Women’s madness: Hysteria to hospitalisation, Misogyny or mental illness?

Why are women overrepresented as ‘mad’? Who decides these women are mad, society, biology or medicine? Is female madness a response to abuse and stress - including the lifelong stress of second-class citizenship?

Is it not surprising that an ‘institutionalized inequality produced by social definition [does] not exact a psychological price upon the inferior group’?

“We educate women to expect equality in many cases, and then we expect them to be happy with the crumbs from the table. It is no wonder we feel mad” (Ussher, 1991)

In Women and Madness Phyllis Chesler questioned the social construction of mental illness stating that it was an expression of female powerlessness and of the attempt to overcome it. She argued that notions of madness were linked to conventional understandings of masculinity and femininity and could be seen as ‘norm’ violations. Deviations from accepted attributes of masculinity and femininity were understood to be madness. However, women were more likely than men to be ‘mad’ because of the inherent characteristics of the ‘well-adjusted’ woman, who was meant to be submissive, emotional and dependant.

During the 1950s and 1960s, clinicians were still being taught that women suffer from penis envy, are morally inferior to men, and are innately masochistic, dependent, passive, heterosexual and monogamous. We also learned that it was mothers - not fathers, genetic predisposition, …and/or poverty- who caused neurosis and psychosis. None of my professors ever said that women (or men) were oppressed or that oppression is traumatizing – especially when those who suffer are blamed for their own misery and diagnostically pathologized….We believed that women cried “incest” or “rape” in order to get sympathetic attention or revenge…In my time, we were taught to view women as somehow naturally mentally ill. Women were hysterics…malingerers, child-like, manipulative, either cold or smothering as mothers, and drive to excess by their hormones. We assumed that men were mentally healthy. We were not taught to pathologize or criminalize male drug addicts or alcoholics, men who physically battered, raped or even murdered women or other men…. [W]e were trained to understand and forgive such super-manly men (“boys will be boys”) (Chesler, P. (2005) Women and Madness. 2nd ed. New York & Houndsmill: Palgrave Macmillan.pp.1-2.)

Hysteria

The roots of hysteria (from hysteros meaning womb) can be found in the ancient Greeks and Egyptians. Based on idea of the womb as a free flowing entity which when a woman was unhappy could leave its moorings and move around the body causing chaos. Hysteria could cause both physical and mental symptoms.

‘the womb is an animal which longs to generate children. When it remains barren too long after puberty, it is distressed and sorely disturbed, and straying about in the body and cutting of the passages of the breath, it impedes respiration and bring the sufferer into the extremist anguish and provokes all manner of diseases...’ Plato

Hospitalisation

‘Madwomen seized with fits of violence are chained like dogs at their cell doors, and separated from keepers and visitors alike by a long corridor protected by an iron grille; through this grille is passed their food and the straw on which they sleep; by means of rakes, part of the filth that surrounds them is cleaned out’ (Foucault, 1967. P. 62)

(Foucault, M. 1967: Madness and civilization: A history of insanity in the age of reason. Tavistock, London)

40% more women are admitted to mental hospitals than men
Treatments for schizophrenia have some strong symbolic associations with feminization and with the female role. From the 1930s to the 1950s, the main English treatments for schizophrenia were insulin shock, electroshock and lobotomy. Despite the ethically dubious nature of these treatments and their relative ineffectiveness none has been completely discredited, and all are still active, albeit in a diminished capacity. In the case of each, women are both statistically and representationally predominant as patients, especially that of lobotomy. Since 1941 the majority of the 15,000 lobotomies performed in England have been on women. 2/3 of all patients lobotomized were schizophrenics

The rationale behind female lobotomy: “psychosurgeons consider that the operation is potentially more effective with women because it is easier for them to assume or resume the role of a housewife” (Smith, 1977, p. 29)


The case of Martha Hurwitz

Henry Cotton a prominent doctor at Trenton State Hospital New Jersey, previously named Trenton State Lunatic asylum. Cotton carried out, in the name of ‘focal sepsis’, a chronic pus infection which poisoned the brain, a vast array of surgeries ranging from tonsillectomies, gastrointestinal surgeries in addition to the removal of teeth. During which he mutilated and killed thousands the majority of which being women.

Martha Hurwitz was brought to the Asylum on December 28, 1928, from her parents’ house [...] She had been born in Russia in 1902 and had arrived in America 1921, marrying some four years later. But her husband turned out to be a drunk and a ne’er do well...Within two months he had deserted her...and stopped paying her court-ordered maintenance... [Martha] soon fell into a depression, ceased to work and became intermittently violent...For a time she was “quiet and gave no trouble” but she has a fall an broke her ankle on the day she was admitted to Trenton, and became talkative and restless, prompting her family to bring her to the state hospital. Provisionally diagnosed as a case of “Septic Psychosis, Schizophrenic Type” ... “Defocalization, institutional and symptomatic treatment” was ordered and ...she received three doses of typhoid vaccine, had a tonsillectomy and several teeth were extracted...In the late summer of 1929, while she was in the midst of divorcing her husband, she fell and broke a leg. Together these events seem to have precipitated another crisis and her mother and brother brought her back to the hospital, complaining that in the aftermath of her accident she was “very nervous and excitable.” ...All her remaining teeth had been removed, rendering her edentulous. Next her doctors turned their attention to her Gastro-Intestinal Tract....With her resistance defined as pathology, and her refusal to share her captors diagnosis of her problems interpreted as a lack of insight, more vigorous efforts were not directed at Martha’s mysterious mental state. She found herself subjected to twenty colonic irrigations...Calcium therapy was tried, along with coagulation of her cervix. Her sinuses were punctured in the search of more sepsis.

(Scull, 2005, pp.241-245)

Martha ...had a third mental breakdown in 1932, remained there for five years, being discharged in 1937. Her admission on March 14 1938, was to prove her last....On September 13, 1938 she had a course of insulin coma therapy. By January 1940...she had received fifty insulin treatments, and her condition was deteriorating. In 1943, her doctors inoculated her with malaria....In 1949 she was given a series of electric shocks...Martha was selected for experimental treatment with Reserpine. At frequent intervals, the dosage she was given was doubled...In 1956, she began a similar trial of Thorazine, and then in 1957, was
given another rapidly escalating course of Reserpine…..Finally in the early 1980s…
notwithstanding the fact that she was now a burnt-out case, a demented old women who has
somehow survived repeated surgeries, the extraction of all her teeth and tonsils, fever
therapy, insulin comas, electric shocks and massive drug overdoses….she was scheduled to be
“deinstitutionalized” and released back into the community.
(Scull, 2005, pp.294-296)

She [Martha] is a distressing example of a patient whose chronic craziness was more than
partly induced and certainly exacerbated, by the tortures of asylum life shores up both the
broad and narrow claims if the anti-psychiatrists by highlighting the power of the asylum as a
total institution, the dangers of unchecked medical experimentation on vulnerable people and
of the treatment fads the profession is prone to. By the 50s and 60s the catch-all diagnosis of
schizophrenia has become so widespread…that any normal person could find herself
incarcerated and unable to leave the institution once its threshold had been crossed.’
(Appignansesi, 2011, pp. 399-400)