WOMEN EXCLUSION PRACTICES IN INSANE ASYLUMS - PORTO ALEGRE/BRAZIL, 1940s

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ABSTRACT
The article discusses historical aspects of the social exclusion of women considered mad and admitted to the São Pedro Psychiatric Hospital of Porto Alegre (HPSP) during the 1940s. Data was collected from hospital (medical records) and journalistic sources. We discuss historical parameters of insanity and their sensitivities relating to females in Brazil (Rio Grande do Sul). The theoretical aspects of analysis are related to the History of Sensitivities (Cultural History).

KEYWORDS
Sensitivities; social exclusion; women; insanity; insane asylum.

Women in Insane Asylums

The following three cases are taken from medical records relating to the 1940s, in the São Pedro Psychiatric Hospital (HPSP) in Porto Alegre (Rio Grande do Sul - RS, Brazil) and are stored in the Public Archives of Rio Grande do Sul in Porto Alegre. They represent a tiny sampling of the many stories of hospitalized women, who were, like all other patients, treated with the same organicist techniques used at the time (insulin therapy, shock by cardiazol and malariatherapy\(^3\)). Most of them were discharged without a cure, as stated in the records. Their life stories and the reasons why they “went mad” were never taken into consideration. Homogenizing means of therapy were generally used, including the preconceived discourse about women at the time. These cases are considered under two different prisms: the psychiatry of the time and the cultural history of sensibilities.

Case 1 - Female, 37, housewife, from Porto Alegre. [Information obtained from medical record No. 12182 of the São Pedro Psychiatric Hospital of Porto Alegre; Box 485; 1941]

She was sent by the police chief and we have the following story told by her son (reported in the “commemorative sheet”, data collected by social worker): “Six years ago she became a widow. Three years later she ordered her husband’s tomb to be opened to remove the bones, but that was not possible as the body was found to be preserved. She was very impressed and turned to spiritualism and managed to speak to the spirit of her husband, and he told her the doctor who treated him had given him an injection that killed him because the doctor was in love with her. She also turned to fortune tellers and had the same

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\(^3\) At the time these fell under the general designation of “convulsive therapies”, i.e. techniques that caused seizures and that would cure the insanity symptoms, particularly hallucinations and delusions. See SANTOS, 2013.
confirmation. Every year she keeps having the grave opened and the body is always found to be preserved. She then decided to tell the police about the crime that the doctor had committed. On this occasion she was taken to this hospital”. Upon examination, the doctor, downtown, says: “Calm, oriented, normal exam. Went to the police station, searched Dr. W. working there, accusing him of killing her husband five years ago. Came to this conclusion because this Dr. tended to her husband at 11 am and he died at 11 pm. That doctor did so because he fell in love with her and she claims to have been sought by him numerous times after her husband’s death. It is evident that the patient has been systematizing an erotic delirium, based often in morbid interpretations. She has no education and only knows how to write her name”. The diagnosis for this patient was “sensitive paranoia”. She was treated once with convulsive therapy (type non-specified) and was discharged within a month (with no improvement) to be cared for at home.

We can only ask what supports this doctor’s conduct. Several other patients received high doses of drugs and several sessions of convulsive therapy for similar delusional symptoms (not in content, but in intensity), but she was discharged after a month (a very short time for the average admission)? We can also think of “compulsory medical immunity” as a doctor was accused of the husband’s death (perhaps by therapeutic error). Some variants are at stake: for example, the accused doctor worked for the police. Couldn’t this be a true story of seduction, like the many in literature and even in historiographical texts? The patient’s imaginary was denied as a reality, whether actual (real case of seduction where the other person was killed) or symbolic (psychological). Once again, it was disregarded as a fact that acted in this particular person, and therefore should have a place in the patient’s treatment of this patient (was she?). In other words, ravings are historical. Erotic delusions can be cured when they occur, if the contents are adequately worked on with the person. In most cases they are symbolic of specific sexual problems. Perhaps what has contributed to the dismissal of this story as a delirium was the fact that the patient had sought an “explanation” in spiritualism. Resorting to spiritualism (and its imaginary) was common practice in our country in this period, but this practice was considered inappropriate for the scientific thought increasingly settling in the medical community. Yet none of this was taken into account. What was left was “discharged to be cared for at home, without improvement”.

CASE 2—“Female, 12, student, from Porto Alegre. Diagnosis of schizophrenia. She was a private patient, i.e., whose family funded the whole treatment. [Information obtained from medical record No. 11631 of the São Pedro Psychiatric Hospital of Porto Alegre; Box 485; 1941]

Admitted July 1941. She was transferred from isolation at the St. Joseph Hospital, where she was hospitalized with typhoid fever. In this hospital, she was in a state of psychomotor excitement, anxious mood, physically weakened and clouded of consciousness. Cried a lot and had no appetite. The recommended treatment for the diagnosis of schizophrenia were numerous sessions of insulin therapy (hypoglycemic coma), totaling 60 in this hospitalization alone. She started to show intolerance to insulin on the first session, and had a serious seizure during the coma. Still, though the patient was “under observation”, the sessions continued. A few days after admission she had the following medical developments: “Upon arrival at this hospital, [the patient] presented a typical clinical picture of confusion. She showed improvements on the short term, becoming a close friend of the sisters. Afterwards she became agitated. After one week of psychomotor excitement, she entered a phase of indifference,
not looking for the sisters as before. She was taken to the insulin therapy service and her mental state has rather improved, as has much of the somatic. Today she presents well-nourished to exam, and apparently with a well-suited attitude. She does not make eye contact and the nurse tells the patient does not look at anyone. Keeps the labial commissure slightly skewed to the left. Sometimes outlines a disheartened smile. Speaks only if questioned. Answers correctly. Is focused on the self, place and time. Sometimes needs some insistence to reach the end of the answer. Shows no incoherence of thought, does not manifest delusions and denies pseudo-perceptions”. The patient’s unstable condition continued, with various complications upon insulin administration (fever, convulsions). In early October she left the hospital to spend the day out at the request of her father. Four days after this outing, it is noted in the chart that all previous symptoms cleared, she presents easy communicability, is well suited and consistent and has behaved well on the outing with her father. Her somatic state is excellent. She was discharged December of the same year, with a note stating that she showed resistance to insulin and was cured of acute mental disorders.

This patient was then re-admitted in February 1945, now 15 years old. She lived in Venancio Aires, upstate. She was in a state of agitation, with logorrhea, abundant gesticulation and speaking theatrically in a declamatory tone. The administered treatment is electroshock therapy⁴, many sessions. In April, the excitation manifestations have dissipated, and she is “calm, adapted and coherent. Works in the laboratory with interest”. In May she is recovered from the psychotic state and can go on an outing in the company of family (father). Upon return her mental state has worsened and she is indifferent, with incoherence of thought and language, disheartened laughter, disregard of attire. She was then subject to treatment with electroshock therapy. Still in May, there is a note in the chart saying “the patient has not menstruated in months”. Later this month, after several sessions of electroshock therapy, she once more leaves the hospital for the day in an outing with a family member (undisclosed) and “behaves in a suitable manner”. In July, after a few more sessions of electroshock therapy, she is discharged, lucid, calm and consistent. In April 1952 she was admitted to the Mental Prophylaxis sector of this hospital, which was an open service, now called outpatient. There are no major notes in the chart on this period. In May 1953 the hospital received a letter from the Canoas deputy, asking if she really was hospitalized there from 1941 to 1944 and justified this question by saying “there is in this police station a police investigation favoring her, which would be the offended”. She tried to sue her father. At this time the patient was 24 years old. There are no other data in the chart and the story reported in this source ends here.

Analyzing this case, we would primarily see: if the initial disease was proven to be typhoid fever, symptoms of agitation and confusion could be explained by this toxic presentation. The diagnosis of schizophrenia was unnecessary to accommodate these symptoms. If the patient already showed intolerance to insulin therapy, why continue to an extreme where she had seizures and then became resistant to the point of no longer entering the induced coma? This treatment lasted from July to November. In December she was discharged. Mid-

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⁴ This treatment instituted in the HPSP in 1944. Advocated and initiated in Europe by Cerletti and Bini in 1938, it largely replaced pharmacological convulsive treatment. It is done with the patient under anesthesia. Its use is extensive and indiscriminate until the present day. At the HPSP it was also used by the sisters to punish patients, as reported by patients, mainly with vaginal electroshock.
way through this hospitalization she went on an outing with her father, and according to him, behaved “well”. When she was readmitted in 1945, electroshock therapy had become the preferred treatment. The teenager, then 15, received around 30 shock sessions. It is reported that in May (she returned to the hospital in February) she had recovered from the psychotic state. Then, two days after this statement, she goes on an outing with a family member. Her mental status worsens the next day, and her chart reads: “proceed with electroshock therapy”. The next “developments” in the chart (on the following two days): “Improving mental state” and “has not menstruated in months”. She goes out of the hospital again with a family member and “behaves well”. More electroshocks. In June, she is discharged - cured!

There are some contradictions and some unknowns in this case. The first contradiction is that schizophrenia had no cure according to doctors at the time. Also electroshock therapy was administered even when the patient did not have “psychotic symptoms”. And what was the problem with her body that caused her not to menstruate? Was she pregnant? And who was with her on her outing? Generally she went with her father. “Well-behaved” depends on the beholder, depends on what you mean about what happened. What does “disregard of attire” mean? This condition was described after an outing with her father. And what could have been the aggression she suffered, which led her to make a complaint at the police station in 1953? As a “private” patient many things could have been done with the family’s agreement.

Little is said about her imaginary, but these symptoms of confusion, irritability, and “theatrical speaking” could symbolize some fact or psychological problem that she had difficulty speaking about. But the main fact is the suspension of menstruation, which suggests a pregnancy; and then, when she became of age, there is an office of a deputy accusing her father of something. Could not this be a case of sexual abuse that made the girl “go crazy”? Much can be discussed on this matter, and this is not the place.

CASE 3 – Female, 22, housewife, married, from Rio Pardo. Diagnosed with schizophrenia. [Information obtained from medical record No. 12127 of the São Pedro Psychiatric Hospital of Porto Alegre; Box 485; 1941]

In the “commemorative sheet”, filled in by the social worker and with information given by the patient’s husband, we find the following story: “Four years ago, a month after the birth of her first child, the patient was washing clothes in a stream when she took a big scare caused by a snake. She started to cry a lot and to speak nonsense and then fled to walk on the road. She had visual hallucinations, but did not explain what she saw. She would not stay in a dark room. A month later she was healed. These symptoms, however, repeat whenever the patient “has family” [i.e., has a child]. Two weeks ago, i.e. two weeks after the birth of her last child, the patient was again upset. She cries a lot and tries to escape. It gets worse at night. She jolts when she goes to sleep and has severe headaches. She complains of chest pain and practically does not eat”. Investigating the rest of the chart, one finds that this woman’s first son died a few hours after birth (four years previously) and she has, at this moment, three living sons. She married at 19, with a 30-year-old man. The doctor’s note reads as follows: “Tired physiognomy. Attentive look. Incomplete answers. Partly oriented to in the self, disoriented in place and time. Left at will, she will remain in silence, side facing us. Does not gesticulate. Poor mimicry. Yesterday afternoon she presented a motor excitation crisis and was aggressive. She walked from side to side, shouting, assaulted other patients and did not listen to nurses. Certificate information is rather instructive. Since her first child, a few
days or a month after birth, the patient has mental disorders similar to those already registered. Diagnosis: delusional syndrome”. In this hospital her treatment are several seizures with ‘cardiazol’. She was readmitted in 1957 and had several sessions of electroshock therapy (and there is no reported history apart from this one, 14 years ago). The first page of her record, where the patient’s identification data is, reads: diagnosis- schizophrenia.

It is noteworthy that, although the doctor qualified the information gathered by the social worker as “instructive”, this knowledge does not alter the administered treatment and medical management of the case. Electroshock therapy is used once again in the absence of a deeper and more humane understanding of this woman’s life, that is, the loss of her first child. A closer look will find that she has a “delusional” crisis every time she “has family”, that is, every time she gives birth. We call this postpartum clinical picture of “puerperal psychosis”, described as a psychosis that affects the mother within the first thirty days after childbirth. Symptoms usually include: severe depression, delusions and/or hallucinations related to the child (their death or disability, or that the mother tries to kill them) or even the denial of birth and belief that she is still a virgin. Its etiology, both for obstetricians and psychiatrists, is related to a preceding underlying psychosis (i.e., there were latent symptoms of mental illness before pregnancy) or an organic brain syndrome, caused by toxicity (e.g., the ingestion of some drugs, such as potent analgesics, which produce these symptoms).

Anyway, and this is what we are trying to demonstrate in this paper, this patient’s delusional presentation was anchored in a real historical experience: the neonatal death of a child. Yet this was not taken into consideration; personal history is buried once more. This was surely a problem the patient did not deal with, and every time she had another child, that past experience returns in her imaginary. At the same time, however, we must not establish such a rational a causal relationship with this fact. If it were so, the mere fact of telling it to the patient might already have cured her (it is almost certain that someone, a family member or friend, may have mentioned this situation to her). But remember the snake. The snake, a “cold-blooded” animal, represents a basic human instinct connected with “visceral” reactions. Often it symbolizes fear before certain events, irrational fear not controlled by reason. Jung (2012) states that because of their poison, dreams of snakes often precede physical ailments. “Usually it expresses an abnormal animation of the unconscious” (JUNG, 2012, p. 421). In this case, fear of the sudden appearance of a snake, a very common situation in rural areas, constellated in this woman an absolutely unconscious hazard reaction. It is an archetypal situation humanity has always experienced. In this case, it represented the death of a child and the mother’s fear of it. It would be an understatement to say the mother feels “guilty” for the death of the child. The archetypal image and her instinctive reaction are stronger, and more human, than any “guilt” one may have for an event that happened against our will. Guilt would be justified if the mother had killed the child or desired their death for some reason. This does not seem to be the case. This woman’s pain, expressed in her symptoms, is more convincing than any reasonable interpretation. But her treatment was “seizures”. Did she need any more seizures?
A little more sensitivity, gentlemen!

Since 1986, as a doctor working with psychiatric patients from a Jungian framework (relating to the Swiss psychiatrist Carl Gustav Jung’s theory of analytical psychology), I have always questioned the organicist methods employed in most Brazilian hospitals and learned in medical schools. I felt the need to think how, or in what way, this organicist psychiatry settled in Rio Grande do Sul/Brazil, along with its connection to the practice of exclusion of patients in hospitals and the representations physicians, society, family and patients themselves had about mental illness. I then headed to History, and did my Masters and Doctorate in Cultural History in order to research the imaginary and sensibilities about “insanity” in our society. There I came into contact with medical records from 1937 to 1950 with homogenizing treatment techniques, within the São Pedro Psychiatric Hospital of Porto Alegre.

I have always had a concern to understand insanity from the point of view of those who imagine, feel and live it- and not only through the vision of institutionalized medical knowledge, scientifically “suited” to characterize it - in short, I have always shared the idea that the doctor does not and cannot know everything about a disease or a sick patient. The patient’s voice has always resonated within me, even when I did not understand what it could mean. It was through the dialogue of Carl Gustav Jung’s concepts of Analytical Psychology - with which I have worked for 30 years my practice - with concepts of Cultural History - such as representation, imagination and sensitivity - and the link between these and the data found in the sources, that I found a way to draw a certain picture of the social imaginary of mental illness and, specifically, with the imaginary of women affected by mental illness. Therefore, this article privileges an interdisciplinary approach. We reinterpret the past from shards and traces of it and give new meanings to the facts and to the therapeutic look on mental illness.

The 1940s brought what came to be called “inpatient overcrowding” at HPSP, with an increase of the absolute patient count. In March 1951, a news report in the “Jornal de Noticias” claimed there were 2961 inpatients in 1950 alone, 714 of which did not have a bed. Most patients were women considered “destitute” (1236 destitute men; 1297 destitute women; 239 male pensioners; 189 female pensioners).  

Years later, with the testimony of some employees, this issue was explicit. In 1971 there were more than five thousand patients living in inhuman conditions such as collapsing buildings, bad food, and outdated psychiatric treatment. With only 1200 beds, patients were forced to join two beds and sleep length-wise in groups of up to five, thus encouraging promiscuity and the increase of infectious diseases.


6 Source: “Memórias de um velho Hospício” (Memoirs of an old Asylum). Internal booklet. Porto Alegre, São Pedro Psychiatric Hospital, 1975-1979. Made in five “chapters” with text by Rui Carlos Muller (head of the recreation service) and research professor Marta Lilia Flores. This booklet was made to publicize the hospital in the year of its centenary, thought to be 1979. It was first written in 1975. Research showed the correct date of the centenary (1984), but these 5 chapters were published in 1979. Courtesy of Dr. Ygor Ferrão, HPSP director of education and research at the time of this research.
Women were admitted in large numbers. Most were brought by their family, especially the husband. Very few had jobs, most were “mistresses of the house” or “housewives”. Some worked as maids - a profession which is very common in Brazil, but only recently regulated. Many lived in rural areas of Rio Grande do Sul and, judging from the records I have had access to, the majority had “mystical or erotic delusions”. Hospitalized women had different diagnoses than men: hysteria, schizophrenia, mystical hallucinations, epilepsy were some of the most common diagnoses.

All cases of hospitalized women (here only three were reported) observed from medical records from 1937 to 1950 have something in common: all are treated by doctors homogeneously, i.e. not respecting each patient’s imaginary or life story. It was enough that a family member reported that the patient spoke of God, practiced some religion or saw figures, for “mystical delirium” to be included in the symptomatology of the clinical picture. Or, in alternative, erotic delusions. Nowhere in the medical record reports does the psychiatrist take into account the patient’s imaginary or their sensitivity to their psychological moment. Years later, in the booklet mentioned in note 6, there are testimonials by patients that had been admitted to the hospital for over 10 years. One says: “I was admitted 14 years ago. There used to be more sisters than nurses, I was terrified of the courtyard, the rooms were closed (cells) and there was a room where the patients were naked and at the end of it there was a small room where the sisters locked the patients to calm them down and gave them shocks [in the vagina] and then left them in a small yard. They only gave soup to men and women, patients were skinny. It’s been 6 or 7 years since everything changed. The kitchen was old, they changed the pots, the floor and it had no guard” (Female patient’s testimony, “Memórias de um velho Hospício”, see note 6)

Analysis of sensitivities (Pesavento, 2003; Santos, 2008) is one of the central elements of Cultural History that surfaced in the penultimate decade of the twentieth century and constitutes another framework for our thinking about insanity. It influences the perception and translation of human experience in the world, through social practices, discourses, images, and materiality. Thus, we work with the translation of the sensible as a form of knowledge of the world - social imaginary, subjectivity, emotions, feelings. Insanity, understood here as a momentary altered state of the human psyche, is a historical question, and consequently cultural and social; it is a broader issue rather than a mere medical or psychological school concern. “Being insane” is a social concept, as explained by Jung (2012).

The understanding of mental disorders involves the understanding of the life story and psychological background of an individual in the most comprehensive way. This story unfolds like a drama, both on an individual level (family environment and psychological background) as well as on a collective one, that is, in living history and in the history of the surrounding world. As we reflect, even if briefly, on the referred cases of women suffering from mental problems and locked up in asylums in the early twentieth century (a reality that is not much different these days – but this is not the place to discuss that), we are sure that psychiatric science, in that historical moment, homogenized human life and its manifestations - religious manifestations, erotic demonstrations, protests against a violent husband, manifestations of loss, among many others. Women, suffering in a world and era dominated by male precepts, were also excluded from the legitimate expressions of their imaginary, be it religious, erotic, or other. This would at least provide some relief from the suffering and would, to a point, be
composed of appropriate symbols for the contents that kept women unbalanced, and perhaps also for their cure.

References