite the deportation of denied asylum seekers. In an unprecedented move, the new legislation removed trauma-related conditions from the list of conditions which rendered an asylum seeker unfit to travel. Following these changes, only those persons suffering from a 'life-threatening and severe illness' met this specification, with the

explicit exclusion of PTSD (Osterloh, 2016: A-353). Thus, in contrast to previous instances in which a trauma diagnosis was mobilized to adjudicate the claims of marginalized subjects, in this case the confrontation did not take place in the framework of a diagnostic debate – the 2016 legislative changes did not mobilize a different paradigm of trauma to deny the claims of applicants. Instead, the new asylum laws somaticize the entire process: only physical injury and illness can function as a stay of deportation. 2019's Law of Orderly Return (*Geordnete Rückkehr Gesetz*) continues on this trajectory by stipulating that medical assessments from psychotherapists can no longer be submitted in asylum hearings, and instead impose a requirement that such assessments be drafted by medical doctors (BAfF, 2019). Psychotherapeutic expertise has thus been declared unreliable in the determination of severe illness, and this skill attributed exclusively to the somatic approach of medical doctors.

As with previous conflicts over the use of trauma diagnoses to secure entitlements, opponents claimed that simulation loomed large and was being used by claimants to gain unfair advantages. In 2016, Minister of the Interior Thomas de Maizière claimed that '70 percent of men under the age of 40 are declared ill prior to their deportation and thus deemed unfit to travel'. The claim turned out to be baseless, and de Maizière had to rescind it shortly after (Eisenreich, 2018). Iris Hauth, president of the German Society for Psychiatry, Psychotherapy and Neurology, recognizes this spirit of mistrust in the new legislation, arguing that '[T]he terminology used in the law gives the impression that asylum seekers regularly feign symptoms of a psychological illness to escape deportation. [But] these days, the diagnosis of psychological illnesses is as reliable as that of somatic illnesses' (Bühning and Korzilius, 2016: A-474).

Psychiatric practice in this instance does not quite come full circle with historical disciplinary precedents of psychiatric statecraft. However, there are a number of notable parallels to the dynamics I traced in this thesis. Once again, a post-traumatic condition has lost its actionable status under entitlement legislation. This, of course, happened previously in 1926, when the Imperial Insurance Office of the Weimar Republic removed traumatic neurosis from the list of actionable conditions under

accident insurance law (chapter 4). In this most recent iteration, PTSD no longer counts among the eligible health exemptions which protect an individual from deportation. Similar to the 1926 change in legislation, the withdrawal of entitlements from vulnerable populations happens in a context in which ‘approving’ psychiatrists – i.e., those seen as too liberal in their diagnosis of PTSD – are accused of bias and lack of professionalism, while claimants – in this case, asylum seekers – are characterized as fraudulent and selfish advantage-seekers.

Yet notably, at least at the time of writing, there does not appear to have taken place the kind of discursive restriction around the figure of Man which I observed in the aftermath of WWI (chapter 4). At this current moment, vehement discursive contestations are taking place around the figure of the asylum seeker, with, remarkably, mostly psychiatric professionals calling for their conditions to be recognized as sufficient grounds to issue a stay of deportation. Psychiatry is thereby mobilizing, once again, an events-based paradigm to inscribe a sovereign figure whose ‘essential limitation’ lies in its vulnerability to the violence of modernity – in this case, the experience of torture, abuse, and warfare in countries outside of the European Union (to what extent this figure also functions as an auxiliary figure, comparable to the figure of the Jewish Holocaust survivors discussed in chapter 5, is another matter).

The German government, however, is inscribing the asylum seeker as a threat to order. De Maizière’s invocation of ‘men under the age of 40’ who are ‘deemed unfit to travel’ under false pretexts calls forth echoes of figures from psychiatric history traced throughout this thesis, including ‘the conman’, ‘the troublemaker’, and ‘the war hysteric’. Each of these figures was found guilty, first by psychiatric knowledge and subsequently by the German government, of producing symptoms which only *appeared* to result from distress, yet in actual fact were entirely self-serving in securing a form of personal gain for the claimant. Like in previous instances where this figure was invoked, claimants are produced as security threats, and are circulated throughout a discursive economy in which the figure of the young, male migrant is increasingly demonized and placed under the suspicion of harbouring extremist ideologies, affiliating with terrorists, and assaulting women (note the AfD’s fearmongering of

‘imported violence enacted by young men from culturally foreign regions’, *Beatrix von Storch: Polizeistatistik*, 2020).

What are we to make of this psychiatric statecraft today, 150 years (at the time of submission of this thesis in early 2021, almost to the day) after the foundation of the unified German Reich? It appears as though psychiatric knowledge in Germany remains locked into the same struggles over the bordering of sovereign subjectivity as it did more than a century ago. In its present diagnostic debates, one side inscribes patients as susceptible to harm from the violence of modernity, now understood primarily as the wars, torture, and deprivation found outside of the European Union. The other side, as ever, seeks to defend the German nation against the insidious threat of an enemy within, now projected onto migrant ‘men under the age of 40’, fraudulently staking their asylum claims on a baseless or exaggerated PTSD diagnosis. Both, as we know, ground different rationalities in politics: while the former shores up the notion of Germany as a safe harbour and citadel of science, offering shelter and protection to a select group of refugees who meet the scientific and international legal requirements of deserving status, the latter perpetuates the myth of Germany under attack from an insidious and wily adversary hidden within, claiming status and resources which should, by rights, be reserved for ‘true Germans’.

While one politics certainly seems more benign than the other, both, it bears recalling, are grounded in a sovereign figure of Man – they are thus premised, as this thesis has laid out, on the inscription and anxious defence against an inhuman, subhuman Other. Both are invested in a politics in the service of Man, and will thus, by necessity, find the marginalization, brutalization, and exposure to lethality of those known as his subhuman Other rational, expedient, and necessary.

The three expositions on the being of Man and the modern episteme which have provided the theoretical footing for this thesis – Foucault’s *The Order of Things*, Ashley’s ‘Living on Border Lines’, and Wynter’s ‘Unsettling the Coloniality of Being/Power/Truth/Freedom’ – all close with the hope, prophecy, or call for, the imminent end of our present order. Foucault writes that Man only came into existence

recently, a mere century and a half (now two) ago, and will soon disappear, 'like a face drawn in sand at the edge of the sea' (2005 [1966]: 422). Ashley, scoping out the possibilities for meaningful political and scholarly activity under the strictures of the present episteme, urges us to engage in the 'dissident ... work of *thought*'. This, he cautions, is only possible if one 'cuts all ties and becomes a stranger to country, language, sex – indeed, any notion of a sovereign identity of man' (1989: 313). Wynter, in turn, calls for the abolition of Man – or rather, an end to his 'overrepresentation' as all humans – by means of a reckoning with, and complete overhaul of, the workings of our present, biocentric episteme. Through a study of the 'semantic systems' through which our 'orders of consciousness' are instated – what Césaire has termed a 'science of the Word' – we can come to understand how different genres of human being are naturalized and internalized (2003: 328). Rendering this hidden process visible constitutes a 'cognitively emancipatory proposal for a new science' (ibid.) which will ultimately permit a 'nonadaptive mode of human self-cognition' (2003: 331). Liberating our thinking from the biocentric prescriptions of our present episteme, according to Wynter, will unbridle 'our fully realized autonomy of feelings, thoughts, behaviors' (ibid.).

I often wonder how our present order of knowledge will be evaluated in 500 years' time. Without a doubt, it will differ profoundly from the present epistemic arrangements, utterly premised on the sovereignty of Man, and without a doubt these epistemic arrangements will seem quaint, quixotic, and perhaps even eccentric. Epistemic orders evolve, and the age of Man does not mark the end of history. Yet to what extent the demise of the order of Man will also mark the advent of a more liberated, autonomous, and equitable order is less certain. We have learned from all three theorists recalled above that the narrative of a growth in humanism and human kindness across history is just that – a narrative.

To become a 'stranger' to 'country, language, sex' (Ashley, 1989: 313) and to unshackle our thoughts and behaviours (Wynter, 2003: 331) from the toxic strictures of our present episteme is exquisitely difficult. To rephrase a famous passage from Judith Butler, the discourse of Man isn't something we put on and take off like an

item of clothing. We live and breathe the discourse of Man, and it retains a hold on our thinking and being in the world even if we self-consciously seek to extricate ourselves. Yet discourses are never closed or complete, and our orders of knowledge are pliant. Over time, they can be reconfigured through practices of dissidence.

What might dissident practice in relation to the treatment of trauma look like? As this thesis has shown, *disciplinary* practice of trauma treatment secures access to treatment and pensions for a select group (at best), or produces vulnerable patients as a threat to public health and denies them essential services (at worst). A dissident practice of trauma treatment would seize medical knowledge and effective treatment methods from selective dispensation by governmental bureaucracies and collectivize them among those who require them. These methods of seizure and collectivization have previously been modelled by vulnerable and/or marginalized communities who have been abandoned by governmental health services. In the 1980s, faced with a disinterested, hostile, and sluggish government response to the escalating AIDS crisis, so-called buyers clubs formed across the United States to provide life-saving medication to persons infected with HIV (Dorf, 2018). These clubs smuggled non-FDA approved experimental drugs into the country and distributed them among fee-paying members, thereby providing a range of different medications to infected persons at a time when not a single treatment was legally available. After the approval of AZT in 1987, buyers clubs continued to operate to offer lower-cost alternatives, as well as to provide drugs with less prohibitive side effects (ibid.). More recently, trans communities have forged online networks to help members navigate an antagonistic medical and legal terrain. These networks provide a means to share medical research and advice, including information on hormonal and surgical transition, to recommend trustworthy doctors and mental health practitioners, and to provide hormonal treatment compounds to those without legal access to them (Gleeson, 2018). In this way, writes Jules Gleeson, ‘trans circles have shared with each other manifold resources and opportunities to assist each other’s transitions in concrete ways, a process which amounts to showing each other how we can both survive and live’ (ibid.). Comparable networks exist for (self-described) mad, disabled, chronically ill, and neurodivergent communities (most well-known among these is the

now-defunct Icarus Project). Seizing and collectivizing knowledge on trauma would mean, at the very least, making the whole gamut of treatment approaches, from psychotherapy to pharmacological intervention, immediately and freely available to those who require and request it. It would mean widely and easily accessible mental health services, free to access and available to use without restriction. More fundamentally, it would mean offering the financial and existential security so essential for recovery from extreme stress, as multiple instances across this thesis made apparent (recall the ‘hysterical’ WWI soldiers whose symptoms returned as soon as they were returned to the front).

If these suggestions sound utopian, this is simply a measure of the depth of depravity of our present order of Man, in which deportation, the withholding of medical care, and evisceration of welfare are made to appear rational, urgent, and necessary. If these suggestions seem excessively idealistic, it is of course because not only the (inadequate) treatment but also the causes of trauma – war, torture, poverty, and abuse – are so deeply imbricated with the structure of our present order. To meaningfully treat trauma requires nothing less than the overhaul of this order.

Radical, grassroots networks and mutual aid groups are not exempt from the hierarchizing effects of the discourse of Man, and we should beware of romanticizing them as ultra-egalitarian and proto-progressive sites (Joseph, 2002). Nevertheless, I believe that the practices of seizure and collectivization, of mutual aid and support modelled by communities cast out from human status under our present order offer our best hope of its eventual undoing.

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