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A Historical Overview of Women's Hysteria in Slovenia

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ABSTRACT The article is a discursive analysis of medical, ecclesiastic and lay articles on women's hysteria published in Slovenia between 1877 and 1935. The analysis shows which discourses of women's hysteria dominated across Europe at the turn of the century and how they influenced the construction of the image of female biological and mental inferiority. Special attention is paid to the issue of how far the medical discourse on hysteria helped to justify the gendered division between the public and private realm. The article presents the wider framework of the medicalization of women across Europe at that time, and tries to trace the ideas which mostly influenced medical doctors in Slovenia. The medical construction of women's hysteria has to be understood in conjunction with the construction of the social space in which segregation of 'social deviants' took place. The spread of hysteria went hand in hand with the psychiatric institutionalization, the pathologization of sexuality and the eugenic movements which appeared in different parts of Europe, to differing degrees, but which all influenced and gendered the everyday life of women and men.

KEY WORDS hysteria ◆ medicalization of the body ◆ naturalization of women ◆ psychiatric institutionalization

> Female power is boundless;
> the mother's mind and influence
> make miracles: a woman cures the ill,
> transforms hardened characters into loveable
> ones and weak characters into heroic ones;
> converts the lazy and despondent into the
> laborious and diligent. (Pajkova, 'Some Words on
> the Woman Question', 1884)

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> Hence we see that this disease
> has not been wrongly named 'Proteus'
> for it is wonderfully ingenious,
> I would say almost infinite in its apparitions.
> Now it torments the patient in this way,
> then suddenly in the other. Due to this,
> it is impossible to give a uniform account of hysteria.
> (Skubic, *Hysteria and Spiritual Pastorage*, 1909)

Why is it that even today hysteria still evokes the interest of so many social scientists, historians and physicians? It seems that one of the reasons for this fascination is the fact that there are very few social phenomena which, having been socially recognized and medically labelled, carry such a proliferation of meanings, images and social representations. Furthermore, hysteria has always been a social phenomenon in which multiple social discourses touch each other, cross over one another and rejoin to form a new picture: another version of the already existing gender map in European societies. Although Central and Eastern Europe are today still marked by a lack of historical research in psychiatry, psychology and gender, reminiscent of the times of communism, some researchers have nonetheless looked at the phenomenon of hysteria (Zaviršek, 1990; Vari, 1997).

During the 19th century – the period of the 'golden era of hysteria' – most major Central and Eastern European cities were already building large mental hospitals and introducing the practice of segregation. In Slovenia, for instance, which was at that time a rural region of the Austro-Hungarian empire, the first psychiatric hospital was opened near Ljubljana in 1827, in the provincial town of Studenec. At that time the lunatic asylum housed 37 'mentally deranged' persons (Bleiweiss, 1878). The number of patients admitted grew rapidly, and soon after the asylum had opened there were consistently around 420 patients, although it could officially only provide space for 200 (Goestl, 1926). By 1926 the number of inmates had increased to 905 'mentally deranged' persons, who were placed in this particular asylum as well as in various other institutions around Ljubljana, which had by now become the capital of the Slovene region.

Large social institutions at that time were, for some people, a refuge and safe space for a relatively short period of time. For others they were places of punishment and control over their lives. The importance of such institutions, which were seen as the promoters of the 'philanthropic vision of society', was precisely in their normative vision of that same society. They were created not so much to cure the sick as to produce an image of an insane person from whom 'normal' individuals could distinguish themselves.

The practice of large-scale confinement spread to Central Europe,

employing the same disciplinary mechanisms as in Western European countries. The space of madness, rigorously separated and controlled, became very important. Hospitals, with their closed and opened wards, their walls and their networks of crowded corridors, marked the boundary where something else started: illness, which soon became a synonym for social deviance. The spatial segregation of these new institutions was seen as the progressive and modern way of treating persons who were seen as insane. Lack of rigorously separated spaces was seen as a lack of the 'right environment' for curing and observing patients. Although there is little known about the ways persons with mental disabilities were treated before the industrial era, it is obvious that they were not spatially segregated from everyday life (Foucault, 1988; Gleeson, 1999). In spite of their devalued and often demonized symbolic status, they remained within the communities, marginalized but included at the same time.

Slovene documents show that until the end of the Second World War a proper network of closed institutions did not exist. In 1926 a local doctor from Maribor pointed out that mental patients still had to be sent to Ljubljana to an 'observation ward' before being admitted to the mental hospital in his town (Dernovšek, 1926). This was obviously viewed as a backward procedure due to the lack of a network of closed institutions in the region. Nevertheless, Maribor, the second biggest city in the Slovene region, boasted a 'furry room', complete with a 'steel-meshed bed and other security accessories', in which patients were kept until they were transferred to the madhouse in Ljubljana (Dernovšek, 1926).

Not much is known about women's lives in Slovene institutions during this period, although Karol Bleiweiss, himself an important physician, noted that 'mad women' in mental hospitals provided 'successful assistance by sewing, preparing vegetables in the kitchen, and helping in the laundry and in the drying loft' (Bleiweiss, 1878). Still, most 'hysterical' women were not to be found in the mental hospitals, but in their homes, securely watched over by their parents, husbands and doctors.

It is important to point out that in Slovenia the whole discussion of madness and insanity was not as apparent as it was in other major European cities, although the elements of a similar discourse could be found. In this article I draw attention to the most important writers whose theoretical perspective became the basis for the discourse on hysteria between 1877 and 1935.

WOMEN INSIDE AND OUTSIDE THE ASYLUMS

There is much documentary evidence to show that a large number of women were sent to rural asylums across Europe from the middle of the 19th century (Cohen, 1992; Busfield, 1996; Gittins, 1998). Around this time

there arose the popular new fashion of building large hospitals in the countryside with plenty of daylight and fresh air. By the end of the 19th century there were some asylums where the majority of inmates were women, locked into the overcrowded and rigorously separated spaces of the women's wards (Gittins, 1998). Those who came to the asylums for the poor were, for the most part, unemployed, widows or unmarried women, for whom psychiatric hospitalization was the only way to get food and a place to sleep. According to Foucault, this was a consequence of the new capitalist labour practices, which required a division between those people who were 'economically useful' and who could fully reproduce the idea of reason, and those who were defined as 'economically unuseful' and had become problematic for the new moral order (Foucault, 1978, 1988). The preindustrial heterogeneity of the body was soon replaced with a homogeneous body which was able to conform to a new time order, perform repetitious industrial work and adhere to the spatial segregation between the workplace and private household. The differentiation between healthy and ill bodies which did not fit into this economic order separated some individuals off to those special places that started to exist in all the bigger European cities.

It is thus no wonder that the first houses of confinement were built in industrial centres at times when a large number of people were threatened by unemployment (Foucault, 1988: 52). While some asylums were opened in order to give work to those suffering from the economic recession, very soon they became places where people were sent for correction and punishment. If times of recession were difficult for men, this was even more the case for women, who were less likely to be able to find a job. Many of them ended up in large rural asylums, but a significant number stayed at home, subjected to the various medical treatments prescribed for 'hysteria', one of the most popular medical diagnoses of the late 19th and early 20th centuries (Bassuk, 1986; Ussher, 1991).

Hysteria, very similarly then as during pre-industrial times, remained an illness that was known by its variety of arbitrary symptoms and images. In the 19th century it was associated with upper middle-class women, whose relatives were able to pay for medical treatment and who were seen as representatives of the new family order established at the end of the 18th century. During this period one of the political demands of the workers' unions in Europe was the fight for a 'family wage' – enough pay to feed dependent and economically unprotected members of the household. Since the family wage system promised to protect dependent wives and children with the money of the single male breadwinner it soon became a base for the larger system of social policy. The institution of family became glorified as the safest, healthiest and most natural form of human life.

The introduction of the new family wage policy also required a scientific-based gender division of labour and new arguments which served the

construction of the two predominantly separated spheres: the private and the public. It was no longer enough to prove the inferiority of women according to religious beliefs. It was necessary to use scientific proof to establish gender difference as well as to naturalize gender inequality. In the new gender order hysteria had become visible proof of an inherent female pathology, demonstrated on the surface of their bodies, in their organs and their psyches. Ljudmila Jordanova (1989) pointed out that the division which was established on the basis of bodily differences during the 19th century was the division between the masculinization of the muscles and the feminization of the nerves.

As mentioned earlier, there was a significant number of women who were locked away in large asylums, but there was an even larger number of those who stayed under the domestic control of the medical eye, and carried the image of the mad woman of the 19th century. The former, together with some men in the larger asylums, were exhibited to a wide public. Foucault reported that as late as 1815 the hospital in Bethlehem exhibited lunatics for a penny to local spectators every Sunday (Foucault, 1988: 68). Only a few years later, Jean Marie Charcot, who became a director of the women's psychiatric hospital La Salpêtrière in 1862, weekly exhibited young women who were labelled as hysterics in front of a distinguished Parisian public. The black and white photograph of him and a young woman whom he was hypnotizing can still be seen today in Vienna, in the museum of Sigmund Freud, on whom Charcot obviously made a strong impression.

Another great wave of women entering mental hospitals took place after the First World War. This time there were large numbers not only of female patients, but also of female nursing staff, since many men had disappeared on the battlefields of Europe the hospitals were forced to employ women. Having been subjected throughout the whole of the 19th century to an ideology of dependency and weakness, women were suddenly welcomed as workers in the fields, on farms and in other 'male' occupations. Those who were admitted to hospitals as psychiatric patients most often stayed because of their poverty and lack of employment. In England, for instance, the new National Insurance Act of 1911 did not cover dependent wives, daughters or domestic servants (Gittins, 1998: 25). Women who were not employed full-time but dependent on the wages of their husbands did not have any economic security when their husbands died, or if they were abandoned, or if they wanted to leave them. The mental patients in psychiatric hospitals were therefore overwhelmingly women over 65 years of age who did not have any financial protection or state pension (Gittins, 1998).

THE MORAL MESSAGE OF HYSTERIA

For most of Central Europe the last decades of the 19th century were marked by big social changes related to the spread of industrialization and the modernization of cities in the region (see Zimmermann, 1997). Such huge shifts necessitated a major redefinition of women's role and their representation in these changing societies. Some of the most influential rethinking of gender differences was carried out by the new science of psychiatry, whose practitioners were keen to acquire recognition. In Slovenia, this new branch of medicine was introduced by a number of medical doctors who were obedient followers of the western pioneers of psychiatric categorization, most often from Germany.

Here, as was the case in other European countries, hysteria became a symptom of the new femininity, attached mostly to women from wealthy upper middle-class families. The fact that many women were labelled as hysterical has to be seen as a moral message which created a new gender discourse at the turn of the century. Women from lower-class backgrounds were, on the one hand, encouraged to internalize the family values of the new bourgeois society, but at the same time warned of the dangers of becoming 'deranged' and polluted by the sickness of the weak feminine lifestyle of upper-class women. The latter were identified either in terms of extreme fragility and passivity, or, if they were actively involved in public concerns, in terms of their 'masculine' wishes. The real discipline of the new gender order was not, at least in public, carried out by force, but under the careful eye of the medical authorities, who developed an image of 'proper femininity' through the invention of 'women's diseases', among which hysteria was paramount. The medical gaze looked from the surface of the woman's body to the inside of her psyche, and through this, into the inner life of the family and directly to the child.

The beginning of the medical discourse on hysteria in Slovenia dates back to 1877. In this year an article titled 'On Nervousness', written by a Dr Edvard Šavnik, was published in *Slovene Nation*, an important national journal. Since it became an important marker for further discussions on hysteria, we should look at this article in greater detail. Šavnik's aim was to analyse nervousness 'in respect of its causes, forms and effects'. Among the causes of nervousness, Šavnik cited heredity, uncontrolled feelings, especially among women where 'the heart and sense organs prevail', too much or too little food, the effect of coffee, tea and alcohol, unsanitary dwellings, an unhealthy climate, the fear of losing property, excessively demanding work, childrearing and religious ecstasy.

The author ascertained that 'nervousness' is much more frequent due to immorality, simple-mindedness and the superficiality of 'today's world'. Furthermore, he believed that from the medical perspective, the number of 'sensory points' in the body was of crucial importance in the

development of nervous diseases. The different number of sensory points in women's and men's bodies was the crucial reason for the female predisposition to nervousness. Since the female body has less weight and volume than a male body, and a larger number of sensory points in relation to other organs and to the entire volume of the body, 'the normal sensory life of a woman is more quickly disturbed, and the effect of such a disturbance is more intense and the result more permanent' (Šavnik, 1877). The danger of women's nervousness is not only a threat to a woman herself but also to those nations 'in which woman has more influence than she was given by nature, and where she dominates over man' (Šavnik, 1877). The author cites North America as the most unfortunate example of such a place, and contrasts it with the 'happy oriental family/harem life', where the nervousness of women does not exist at all. In America and in similar countries, in contrast, 'the bodily system of women is completely pathological, that is, in poor health'. In these countries one can also observe 'the decay of moral life, the lack of virtue' (Šavnik, 1877).

In the first part of his article, Šavnik establishes the basis for the biological and essentialist differentiation between women and men and links it with a discussion on morality. The prescription of how a woman should demonstrate her femininity becomes strongly linked with the biological explanation of her bodily difference from men. The article expresses a warning to all women who might try to cross gender boundaries, either if they want to work in the paid professions or if they want to take any public role.

In the second part of his article, the writer attempts to address other dangerous elements which might threaten women's health, and offers a number of examples to clarify his arguments. Many women sin, cease to look after their bodily health, do work which is not appropriate to their gender, and consequently fall into a 'nervous state'. Since the female imagination is easier to excite and their sensory points are more easily irritated, the most important cause of female nervousness is 'women's way of life'. Šavnik first constructs the woman as the weaker creature and then tries to prove that exactly this type of weakness prevents her from doing the same activities as those done by men. Here we can see a double explanatory model, which is partly based on a biological construction of female nature and partly based on gender differences that could be proved by looking at the everyday life reality.

Šavnik stressed that a woman 'must remain within the family, in the sphere of activities determined by nature and her constitution'. It is especially dangerous for her to become a breadwinner. The latter can best be observed in North America: 'The American woman is extremely emancipated, participates actively in public life, fighting in political party discussions, which is exciting enough to the sensory points of men, let alone to those of such fragile creatures as women' (Šavnik, 1877). Furthermore,

if a woman acquires 'bad habits of civilisation', such as drinking alcohol, or 'fighting for bread', she does not only become nervous, 'she is in a great danger of becoming insane'. The way in which Šavnik distinguished between nervousness and insanity, emphasized the normality of nervousness between women who can, in extreme cases, also become insane. Nervousness was socially accepted and derived from the very nature of the woman herself. This can be blatantly observed in the second part of his article when he warns again: 'The little habit becomes a bad addiction, which turns into a disease that harms 13 percent of the sensory points, brain and mind' (Šavnik, 1877). It is obvious that the gendered moral order was not only focused on the working place of men and on women's work at home, but also on the leisure time of the latter, since all life spheres became strongly gendered and women's free time controlled to a great extent.

In addition, Šavnik draws attention to women's reproductive function. For him, women have another feature that often causes nervousness, which is her 'task given by nature'. Women have to perform their natural mission of miraculous creation but are at the same time inclined not only to nervousness but also to other mental illnesses. This appears to be the real concern of the writer, who eventually addresses all women with a moral message:

> In this short reflection I have tried to draw the attention of the fair sex to several cases who appear to have a calm surface, mostly showing their pleasant sides and humble faces, and seeming to be extremely innocent, but who are at the slightest contradiction able to show their other, bad sides, as signs of threatening nervousness. (Šavnik, 1877)

This moral warning was addressed to women themselves, since, Šavnik believed, their emotional and unstable nature seduces them into so many dangerous traps that they must, like small children, be protected from themselves. The biological gender differences were obviously of crucial importance and although some writers made the link between everyday pressures and nervousness, the women's biological reproduction remained the major cause for their weakness and pathology. Another physician, Fran Goestl, wrote in 1893 that insanity among women appears accompanied by other 'physiological and pathological symptoms' such as menstruation, pregnancy, hysteria and epilepsy.

Šavnik also paid some attention to men, who do not become nervous but melancholic. He was extremely disturbed by the case of a young man who drank tea and became melancholic. He concluded that melancholy developed in men who could not find love with a 'member of the opposite sex'. Although it is not clear if he wanted to draw attention to homosexual behaviour, but it is obvious that men's mental distress was viewed as something situational and not essentially inscribed into man's nature.

Since Šavnik still used the term 'nervousness' when he wanted to point out the problems of a 'nervous generation', writers after him started to label nervousness with another term: 'hysteria'. 'Hysteria' was both an old as well as a modern term. Since it had been used by both the ancient Egyptians and Greeks, the term also marked the victory of 'modern psychiatry' over the almost entirely somatic explanations of mental health symptoms in the past.

The moral message was the same everywhere. Hysteria or insanity is immanent in women, who because of their biological differences get ill more often than men. Being different meant differing from the normative maleness, from the norm. Much older ideas of sexual difference now became connected with women's immorality, due to dependency on substances like alcohol and drugs, work in the sphere of public life, or deviant sexuality. From the end of the 19th century, the discourse on women shifted between two extremes, the adoration of women and their procreative mission, and admonitions about their cunning nature, diminished intelligence and frequent inclination to infidelity. The writers started to use their medical authority to 'cultivate' women, since only a cultivated woman could be a proper mother and educator of her children.

After the First World War, hysteria was more often listed as a mental disease than other forms of insanity. It also became the one which women could bring with them into a marriage. In 1926, the magazine *Zdravje* ('Health') published an article titled 'Find Yourself a Healthy Bride' by a medical doctor Andrej Arnšek (1926a). In it he first draws the reader's attention to the fact that a healthy mother is of utmost importance to the health of children and the happiness of a family. He therefore finds it important to acquaint (male) readers with the risks of marrying unhealthy young women, and lists the external symptoms that a man must recognize to avoid an unfortunate bride. Arnšek claims that the character and the human soul are best reflected in the eyes, face, and the body.

Pathology and illness can therefore be recognized on the surface of women's faces. He stresses that 'strongly developed, bony cheeks, in particular the lower jaw, in relation to the skull, indicate a lack in the women's spiritual life' (Arnšek, 1926a). He also gives some more obvious examples: 'Red rimmed eyes, with frequent inflammation and hypersensitivity to light indicate scrofula, a chronic inflammation thought to cause trachoma or the "Egyptian disease", which can lead to blindness if not cured; shortsightedness, farsightedness, innate curved mouth, distorted gait, curved writing (now to the left, now to the right and now upright) shows a distorted, inconsistent, cunning, capricious mind and a character full of inner contradictions' (Arnšek, 1926a).

It is obvious that the Charcot legacy of focusing on the bodily characteristics and bodily postures was highly present among Slovene practitioners in the 1920s. Although Charcot's aim was to give a scientific

explanation of hysteria as a disease of the nervous system instead of the bodily organs and liquids, he could not free himself from the dominance of physiology, for instance the idea that the ovaries were the source of the hysterical attacks. Even more, for him it was the whole bodily surface and bodily gestures that were the proof of the hysterics. His public displays 'performed' by his patients for the Parisian public were a performance for himself as well, since he was the observer, the voyeur of different approaches to the instrumentalized bodies. Very soon after the discovery of photography in 1839, Charcot started to use it as the ultimate proof of his scientific discovery. By 1856, photography had become a part of the psychiatric documentary and its founder, Hugh W. Diamond, was himself a doctor in the female department of the Surrey County Lunatic Asylum (Furst, 1999: 25). Photography was a unique tool which was able to freeze 'reality' and became the 'objective truth' of the medical profession. The use of photography in psychiatric work in the second part of the 19th century shows that hysteria as well as many other forms of insanity were traced on the surface of the body. The body and its gestures were the narrators of the illness. Charcot even opened a photographic laboratory at La Salpêtrière, where the photograph documented the manifestations and the progress of the disease: 'The focus was on the hysteric's asymmetrical, anaesthetic face, and particularly on the eyes as the most evident expression of a disease believed to stem from a lesion in the neutral network that controls the eye' (Furst, 1999: 25). For Arnšek also, the illness of a female patient was seen in her eyes and other bodily appearances.

Beside the bodily narratives captured by the gaze of the psychiatric camera, women had no narratives of their own. Women's stories were pierced and wounded by the stories of others: medical professionals, lawyers, priests, new philanthropists and the photographer. Most Slovene writers from that period stressed that the woman must have control over her overdeveloped sense of passion, which meant control over her 'nature' and her body. Beside medical texts in a similar vein, another type of article began to appear at the end of the 1920s. These advised women how to subject their bodies to physical exercise, which could help them to master an unbalanced inner self, interwoven with sensory points. In Slovene newspapers numerous articles with similar titles were addressed to a female audience: 'Modern Woman and Physical Education' (Šlibar, 1929), 'Sportster, Wife, Mother and Housewife' (IST, 1933), 'Gymnastics for Housewives' (A.D., 1933).

Even psychoanalysis, which was, as Foucault pointed out, 'established in opposition to a certain kind of psychiatry, the psychiatry of degeneracy, eugenics and heredity' (Foucault, 1980: 60), appropriated women's narratives while giving them the opportunity to talk. The beginnings of psychoanalysis are marked by an ambiguity that was never solved: while discovering the 'talking cure', it freezes the stories of women

in the ice-blocks of envy and castration. Women's stories remained damaged stories, which some women internalized as a 'moral truth' of themselves, while others tried to resist their structural power.

ECCLESIASTICAL CONCERNS: SEXUAL MATTERS

It seems that ecclesiastical discourse also wanted a more 'scientific' understanding of 'woman's nature' at the turn of the century. One of the most influential articles to come out of the church was published by Anton Skubic, an influential priest, in 1909. He titled his work 'Hysteria and Spiritual Pastorage'. It is evident that the writer's aim was to protect young priests, to whom hysterical women were most likely to come and who 'bother a priest with all their importunity' (Skubic, 1909: 59). Owing to the immoral nature of hysterical women, they can set numerous snares for an unsuspecting priest, or accuse him of abuse, if he trusts them blindly or tries to help them. Skubic states: 'Under the cloak of religious reverie is often cunningly hidden a sexual hunger similar to nymphomania, which is capable of deceiving the environment, and even young doctors or priests, in a most unfortunate manner' (Skubic, 1909: 59).

The church saw sexuality as the most dangerous symptom of hysteria. Skubic stressed that very often 'premature sexual desire' could cause hysteria. His instructions continued:

> A hysterical person can often be recognized very quickly. Nervous restlessness causes a pronounced bizarreness in her behaviour. The paleness is due to lack of blood. If such a woman happens to exert power over her relatives – as is the case with housewives – then she will be the centre around which everything has to turn. Her impatient character makes her tyrannize the vicinity; the attention and fears of which are retained by her nervous complaints and convulsions. Her unstable will is law, and if she is not obeyed the most diverse nervous symptoms are manifested; she laughs or cries, is seized with convulsion – all just to attract attention. But there are also other persons who hide their disease in a sophisticated manner. They are as white as a sheet and have very fragile figures, they are patient and kind, but at the moment of any bodily transformation, in particular before the menstrual period, the disease erupts. In general, doctors say that hysterical manifestations are most powerful and most frequent at the time of the menstrual period; hence the old-fashioned conviction that hysteria is only some sort of a venereal disease. (Skubic, 1909: 60)

Skubic not only wanted to give instructions on how to recognize a hysterical woman who is trying to attract the attention of doctors, relatives and priests, he also wanted to educate priests on how to protect themselves in such cases. His major argument was trust: a young priest should not trust a woman, since a hysterical woman often deludes priests with

stories about fantasies she has had. He continues that such fabrications usually include a great deal of malice, mischief and wickedness, which can completely destroy an honest priest. Most threatening to a clerical career are those women who couple their wickedness with a strong sexual desire: 'One single innocent word, one single cheerful smile and such a woman starts thinking of *venerea*, and in her diseased malice is capable of slandering the priest, yes, she is even capable of swearing that he wanted to ravish her' (Skubic, 1909: 60)!

Whereas the popular articles written by the medical authorities were addressed to women themselves, the ecclesiastic articles were aimed at a male public, especially young priests: 'If a priest devotes any of his attention to such persons, even if only by lending a sympathetic ear to such idealistic talk, then such persons become unbearable monsters and will follow him everywhere' (Skubic, 1909: 61). Skubic's writings are blatant examples of denied gender hegemony seen in the phenomenon of the hierarchical turn, wherein he drew the line between the innocence of priests and the evilness of women. The hierarchical turn can be said to be the point where someone with less social power is viewed as the one who controls and decides for the one who is in reality more powerful. In spite of the well-documented economic, social and symbolic power enjoyed by priests in rural communities such as Slovenia, Skubic portrayed priests as the victims of women who appear to be the ones with more power.

HYSTERIA BETWEEN PLATO AND CHARCOT

During the centuries in which hysteria was initially an illness of the womb which also influences other organs (Plato, Hippocrates, Galen), and later an illness of different bodily organs and of 'reason' (Paracelsus), it slowly became connected with damage to the brain. (Schaps, 1982; Schuller, 1982; Suleiman, 1986; von Braun, 1988). Nevertheless, the idea that it is the womb which causes brain damage never completely disappeared. In the 17th century, Edward Jordan developed the theory of vapours that come up from the womb to the head and can cause damage to the memory, imagination and intelligence. Well-known doctors from the end of the 17th century and the beginning of the 18th century, such as Cullen, Sydenham and Pinel, were already using the word 'neurosis', and for Pinel hysteria was a 'genital neurosis of women'.

Hence, what remained in the 19th and at the beginning of the 20th century was a strange mixture of different theories floating around within medical and public discourses. In the Slovene article by Anton Skubic mentioned previously, there was a most interesting description of a hysterical fit:

> Hysteria has its base in the head, in the cerebrum (*Grosshirn*), from where it visits first this organ, then another one, first it attacks this nerve and then another one; the entire body with all its organs can successively become victim to this disease. (Skubic, 1909: 59)

His description is a meeting of the ancient Greek understanding of hysteria and a more modern one, which was gaining ground with those attempting to establish neurology as a branch of medicine. The hysteria which visits organs around the body is an old remainder of the Platonic understanding of the disease found in Timaeus. According to Plato's understanding of the universe, all diseases arise from the defects, imbalance or changes in the natural places of the four elements of which a body consists: earth, fire, water and air. For Plato one of the 'disorders of the soul' is madness (Hamilton and Cairns, 1996: 1206), under which he also classifies hysteria, the illness of the womb which moves within the body and brings other organs into disorder. Like so many other writers both before and after the Middle Ages, he suggested procreation, sexuality and marriage as successful treatments for hysteria:

> The animal within them [i.e. within the uterus], is desirous of procreating children, and when it remains unfruitful long beyond its proper time, gets discontented and angry, and wandering in every direction through the body, closes up the passages of the breath, and, by obstructing respiration, drives them to extremity, causing all varieties of disease, until at length the desire and love of the man and the woman, bringing them together and as it were plucking the fruit from the tree, sows in the womb, as in a field, animals unseen by reason of their smallness and without form. (Hamilton and Cairns, 1996: 1210)

This Plato idea, so alive at the beginning of the 20th century in Slovenia, shows a coexistence of a huge diversity of discourses across European regions at that time: from an entirely somatic understanding of mental health symptoms to more and more psychologically oriented treatments and explanatory systems such as psychoanalysis.

Almost 30 years after Skubic's description of hysteria, another doctor, called Arko, published an article with the title 'Hysteria' in a non-medical journal. Arko's description of a hysterical fit was very similar to Charcot's descriptions of a *grande hysterie*, as Charcot called the impressive hysterical attacks suffered by his patients in the La Salpêtrière. Arko described a serious hysterical fit as follows:

> Prior to a fit there are hallucinations of sight or hearing, vomiting, trembling, dizziness, patients feel as if something was coming up their gullet; finally they become unconscious, although not completely. This stage is followed by a phase of spasms, just as with epilepsy. A patient falls on the floor, the entire body seized with cramps. This leads to clown-like gestures. Patients form a bridge i.e. they touch the floor with only their head and feet, with the

> rest of the body curved upwards. Then there are different poses such as ecstasy, fury, infatuation, etc., followed by a stage of delirium manifested in screaming, preaching and later on singing and crying; finally the patients calm down again. (Arko, 1935)

There was also a type of minor hysterical attack, which Charcot called *hysterie mineure*, which was described under Arko's list of 'marginal hysterical symptoms' such as: blinking, snorting, yawning, hiccuping, sneezing, stuttering, and muteness (Arko, 1935).

Arko himself was ambivalent about whether to understand hysteria simply as a hereditary disease caused by infections, or as a way that women manipulate people. He pointed out that many women show a lot of symptoms 'although their blooming faces suggest a healthy person' (Arko, 1935). Medical doctors were, as Arko shows, highly influenced by other discourses on gender which were busy to distinguish women as biologically and morally inferior to men. Arko therefore stressed that: 'Typical are fighting fits of women who soon recover their senses when nobody pays attention to them or when they hear an unkind word from their relatives' (Arko, 1935). Apart from women, children – similar to women in their emotional nature – could also get hysteria. In 1930, a physician called Ivan Theuerschuh wrote an article titled 'Occurrences of Hysteria in Children', in which he explicitly drew the link between women's and children's (of both sexes) hysteria: 'Women and children are especially susceptible to suggestion, which is not the case with men, who are inclined to logical thinking. This is the reason for widespread hysteria among women and children' (Theuerschuh, 1930).

The discourse on women's hysteria, however, could not have influenced the discourse on gender to such a great extent if there had not been other powerful debates which tended both to reveal illness as a social pathology and to promote health. These debates became part of a new social medicine. Two of them were especially powerful: the one on prostitution and the one on eugenics.

THE HEALTHY DISCOURSE: THE 'HEALTH POLICE'

As pointed out by Sander Gilman (1994: 326), 'fin-de-siecle medicine madness was marked not only on the face but also on the genitalia'. Each country invented its 'health police' to discover, control and punish particularly women prostitutes, who were the 'embodiment of the degenerate and diseased female genitalia in the 19th century' (Gilman, 1994). The Slovene discourse on social medicine was strongly influenced by the Italian psychiatrist Cesare Lombroso, who established a 'health police' in Lombardy at the end of the 19th century. In his anthropological survey of

the human physiognomy of prostitutes, ill persons and lunatics, he tried to find scientific proof to label poverty, illness, prostitution and madness as social pathology. His work greatly influenced the well-known Slovene anthropologist Božo Škerlj, who founded the Department of Anthropology at the Institute of Hygiene in Ljubljana in 1929. Lombroso tried to stop an infectious disease called Lombardian leprosy (pellagra), which was spreading among poor farmers in this area. Some people from the region also called it 'the poverty disease' (*male della miseria*). Lombroso established a network of medical inspectors who surveyed the living and working conditions of the rural population. He eventually denied any connection between pellagra and poverty, but claimed that pellagra was an illness of a toxic-infectious origin. In order to prevent an epidemic he set up a 'health police' whose job it was to divide healthy from unhealthy individuals. First they separated children from infected families and sent them to institutions, and later they also segregated adults into lunatic asylums.

In Slovenia, similar 'health police' practices emerged after 1915, when numerous articles raised the issue of venereal disease, which was seen, as one medical doctor claimed, not so much as a medical matter, but 'first and foremost a moral issue' (Derganc, 1916). Derganc therefore suggested a segregational practice, which was gradually adopted all over Europe: 'Promiscuous people are either patients or criminals and as such should respectively, be put in a mental hospital or prison' (Derganc, 1916: 14). In terms of the medical world at the turn of the century, the criminality of women was closely connected with their sexuality. It was thus no wonder that the most important debates on health as a moral concern were the studies of prostitutes and the eugenics debate. Both were strongly influenced by the anthropologist Božo Škerlj, who in the 1920s began, as he called them, his 'anthropological studies of inferior children and prostitutes'. In his scientific manner, Škerlj completed social-anthropological research on the genealogies of 30 prostitutes from Ljubljana, their social environments and their physical characteristics (which he conducted with anthropological surveys between 1929 and 1932). He linked the personal characteristics of prostitutes with his research on the 'moral destruction' spread by women who deal with sexual matters. He tried to establish a distinction between the prostitutes who came from lower social classes and entered prostitution because of their 'moral weakness', and those women who came into prostitution from a better social background and embarked on sex work because of their 'psychopathy' (Škerlj, 1930b, 1930c, 1930d). Since Škerlj clearly did not recognize that for some women sex work was the only available – and, paradoxically, encouraged – paid occupation, he connected prostitution with either the moral issue or with mental illness. His use of the language, as, for instance, 'female psychopathy', is obviously an allusion to psychopatia sexualis, a psychiatric

diagnosis which marked all 'perverse pleasures of adults' at that time (including promiscuity, homosexuality, nymphomania, masochism, sadism and fetishism).

The word was invented by the well-known Austrian psychiatrist, university lecturer and asylum director Richard von Krafft-Ebing, who wrote his book *Psychopatia Sexualis* in 1886, and whose interest had hitherto been predominantly focused on forensic psychiatry. Psychopatia sexualis became the first medical classification of sexual disorders. The importance of Krafft-Ebing's work, as has been pointed out by Renate Hauser, was predominantly due to the shift towards psychology which happened in the field of sexual sciences: 'Sex had moved from the physical body into the "soul" and was no longer located in the genitals, but rather in the brain' (Hauser, 1994: 215).

In both *Psychopatia Sexualis* and his later work, Krafft-Ebing used a clear gender division when describing various sexual behaviours: the subordination of women was for him a physiological phenomenon due to their procreative function and manifest in their voluntary submissiveness within sexuality. Woman is more dependent and man more autonomous but also more ruled by his sexuality (Hauser, 1994). This clearly meant that though prostitution was a problem, it was not discussed as one of men's morality but as a problem of the morality of women. Since sexuality was not seen only as a bodily function serving the purposes of procreation, but also as a psychological fact, the science of sexuality moved closer towards psychiatry and to the idea of curing sexual disorders. Within this framework it is easier to understand Škerlj's distinction between prostitution as 'moral weakness' and 'psychopathy'. Since the former is widespread among lower-class women, it can be cured by moral order and health control, while the latter can be cured as a psychiatric illness or mental disorder. Lower-class women could be punished by sending them to houses of correction, while upper-class women could be controlled as patients at home under the guard of family members and doctors. The distinction reveals the pathologization of poverty as a form of social deviancy. Lower-class women were seen as more deviant and symbolically polluted and were therefore put under surveillance through spatial segregation (houses of correction, madhouses). The middle- and upper-class women were seen as curably ill and were monitored by the urban health police practices, as, for instance, by the symbolic control of psychiatric diagnosis.

By the late 1930s, it became clear that the psychiatric discourse was coming into conflict with the eugenics movement. While medical doctors and psychiatrists were in favour of building new mental health hospitals, some other advocates of 'health police' suggested a strict eugenic policy. Božo Škerlj for instance claimed that institutions cost the state too much money. Instead, radical eugenic methods (castration, sterilization) should be employed, especially for 'biologically inferior' and 'sick individuals'.

Škerlj considered that the very fact that 'the healthy part of society has to support the inferior' was unethical (Škerlj, 1933: 70). It is evident that early Slovenian anthropology walked hand in hand with social medicine, whose medical procedures were in the service of social control and violence against physically or mentally disabled persons as well as all those who were labelled as immoral. In 1932 Škerlj himself published an article in a medical journal titled 'Anthropology in the Service of Social Medicine' (Škerlj, 1932a). But by 1930, Škerlj had already begun to promote the eugenic policies through which reproduction of biologically inferior and ailing individuals was to be prevented: 'Eugenics is urgently needed, and a biological, eugenic policy must be the ultimate goal of all societies and leaders who cherish their states, otherwise there is a threat that states and societies will decay' (Škerlj, 1930a). He believed that society could only be saved by both positive and negative eugenics, since inferior people 'reproduce themselves excessively', whereas the 'superior are becoming extinct'. Positive eugenics was based on the elimination of 'abnormal individuals' by placing them in various institutions, and on giving financial support to 'superior individuals' at childbirth (Škerlj, 1930a). Negative eugenics, on the other hand, required 'sterilisation of those that have been established as inferior by scientists' (Škerlj, 1934b). For Škerlj the first rule of eugenics was that 'the individual is less than the whole' (Škerlj, 1934c).

Clearly, it was not only the discourse about hysteria that influenced the normative image of femininity, but the normality discourse also embraced the debates about health, sexuality and reproduction. The 'health police' entered petit bourgeois households either directly via the medical gaze, or indirectly via the public images of normal femininity. Normative images were also addressed to all those women who wanted to become closer to the bourgeois lifestyle, since they were responsible for raising children, and, through them, for the whole nation. This was best demonstrated in the writings of another medical doctor, Matija Ambrožič: 'The entire household is in closest relation to the national health. If a wife is a good housewife, she has accomplished more than half of everything that the rules of hygiene demand of her' (Ambrožič, 1925).

The criminalization of prostitution and its links with medical and eugenic discourse has to be understood as a part of the European ideology of 'faulty genes' current at the beginning of the 20th century (Pilgrim and Rogers, 1996). Since both mental illnesses and prostitution as a form of 'mental degeneration' were seen to be a result of brain disease caused by 'faulty genes', there had to be an effective policy to prevent such people from biological reproduction. They should not be allowed to reproduce themselves since their life was defined as 'life devoid of meaning' (Gittins, 1998: 19).

The history of hysteria offers an overview of the short-term and a long-term historical legacy of pathologizing women. Both legacies culminated

in the early 20th century with a large number of women being admitted to psychiatric hospitals and in current days where women are still overmedicalized and too often treated as inherently mentally distressed (Suleiman, 1986; Ussher, 1991; Zaviršek, 1997).

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