In search of a cure: the patients of the Ghent homoeopathic physician Gustave A. Van den Berghe (1837-1902)

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Citation for published version (APA):
Dealing with Diseased Bodies.
Gender and Attitudes Towards Illness

Coming closer to the patient, from being part of a doctor’s clientele to being an individual sufferer, enables an analysis of the coping strategies for illness in the past. The previous narration of patients’ individual suffering and their personal stories about illness reflected on the ailments, behaviour during treatment and the relationship patients entered into with Van den Berghe. An even stronger ‘micro-perspective’ of dealing with illness is now offered.

A supplement to gender history of suffering ‘from below’ is attempted, a line of research that seems to be in its infancy. Gender history can be studied from three angles, as a history about women and femininity, as a history about men and masculinity or as a history about men and women and their shifting concepts of femininity or masculinity. This last category of gender history, resulting in an integrated study of the perceptions and experiences of women and men about illness and their bodies, has received comparatively little scholarly attention. Studies of attitudes towards health, illness and healing from a gender perspective focus predominantly on women. However, experiences and testimonies of suffering women have been barely highlighted. The interest in male experiences of health, illness and the body is making headway, although only recently, contributing to an understanding of male responses, knowledge and conceptualisation of health-related issues. Nevertheless, most knowledge of the impact of gender on illness and body perceptions has been established, in general, either by studying solely women and femininity or by concentrating exclusively on men and masculinity. The

2 Cf. Paragraph 3 of this chapter.
masturbation discourse of the eighteenth and early-nineteenth century, as an example, aimed solely at eradicating this debilitating and even life-threatening deed from human life. Men formed the primary, but not the exclusive target of warnings and advice; that women engaged in this act was virtually kept hidden. Medical and social discourse on masturbation in men and its consequences for health has been well-studied; the experiences of the individual female masturbator have not yet been taken into account.4

It will be possible, by combining the views of men and women, to ascertain to what extent gender may have generated or contributed to particular ideas, attitudes and behaviour as the differences and similarities of suffering between men and women are examined. It is known that distinct differences exist between men and women with regard to the state of their general health as well as their individual experiences of being ill.5 This was and is related to hormones, but also to work circumstances and behaviour. Men and women display distinctive conceptions of illness, body perceptions and self-images in their suffering. The difference or conformity in male and female conceptions, awareness, understandings and attitudes as regards health and illness, thus, will be studied.

Firstly, how sense was made of suffering for both men and women will be discussed. Secondly, men and women will voice their experiences with sexually transmitted diseases and sex-related ailments. Most venereal suffering was endured and expressed by male patients, hence the impact of sexuality on the body will be told mainly by men. Although women like men consulted Van den Berghe about conditions other than gender-related complaints, the female patient finally finds her voice in the experiences and ideas regarding the impact of menstruation, pregnancy and delivery on a woman’s health and body. These typically feminine affairs left on the body, besides the physical traces, the psychological consequences of having a suppressed menses, enduring miscarriage or unwanted pregnancy, and failing to become pregnant.

The women in Van den Berghe’s clientele have received more attention than the men.6 The methodological aim of continuous and systematic comparison between the experiences of men and women may appear

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6 Also in the use of secondary literature.
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unsatisfactory. Why not assess how male and female patients responded to having the same, not-gender related, illness such as an affection of the respiratory organs? The women patients told or, possibly were asked by Van den Berghe, considerably more stories of their personal experiences than the men. Therefore, except in cases of venereal disease or sex-related ailments, it is rather problematic to compare the narratives of men and women. Moreover, the emotional impact of illness was communicated predominantly by women. The casebooks noted that women dreaded the loss of a child or a yet unborn child, but the grieving of a father was hardly mentioned.

7.1 Making Sense of the Suffering: Reasoning Physical and Mental Hardship

Individuals often started a search for explanations to grasp what was happening and to make sense of their suffering. A definition of the source of distress made the ailment understandable and, for some, facilitated the management of the pain. The causes stated by the patients were considered essential by Van den Berghe for the results of treatment and he made inquiries about their ideas on the origin of the ailments.

Health care seeking decisions, in favour of a particular practitioner or treatment, depend primarily on the 'lay theories of illness causation'. The sufferer's idea about the causes and nature of the symptoms are the main components of the therapeutic choice. Those suffering acute illnesses in Taiwan, for example, consult professional practitioners, whereas those with chronic disabilities visit 'folk' healers. An explanatory model, in anthropological terms, would be helpful in ascertaining the illness theories of Van den Berghe's patients. The ideas held by all the participants, sufferer and practitioner, on the illness period and its treatment would be examined within this model. Lay ideas are influenced strongly by cultural factors, including medical knowledge, and by personality; whereas licensed practitioners, orthodox and others, tend to maintain their professional pattern of thought.

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7 For a discussion on the perspective in the sources (casebooks), cf. Introduction.
8 This is an interesting subject that, amongst others, reflects the consequences of suffering for personal well-being and that of the individual's environment. At the end of this chapter, the female patients' stories of gender-specific suffering have been selected rather than attempting to present an incomplete discussion of the way in which men and women dealt with another particular disease. Nevertheless, as will become clear, the male patients will still receive the ample attention that they also requested from Van den Berghe.
11 Kleinman, Patients and Healers, 104-118; Helman, Culture, 94-113.
This explanatory model provides for four different types of illness explanation. Individuals blame themselves for having fallen ill; the natural environment, including accidents, is considered as the cause of the ailments; others in the social environment have inflicted the illness, witchcraft, magic etc.; or supernatural powers, ghosts, gods, ancestors, are at work. The first two explanations, personal responsibility and natural environment, are the most common ones in the modern Western world. However, the anthropological explanatory model cannot be projected simply on to Belgian society. It has been designed for non-Western traditional societies in which religion and spirituality are omni-present. Although religion, at times, still played an important role in the lives of nineteenth-century Ghent people, persistent belief in the supernatural was not common. Stories regarding witchcraft, magic or other supernatural forces as the cause of illness were not told, apart from an occasional exception. Moreover, the model passes over the possibility of patients explaining their ailments as resulting from coincidence. Finally, those suffering ill health did not always point out one single cause, but considered it to be the result of a combination of factors.

If Van den Berghe’s patients offered an explanation for their suffering, the causes can be fitted into one or more of the following illness theories: illness caused by emotional factors, illness resulting from natural or medical factors and suffering originating from personal conduct. Emotional factors consist of situations through which people became affected emotionally resulting in temporary or permanent physical or mental deterioration. Natural or medical explanations are those cases in which working and living conditions as well as other medical disorders or situations are mentioned as causing the affliction. Suffering originating from personal conduct refers to patients stating that their own behaviour had led to their illness. Some patients, obviously, had developed complaints after they had been afflicted simultaneously with several of these ill-making factors.

Many a patient reported that emotional states like ‘colère’ (anger, rage), ‘saisissement’ (fright, terror) and ‘chagrin’ (grief, unhappiness) had triggered the ailment. Yet, why patients became angry, frightened, and unhappy or upset was not always specified. Grief was often connected to the loss of loved-ones such as parents or children. Hortence VandenDriessche (38) told Van den Berghe that she often suffered from fear and melancholy resulting in all types of ailments. The unmarried Hortence lived with her mother and her brother Polydore and his wife, who had four small sons. Three of her nephews died in 1883 and her brother passed away suddenly in 1887, leaving her in great anguish. Finally, Hortence had to cope with the death of her mother in 1895.

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12 There is nothing in the casebooks to support sustained supernatural belief.
She was extremely upset about this loss and told Van den Berghe that she thought she was going mad.\textsuperscript{13}

The experiences of frightened and shocked patients differed markedly. A reference to the supernatural has been found in one case. Gerard Cazier (36) told Van den Berghe that he had suffered from asthma since the night he had seen a ghost in his bedroom five years previously. Another male patient had an attack of fear when he passed through the great Alps tunnel and, subsequently, had been suffering from mental alienation. Catharina Douliez (34), a mother of seven, remained more ‘down to earth’. She consulted Van den Berghe in 1895 with a menstrual disorder and told him that she had a suppressed menses because of ‘d’une colère au sujet du socialisme’ (rage regarding socialism).\textsuperscript{14} He did not note what she meant but, in 1895, the trades unions had been active in the Ghent textile industry and a strike broke out at one of the largest factories.\textsuperscript{15} Catharina’s husband, Franciscus, was a day labourer in a cotton factory and, perhaps, she was afraid that he would lose his job. He did change jobs in 1897 and became a typesetter. François Blocqué quoted a combination of factors as the cause of his cardiac complaints.\textsuperscript{16} He had lost his wife in August 1881 and was overtaken by so much grief that he had started drinking. Other sufferers narrated accidents that had caused fits of fear; the swallowing of a button, a brush falling on someone’s head and relatives tumbling down the stairs.

Natural and medical factors were raised also as causes of illness. Accidents, hard work, bad living conditions, food and climatic circumstances could be a source of a diversity of ailments. Individuals suffering a cold were often caught in the rain or were forced to work outdoors in cold and humid circumstances. Others, on the other hand, were working in too warm and dusty environments that caused their suffering. A thirty-six year old woman told Van den Berghe that she was happy in her housekeeping, but that her shop brought her worries because of defaulters. The miserable domestic circumstances of many of the working class created other diseases as humid dwellings were considered to endanger health.\textsuperscript{17}


Occasionally the patient had been the victim of another's behaviour; assault or a fight had caused the suffering. Hortance Baele was a victim of domestic violence. She had a painful contusion on her foot that was inflicted by her drunken husband. Stories about ailments resulting from rape are rare but, in such cases, the injured party suffered twice. One case of sexual child abuse was recorded in the casebook: a girl of eight with leucorrhoea and a painful vagina told Van den Berghe that her ailments were the result of a sixty-year old man having intercourse with her. Accidents as a source of suffering were told more frequently. Petrus Lievens, a forty-two year old shopkeeper, had a bad fall and needed treatment for a sore left knee. Three consultations and treatment with *arnica* improved his condition. Fractures were never directly taken to Van den Berghe but those with pain complaints after the fracture had healed consulted him at times. Mr. Duchène, a cavalry captain, had an ‘industrial accident’ when he fell off his horse causing him pain in his loins and left leg.

Rosalie De Mil, a living-in barrister’s servant of twenty-five, was convinced that she was still facing the consequences of a vaccination received seven years earlier. She claimed that her constipation, insomnia, lack of appetite and occasional skin eruption all had their origin in that one experience. The pocks resulting from the vaccination became ulcerated and produced abscesses on her entire arm. Subsequently, she suffered from time to time a rash, palpitations, agitation and similar conditions. That her abuse of purgatives could harm her general state of health apparently did not occur to her. She continued her self-dosing during Van den Berghe’s attempts to improve her gastro-intestinal condition. Other medical conditions mentioned as the source of suffering illustrate lay knowledge on medical issues and demonstrate an ability to ‘diagnose’. Many current complaints were considered as the remnants of or the result of a previous ailment.

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18 Casebook 17 (1898-1901): p. 798.
19 There is one case known, that of a nineteen-year old girl suffering pain on the external parts of her vagina since a stranger forced her to have sex with him. Cf. Casebook 16 (1896-1898): p. 412.
21 Casebook 4 (1871-1873): p. 505. DSG, Straatnamenregister 1867-1880: Hamstraat 4, district 7. Petrus Franciscus Lievens (Olsene, 1829, Ghent 1909). In 1871, the year of his visits to Van den Berghe, Lievens was married to his second wife Joanna Catharina Breusegem (1825-1880), the first one had died in 1865.
23 Casebook 13 (1889-1891): p. 349. DSG, Straatnamenregister 1881-1890: Hoofdkerkstraat 3, district 1. Rosalie De Mil (b. Moortsek, 1865 – d. ?). She left Ghent in 1896, hence the unknown date of death. She was Van den Berghe’s patient from July 1890 to March 1893, not consulting him in 1892.
An occasional complaint about the ill-making effects of non-
homeopathic medicines was not uncommon. Jeanette Verdonck-Daese had
developed piles, resulting from giving birth to a daughter, Maria Francisca, at
the turn of the year 1894. She started taking allopathic drugs (remèdes
allopathiques) to counteract this uncomfortable condition. Four years later, in
August 1899, she consulted Van den Berghe as the medication had caused
chronic diarrhoea. One male patient was suffering the negative side effects of
drug taking. As a syphilis sufferer he used mercury intensively, causing all
types of other ailments.

Some were concerned particularly about contamination. Patients who
had taken care of ill family-members, or who had continued sleeping next to
their terminally ill spouses, were very anxious about catching the same disease.
When Ivo Van Bastelaere (31) visited Van den Berghe in January 1879 he had
just lost his wife to tuberculosis. He had some of the symptoms, suffering
from a cough, expectoration and an impeded respiration and he was afraid that
his wife had contaminated him. A year later Van Bastelaere returned with
tooth-ache. On this occasion, no emotional or natural explanations were offered
for this dental ailment. Ivo looked upon the ailment from a behavioural point
of view as, during a trip to Brussels, he became drunk and fell asleep on the
street.

Explaining illness as the result of emotional or natural/medical causes
demonstrates the patient’s perception of illness as outside their control, beyond
their own responsibility. Behavioural considerations, conversely, give an
insight into a sense of being personally accountable for their precarious health.
Not eating properly, forgetting to take medication, excessive behaviour in
relation to alcohol, sex and work, were all within individual’s control and, if
illness was the consequence, these were the result of personal failures about
health. Patients blamed themselves for not being more cautious or alert, as they
were aware that certain behaviour could lead to specific conditions. This
becomes particularly clear in the stories of people afflicted with sex-related
disorders, such as venereal ailments, or with other ailments considered to be
induced by sexual activities such as masturbation.

24 Casebook 17 (1898-1901): p. 323A. DSG, Straatnamenregister 1891-1900: Zwijsnardse-
steenweg 250, district 5H. Joanna Maria Daese (1869-1904) had married Frederik Verdonck,
who became Van den Berghe’s patient in 1900, on February 3d 1894. They had one child still
living in 1899.
26 Casebook 6 (1876-1879): p. 1766. DSG, Straatnamenregister 1867-1880: Godshuismam,
district 3. Ivo Van Bastelaere. (Evergem, 1848 - Ghent, 1892) widower of Virginia Strobbé
(1848-1878). DSG, Archive Burgerlijke Stand Gent, death certificate 3310/1878.
27 See the next paragraph.
An analysis of the relation between patients’ behavioural explanations and certain disorders, however, does not produce many conclusive findings. Men and women gave a variety of explanations for very diverse conditions, yet some illness theories were more frequently used than others. Natural and medical explanations (43 per cent) predominated in the explanatory stories, but emotional alterations (38 per cent) were also the basis of many instances of illness (Appendix 9). Anecdotes were less frequently recorded on how personal conduct had resulted in suffering (19 per cent).

Although diverse ailments were explained by equally diverse reasons, some conditions were more often ascribed to a particular cause than others. Men, for example, attributed their sexual and venereal ailments exclusively to personal behaviour. Furthermore, those afflicted with mental problems developed their complaints after emotional mishap which had thrown them off balance. A little over fifty per cent of the patients suffering a cough and/or expectoration exclusively explained their condition by natural and medical causes. Some of these coughing patients offered a more specific diagnosis and attributed their condition to influenza. An unmarried factory worker, August Claeijs, of twenty-four consulted Van den Bergh during the winter of 1898. He was constantly coughing and had brought up large amounts of blood. The patient said he thought he had influenza (suite dit-il de influenza), but the homoeopath drew an additional conclusion. The presence of a ‘tubercular point’ in his right lung confirmed that pulmonary consumption had joined the influenza. The patient would not recover, dying on 1st April 1899, four months after his last consultation with Van den Bergh.

Abdominal and intestinal complaints, although often resulting from ‘ordinary’ medical conditions, were explained predominantly from an emotional viewpoint. This is most likely because women were more prone to gastro-intestinal conditions than men and because female patients displayed a tendency to explain suffering by an assault on their emotional state of health. An analysis of the suggested illness theories from a gender perspective implies that the sexes displayed differing perceptions about the origins of their ailments. Of the 1,826 sampled Ghent patients, 181 men and women (or ten per cent) told Van den Bergh explicitly to what they attributed their suffering. Although it is not possible to make any generalisations, the following can still be conceived as an outline of male and female inclinations in explaining illness. Male sufferers attributed their ailments predominantly to behavioural or

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29 Cf. Chapter 4.
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natural/medical causes, whilst women hardly ever spoke about their personal responsibility, i.e. their conduct, as the source of evil.\(^\text{30}\)

Julienne Baeckeland (25) formed an exception as she suspected that she had enjoyed herself too much. Her armpit hurt, she had trembling and burning sensations, she coughed, had an impeded respiration and was constipated; all since she had celebrated the carnival with exuberance.\(^\text{31}\) As male natural/medical causes often referred to environmental factors of life and work; female natural/medical explanations predominantly mentioned gender-specific health circumstances, such as pregnancy, child bearing and nursing, as causes of suffering. Furthermore, one-half of the female patients considered their suffering to be the result of emotional situations, compared with less than one-quarter of the men.\(^\text{32}\)

Patients' perceptions, therefore, of the origin and nature of their suffering were, at times, gender related, but this does not provide confirmation that explanations influenced the decision to make use of Van den Berghe or homoeopathy. His patients barely displayed extraordinary perceptions of their afflictions which may have influenced their decision to try homoeopathy. One type of explanation for suffering was found more than any other, but remarkable differences were not noticed. However, to make further statements it would be necessary to make comparison with the illness perceptions of patients in a nineteenth-century orthodox practice.

7.2 Masculinity and Femininity: Sex and Venereal Ailments\(^\text{33}\)

The existence of venereal ailments, although often considered as shameful and resulting from promiscuity, was not hidden. Many developed venereal disease, at least once in their lives, and sought treatment. Van den Berghe regularly met sufferers from the consequences of venereal disease. Those can be distinguished rather easily within Van den Berghe's clientele, despite the lack of

\(^{30}\) 80 men and 101 women mentioned the following explanations. BE (=Behavioural explanations), EE (=Emotional explanations), NME (=Natural and medical explanations), CE (=Combination of explanations).

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\begin{array}{ccc}
\text{Men:} & \text{Women:} \\
\text{BE} & 29 & \text{BE} & 5 \\
\text{EE} & 18 & \text{EE} & 51 \\
\text{NME} & 30 & \text{NME} & 44 \\
\text{CE} & 3 & \text{CE} & 1 \\
\end{array}
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\(^{32}\) Why women were inclined to attribute their conditions to a contemporary decline in mental stability is an interesting question that will be considered in the third paragraph.

\(^{33}\) An earlier draft of this paragraph has been published in MedGG. Cf. Anne Hilde van Baal, "J'ai Vu une Femme Publique." Sexuality, Venereal Disease and Homoeopathy in Nineteenth-Century Ghent: the Tale of the Patient, MedGG 20 (2001), 179-196.
unequivocal diagnostics. In some cases, a single symptom, such as a venereal abscess (chancre), is sufficient to identify the disease; in other cases, a wide range of symptoms are described. Nevertheless, it is relatively easy to infer the nature of the ailment of the five hundred patients afflicted with venereal conditions, over two hundred can be diagnosed unmistakably as suffering from gonorrhoea, syphilis or genital herpes.

Sexuality in Society: Religious, Medical and Social Views

Whilst it is true that, during the Enlightenment, Christian conceptions of sexual sin and virtue were replaced gradually by scientific approaches to sexuality, long-standing moralistic sexual norms were never entirely overthrown by the philosophes. The proper place for sexual activity remained the conjugal bed, and any act not focused on legitimate procreation, such as masturbation or intercourse based on lust, was judged sinful and perverse. These basic moral beliefs and a related repulsion towards free, unchecked sexuality clearly affected medical discourse.

Orthodox medical views on sexual matters warned against the evil of excessive sexual behaviour and masturbation, which were considered physically dangerous as well as morally pernicious. This vehement resistance against 'self-pollution' was not a nineteenth-century invention. The famous Swiss doctor Samuel August Tissot had introduced it to the medical agenda a century earlier, but he based his L'Onanisme (1760) on much older ideas. Male masturbation was denounced primarily because of its debilitating effects on the body. The deed in itself was considered a disease, but it could result also in other dangerous illnesses such as consumption, madness and even death.

Semen was seen widely as an essential and vital body fluid; its wastage in acts of masturbation damaged physical and emotional strength. Health guides and educational literature, therefore, were punctuated with warnings against the dangers of excessive sperm-loss through intercourse and 'self-abuse'. The message of anti-masturbation discourse was one of self-control,

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35 Stolberg, 'An Unmanly Vice'. 1-21, q.v. 3; Ibidem, 'Self-Pollution', 37-61, q.v. 43-48.
37 A. Sovet, Manuel d'hygiène publique et privée (Brussels: Jamar, 1875), 14; Willem Colen, Geschiedenis van de geheime zonde. Onanie-vertogen van Tissot tot Dr. Spock in wetenschapshistorisch en cultuurhistorisch perspectief (1760-1945). Unpublished licentiate thesis (University of Ghent, 1992), 28; Stolberg, 'An Unmanly Vice', 3. For a survey of masturbation literature see: Jean Stengers and Anne Van Neck, Histoire d'une grande peur, la masturbation (Brussels: Ed. de l'Université de Bruxelles, 1984).
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propagating respectability and character. A Dutch brochure, published in 1886, offers the following admonitions:

Premature excesses in love and outside of marriage shortens life; male strength will be lost! One will become ill, weak, miserable and old before time and one exposes oneself to venereal infection, the terrible poison that is spreading and that takes people away secretly.

The active interest in sexuality in the nineteenth century had strong social components and was based on ‘wider social anxieties’. Notions of sexuality were linked intricately to class, gender and public health issues. The middle classes used sexual morality as a standard for differentiation from both the aristocracy and the lower classes. Public health campaigns were aimed primarily at the urban poor. ‘Sexual immorality was understood as a class issue, specifically linked to the habits and living environment of the urban poor and seen in direct relation to the themes of disease, filth, depravity, overcrowding, bad housing, crime and disruptive behaviour in working class culture.’ Ideas on sexual behaviour also were strongly gendered. Men were considered to have a strong animalistic sexual urge, never fully controllable. Moderation and abstinence were strongly advised, but could hardly be expected. Women, on the contrary, were regarded as asexual beings, with a weak sexual drive and no need for erotic gratification.

Serious grounds existed for sexual anxiety and sexual fear in the nineteenth century. Venereal disease lay in wait everywhere and became more prevalent. Although conclusive statistics are not available, it has been estimated that five to ten percent of the Belgian population had suffered from venereal disease during the period in question. Social concern about venereal disease and sexual behaviour was considerable in Belgium as in other European

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39 Anonymus, Volksgeneeskunde, of meer dan 500 van de beste huisgeneesmiddelen tegen 145 ziekten der mensheid (Utrecht: P.J. Diehl; 17th edition, 1886), 6. For the original Dutch text see Appendix 2.
41 Oosterhuis, Stepchildren of Nature, 30.
42 Ibidem, 30-31.
43 Hall, Hidden Anxieties, 32.
Venereal disease was regarded as a social evil that had to be wiped out just as tuberculosis and alcoholism.

Prostitutes were widely perceived as the source of 'venereal evil' and a threat to the nation at large. Brothel-visiting men introduced gonorrhea and syphilis into the conjugal bed, infecting wife and offspring. Medical discourse echoed and fed these anxieties, warning against the dangers of inherited venereal disease. Declining fertility and a growing number of unhealthy newborns would soon produce widespread social degeneration according to many doctors. Syphilis, alcoholism and tuberculosis were often depicted as the ills of society, initially affecting the individual, but eventually affecting the entire nation. The practice of prostitution was cordonned off in specially designated areas to protect public health, and medical inspection of prostitutes was made compulsory. However, from the 1880s, the regulation of prostitution came under attack in Belgium and throughout Europe as controls had not curtailed venereal disease, but only institutionalised sin and vice.

Even though Belgian doctors played a substantial role in the public debate on the war against immorality and prostitution, they did not make great efforts to provide sex education for the young. They wrote little on the subject until the 1920s unlike

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their colleagues in other European countries. School physicians were pre-occupied mainly with school hygiene and infectious children’s diseases such as smallpox, measles, whooping cough and ophthalmia.48

Venereal disease and masturbation were surrounded, in general, by fear and shame. Men and women suffering a venereal disorder were stigmatised as sinful and immoral; many hospitals refused them admittance and health services usually denied any compensation of their expenses. Most of the country’s health funds, according to one Belgian physician, denied medical or pharmaceutical services to patients whose ailments resulted from their own ‘misbehaviour’.49 Venereal patients not only shouldered the entire financial burden of their treatments, but also were forced to seek treatment from physicians intent on avoiding the stigma of treating them. Conventional physicians in England, for instance, were not prepared to treat venereal disease and patients were forced to seek unorthodox practitioners.50

The pre-occupation with the impact of venereal disease on health was not only an ‘allopathic’ matter. Homoeopathic practitioners also contributed to the publication of material on venereal disorders. Hahnemann was concerned with these ‘maladies secrètes’ and left behind instructions on the proper treatment of venereal disease.51 Nineteenth-century Belgian homoeopathists, in contrast with their foreign colleagues, do not seem to have published specifically on the subject. They published thirty medical guides and handbooks between 1874 and 1914 but none of these were concerned directly with venereal ailments. Nevertheless, there were other sources of information for those intent on finding them.52

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51 B. Laborier has made a study of Hahnemann’s ideas regarding venereal disease as exposed in his writings. Furthermore, Laborier explored the way in which these ideas were brought into practice by studying some patient files from the Paris practice. See: Bruno Laborier, ‘Les maladies sexuellement transmissibles et leurs traitement selon Samuel Hahnemann’, available on http://homeoint.org/site/laborier/mst.htm.

52 In the library of the Institute for Medical History of the Robert Bosch Foundation various homoeopathic publications on venereal disease are available. Edward P. Anshutz, Sexual Ills and Diseases: a Popular Manual Based on the Best Homoeopathic Practice and Textbooks (Philadelphia: Boericke and Tafel; 2nd ed., 1910); Jean Phlèbert Berjè, The Homoeopathic Treatment of Syphilis, Gonorrhoea, Spermatorrhoea and Urinary Diseases (Philadelphia: Boericke, [around 1880]); Jonathan Braun, Die Krankheiten und Schwächezustände des männlichen und
Men and women suffering from venereal disease in Van den Berghe’s Ghent had few treatment options open to them and many reasons to seek help outside official channels. Orthodox nineteenth-century medicine was barely effective in averting a venereal crisis. Therapeutic possibilities still offered little hope despite a considerable expansion in the body of knowledge on venereal diseases during the course of the century. Traditional treatments were very painful, often causing more suffering than the disease itself, and hospitals and physicians were far from eager to treat these patients.33

The shame and disgrace surrounding venereal disease also increased the appeal of home remedies and of medical options outside the official channels. Some of Van den Berghe’s patients came to him after attempting to relieve their ailments themselves. Others reported trying numerous remedies and consulting various practitioners, without ever finding a cure. Advice on the prevention of venereal disease in self-help guides focused primarily on ways of avoiding sexual temptation. Sports, physical labour and avoiding heavy meals or alcohol were all recommended as ways of resisting sexual urges. If the excitement was too strong, intercourse could be blocked by rubbing the penis with a special ointment. How women could avoid venereal disease was never a subject of discussion.34

The Patient Speaks: Sexual Activity and (Venereal) Illness35

While most of Van den Berghe’s patients were aware of the physical and moral dangers associated with sexual excess, sexual abstinence was not a reality in daily life. Many patients reported frequent sexual activity, not always necessarily within marriage. Stories about intercourse with lovers, extra-
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marital relations or children born out of wedlock and unmarried motherhood are not uncommon. Moreover, men as well as women maintained multiple sexual contacts.

Although women were believed to be sexually non-desirous and, perhaps, even forced to be so, the casebooks show otherwise. They disclose that women, despite the risk and shame of getting pregnant, had intimate sexual relations without being married. When Eugenie Holleck consulted Vanden Berghe for the first time in 1870, she had already two children but no husband. She did have a relationship with the biological father of her children but they married only three years later. Another unmarried woman, seeking treatment for a vaginal ailment, reported that she engaged regularly in intercourse, about twice a week. These two women were no exception.

It was very common for a husband to engage in sexual relations with someone other than his wife. A man with a tumour on his testicles told Vanden Berghe that he had developed the ailment after having intercourse with a woman who was not his wife. Lack of gratification within the confines of marriage was not the excuse for these affairs as the casebooks do not record a single case where a man explains his unfaithfulness on these grounds. Sometimes, something more may be learned about the sexual feelings between spouses as the casebooks include instances in which ailments resulted from matrimonial sexual activities. A forty-four year old man forced himself onto his wife whilst drunk and she ‘let him have his way’. However, he could not ejaculate and was left with a painful and grazed penis. The ‘letting him have his way’ sheds light on the power relations within nineteenth-century marriages. This husband demanded sex from his wife and, instead of resisting him, she submitted to his will. Indeed, the law itself stipulated that a married woman was entirely subordinate to her husband. As head of the household, the nineteenth-century Belgian man was free to discipline his wife, sexually and

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56 Casebook 3 (1870-1871): p. 356. DSG, Archive Bevolkingsregister Gent, filing cards; DSG, Archive Burgerlijke Stand Gent, marriage certificate 773/1873. Eugenie Holleck (1844-1894) married Auguste Wille (b. 1835, d. ?), manufacturer, in 1873. Both their children were born and had died in Ledeberg.
58 Archival research attests that many women conceived and bore children without being married.
59 There are no accounts in the casebooks of married women being unfaithful.
otherwise. In another case recorded by Van den Berghe, a husband developed an inflamed testicle after frequent relations with his wife.

Housing conditions also could lead to awkward situations and literally disturbed sexual relations between spouses. M. visited Van den Berghe in 1894 with an ailment of the ureter. He thought the disorder was the result of an interrupted intercourse when his children had knocked on the door just as he was about to ejaculate. Some husbands were very worried about their inability to perform the sexual act, their failure to 'serve their wife.' A thirty-one-year-old joiner was unable to make love to his new bride. When he consulted Van den Berghe for the first time on 29th December 1895, he was a newly-wed. He was plagued by complete impotence in addition to severe backache and pain in his loins. The patient remained under treatment for nearly two years, but his condition did not improve, and the couple remained childless. A twenty-nine-year-old barrister tended to blame his wife for his sexual 'failure', elaborating on his frustrations after two years of marriage. However, it is likely that the insufficient erections and inability to have intercourse were the consequences of gonorrhoea for which he had been treated before marrying. After six months of treatment with Van den Berghe, the barrister reported that the medication produced desires of the flesh (de desirs charnels) and ejaculations, but no erections. After an additional year of treatment, his sexual performance had not improved.

Some men who had been diagnosed with a venereal disease continued to expose their families to danger by keeping silent about their condition. One poignant example is that of the A. family where two young girls were infected by their parents. At first, Van den Berghe treated the two girls; the younger one, aged only four, was suffering from a vaginal ulcer and an eye-infection resulting from gonorrhoea (ophthalmie gonorrhéique). Both the girls would be cured. The two parents were less fortunate and faced a re-occurrence of the disease. How these adults became infected, how all members of the family experienced the disease, or how it affected their daily life is not known. Patients seemed aware of the contagious aspects of venereal disease in other

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cases. Several husbands were very worried about the possible consequences of their infection; they were honest and told their spouse.

The extent to which there was an awareness of the diseases being carried or the potential of transmitting them to offspring is unclear. Van den Berghe, in one case, treated a baby of ten weeks who suffered from constitutional syphilis, probably a victim of his parents' ignorance. This baby boy was covered with a rash, had swollen feet, was extremely emaciated and his face looked 'like that of an old man'. Van den Berghe noted, at his second consultation, that he was an 'enfant misérable'. The child would not return to the practice and it is not unlikely that he died of the disease.66

The casebooks yield substantial information on the subject of sexual activity and behaviour but, mostly about male patients and solely about heterosexual activities. The lack of a single mention of homosexual relations is striking. While men's sexual behaviour was the central focus of medical inquiry; for women, it was the history of their reproductive organs and their sexual anatomy. The focus, more specifically, was on their 'uterine histories' and their physical and emotional experiences during pregnancy, labour, confinement and menopause. Their 'uterine histories' and sensations were closely evaluated. Women told Van den Berghe, about, for instance, sensations of the uterus moving around and wanting to leave the body through the vagina. These perceptions are related closely to the medical belief that women were ruled by their 'irritated' wombs.67 One late nineteenth-century French author wrote that 'In women, the uterus also suffers from the numerous influences caused by emotions. Love [...] leads to a large number of damages to the sensibility of this very irritable organ'.68

Masturbation was considered the cause of a host of emotional and physical disorders, debilitating both males and females. The deed could lead to troubled nerves, general weakness, feeble sight, painful stools and loins and, even, epilepsy. Although masturbation was seen as dangerous to body, mind and soul, it was practiced widely by Van den Berghe's male patients. Patients told him that, in many cases, they no longer masturbated, but had done so extensively in the past. Some patients attributed to masturbation their

68 A. Becquerel, Traité élémentaire d'hygiène privée et publique (Paris: Asselin, 7th ed., 1883), 850. 'Chez les femmes, l'utérus ressent aussi de nombreuses influences de la part des passions. L'amour [...] entraîne à sa suite une foule de lésions de la sensibilité de cet organe si irritable.'
problems ranging from failing sexual performance and erection problems to backaches. There was no explanation for why some patients continued masturbating when they saw this as the cause of their ailments. Ceraphine Van P., for example, told Van den Berghe that he fell ill due to self-abuse. He continued to masturbate without any explanation or justification despite suffering nocturnal emissions and pain between his shoulder blades and in his loins.\(^69\) It is known that some doctors advised their patients to copulate to prevent masturbation.\(^70\) Whether patients ever received such a prescription from Van den Berghe is not known from the casebooks, but he may have said so during the consultation.

Women also were not able to control their propensity to masturbate. However, women patients did feel the need to excuse and explain their masturbation. They renounced responsibility, in many cases, by claiming that they were biologically impelled to do so. Xaveria Van B. explained that normally she had no urge to masturbate unless she was affected by a fit of vaginal itching. She ‘did have a fit at the beginning of her menstruation, forcing her to touch herself.’ She also touched herself in her sleep, an unconscious act for which she could not be held responsible. Another patient, Stephanie, sensed strong itching in her vagina, causing a fit of nymphomania and, thereby, forcing her to masturbate. She saw herself also as dominated by her physical urges.\(^71\)

Rosalie VanderV. (21), a patient from outside of Ghent, wanted treatment for her masturbatory tendencies. She could not abstain from the act but, afterwards, always felt nauseated. She travelled three times to Ghent in October and November 1876. Her condition improved, probably meaning that she did not feel the need to masturbate any longer, and did not consult Van den Berghe again until June 1879 when her masturbating had returned and extensively. Rosalie explained that she masturbated three times a week to avoid developing burning sensations, heart palpitations and becoming agitated. She was not the only family member who could not resist the urge to masturbate. Her sister, Emilie, had a gland inflammation in her armpit and menstruation-related complaints and, above all, she was sexually over-excited (surexcitations sexuelles).\(^72\) She was under treatment between 1877 and 1884 and Van den Berghe used a broad spectrum of words to depict her continuous sexual urges: masturbation irresistible, forte excitations sexuelles, encore excitations sexuelles, vives excitations sexuelles, nymphomanie, excitations sexuelles irresistible, and excitation venerienne. Emilie’s general well-being was subverted by her

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\(^70\) Cf. Hall, ‘Forbidden by God, Despised by Men’, 365-387, q.v. 370.
\(^71\) Casebook 6 (1876-1879): p. 527, 6th May 1877 (Xaveria); Ibidem: p. 164 (Stephanie).
\(^72\) Casebook 6 (1876-1879): p. 223 (Rosalie); Ibidem: p. 947 (Emilie).
female constitution as she always needed to masturbate after her menses and her vagina constantly itched.

Masturbation in women was considered a separate condition from that in men, and a separate term was used: *nymphomanie*. A second distinction between male and female masturbation was found in the feelings of pressure women almost always sensed in performing self-gratification. The casebooks reflect these feelings in the notation of 'she needs to...' (*elle doit*). A woman's shame about touching her own body is more apparent than that of a man, perhaps, because of negative considerations about female sexuality and masturbation in the nineteenth century. Masturbating women over-burdened their already weak nerves; moreover, masturbateing married women invaded the sexual rights of their spouses.73

Although the casebooks contain more cases of venereal disease among men than women, this finding must be handled carefully. Ghent women also could have been inflicted frequently with gonorrhoea or syphilis yet, may have tried other means of healing than men, for instance, because they wanted to be treated by same-sex healers.74 Furthermore, it could be that the diseases were simply more obvious in men who could hardly ignore the outward manifestations on their sexual organs. Women, on the other hand, could be infected without visible symptoms; and such symptoms of venereal disease as an itching or burning sensation in the vagina easily could be mis-diagnosed. Forty-five year-old Mrs. K. came to Van den Bergh after five weeks of suffering extreme pain while urinating and having a noticeable lump in her left groin. He suspected a chancre or gonorrhoea. The woman said that her husband currently had an ulcer on his 'private part' but that she had not paid any attention to its nature.75 Her husband's ailment was visible; her's was not.

The visibility of the ailment must have contributed to male shame and fear of venereal disease whilst the threat of contracting gonorrhoea or syphilis contributed to the development of other ailments. One patient, for example, developed syphilophobia. 'Eighteen years ago has had a chancre, not yet completely cured. From the minute he has intercourse, he is taken over with syphilophobia'.76 Another man explained his headaches by the fear that he had been venereally infected, although Van den Berghe did not confirm his

73 Coolen, Geschiedenis van de geheime zonde, 100.
76 Casebook 17 (1898-1901): p. 37. 'Il y a 18 ans a eu un chancre, n’a pas encore été complète-ment guérie. Du moment qu’il fait le coit, la syphilobie le prend'.
opinion. Moreover, men were very anxious about the impact that involuntary seminal discharge might have on their general health. The number of patients consulting Van den Berghen in connection with nocturnal emissions, spermatorrhoea and semen in their urine or defecation is considerable. Another disturbing feature of venereal disease was that, once a patient passed the acute symptoms of gonorrhoea or syphilis, he might well continue being infectious. The casebooks include some heartbreaking stories of newlyweds inadvertently infecting their new spouses.

Trepidation, embarrassment and doubts about whether the ailment was definitely cured were common among sexually active men. Yet, the casebooks do not reflect a conscious change in conduct. Many male patients gave evidence of their knowledge of the connection between their sexual behaviour and their state of health and attributed their genital ailments to intercourse with prostitutes. They told Van den Berghen that they had developed the symptoms after having contact with a prostitute ("femme publique") or having visited a brothel ("maison publique"). Two young men (age 20), for example, visited the same prostitute and both became infected with gonorrhoea. Another male patient admitted he had made love to a street-girl ("coureuse"). Yet, in the perception of some, gonorrhoea not necessarily developed merely after intercourse. A young man thought he had contracted the disease after manual gratification ("laisse masturber") by a prostitute.

Prostitution is not always named directly; on many occasions the patient only mentions being with a woman, "j'ai vu une femme". Excessive sexual activity, not necessarily with prostitutes, was seen also as the cause of venereal ailments. Expressions like "abus des femmes", "exces venerien", "exces sexuel" and "appetit venerien" are used frequently to explain ailments, even if these emerged years after the sexual act in question. A patient suffering from impotence, he was able to get an erection but it failed him during intercourse, explained that he had been a masturbator in his adolescence.

Impure intercourse was suggested also as the source of venereal disease. Although it is not clear how the word 'impure' should be interpreted, it probably refers to women who were considered to be impure. Jean D., for instance, claimed he developed acute gonorrhoea after having intercourse with a woman with leucorrhoea. Nevertheless, his awareness of this 'impurity' did not prevent him from indulging in intercourse with her. Prolonged or repeated

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79 AVB, Symptome médicamenteux observés sur mes malades et observations clinique, inv. no. 30, [not dated], 77.
Dealing with Diseased Bodies

intercourse is mentioned as the cause for health problems in various cases. A nineteen-year old male argued that his incontinence was due to having intercourse twice in half an hour. However, prolonged abstinence was seen also as a cause of genital ailments. One anonymous patient, who had suffered from gonorrhoea in the past, consulted Van den Berghe for treatment of excessive ejaculations ('exces d'éjaculations') and testicular pain. According to the patient, it was the result of long-term abstinence, or unfulfilled desire. The twenty five-year old E. was thought to have developed an acute inflammation of the urethra because of a single instance when a woman had powerfully excited him but alcohol had made it impossible for him to have intercourse with her ('la baiser').

Male explanations for venereal disease or genital ailments show that it was considered a matter of personal responsibility. Moreover, the prevailing professional belief that sexuality and sexual activity could harm health was also common among lay people. Van den Berghe's casebooks reflect that most male patients held themselves primarily accountable for their ailments. His female patients tell a markedly different story, they liked to put the blame elsewhere, claiming it was out of their control and taking the role of victim. Just as women patients held their uncontrollable physical urges accountable for their masturbatory habits, they blamed their husbands for infecting them with venereal disease. As women had to be of irreproachable sexual conduct the stigma of venereal disease burdened them more than men. Therefore, pinpointing the 'other' served to acquit a woman from accountability. Women suffering from venereal illnesses were depicted often as innocent preys to their lecherous husbands and it is possible that women embraced this concept solely as a way of disguising their sexual escapades. It is also likely that women patients adopted the role of victims of their own bodies and of their own husbands because this was the role that society had assigned them.

Although he treated a number of patients suffering from venereal diseases and, sometimes, also participated in professional debates on these illnesses, Van den Berghe did not advocate himself as a specialist in venereal diseases. He discussed his findings on venereal disease with colleagues during meetings of the Cercle Médical Homoeopathique des Flandres and published these experiences in Union. Van den Berghe gave a case description on one occasion

83 Ibidem: p. 1574.  
84 This relation between responsibility and gender has been found also in research on present-day diagnoses of hysteria. Men are viewed generally as responsible for their actions, women are seen as 'out of control'. Cf. Laurence J. Kirmayer, 'Mind and Body as Metaphors: Hidden Values in Biomedicine', in: Margaret Lock and Deborah Gordon (eds.), Biomedicine Examined (Dordrecht, Boston and London: Kluwer Academic Publishers, 1988), 57-93, q.v. 70-71.
to exemplify that venereal disease was not always contagious and transmissible. A young husband developed an inflammation of the urethra during the first days of his marriage. He accused his wife of having infected him, but examination revealed that she was not afflicted. Then, the husband confessed that he had suffered from the ailment before but that his physician had declared him completely cured. The insufficiently treated inflammation, according to Van den Berghe, returned as the result of an orgasm.85

Why did these patients with venereal disorders consult Van den Berghe? Patient accounts reveal that shame was one of the motives for visiting him. Some files of patients who suffered from venereal diseases are anonymous, with no reference to name, age or residence. There are also several patients who came from outside Ghent to consult Van den Berghe, probably to hide their illness from their own communities. Privacy was crucial for nineteenth-century patients who suffered from venereal disease, just as it had been for their early-modern predecessors.86 Harsh treatments, fear and shame are all plausible explanations of why patients consulted Van den Berghe. Financial considerations also may have been the basis of the decision as the poor could turn to him for gratis treatment; and workers could avoid losing their social security.87 However, although financial advantages motivated some ‘non-venereal’ sufferers to consult Van den Berghe, only a handful of patients with venereal and other sex-related ailments were treated free of charge. Whether venereal disease was of more concern to middle-class people, however, requires further examination of the social background of these patients.

The consequences were considerable whether suffering acute or chronic venereal disease, whether this was the result of sexual excesses or brought about by a partner. Venereal disease was hard to cure and symptoms varied from itching and discharge to impotence and infertility. The emotional damage also should not be under-estimated. Health-advice guides depicted excessive intercourse and masturbation as hideous and sinful acts, thus, causing anxiety, fear and shame in sexually active individuals. Moreover, the feelings of those who only discovered their partner’s marital infidelity after visiting a doctor and discovering they had been infected with a venereal disease can only be guessed at.

7.3 Women and Illness

Van den Berghe was not a specialist women’s doctor, but his growing popularity amongst women, the gender ratio changed from 80 in 1869 to 58 at

85 Anonymous, ‘Comptes-rendues de Sociétés médicales homéopathiques. Cercle médical homéopathiques des Flandres’, Union 1 (1886-1887), 76-80, q.v. 77-78.
87 Velle, ‘De syfiliskwestie’, 337.
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the end of the century, cannot be overlooked. Therefore, it is logical to take a closer look at women’s attitudes towards health, illness, Van den Berghe and homoeopathy. Women have conquered their own territory in the historiography of the social history of medicine. Yet, they are often considered as if they were the only sex. No account is taken of what women felt, thought and did about medical decisions and issues when, in practice, these were instigated often within the boundaries of their gender and influenced by their position in relation to the opposite sex. The concept of gender, the basis for formulating the ‘socio-cultural construction of male and female identities’ and, thus, the comparison of the behaviour of women to that of men and vice versa is often left out. However, a new agenda changed this approach and turned women’s history into history from a gender perspective. This perspective has been used also in recent studies in the social history of medicine, although its output is still limited. There is also relatively limited knowledge on men and women as sufferers and, especially, on the supposed preference of women for treatments offered by unorthodox medicine in the past and the present.

Historical perceptions of women and their diseased bodies have become a fascinating research object for scholars, yet, mainly from the viewpoint of gender as a building block for social, political and cultural relations. Roy Porter wrote in 1991 that we were remarkably ignorant about how individuals dealt with pain and illness in the past and, consequently, conceived their own bodies. A decade later, Porter, although he denied credit for it, was pleased to see that scholars of diverse disciplines had followed his agenda for a history of the body, resulting in a notable list of studies. However, body perceptions of the everyday historical individual remain a complicated research category.

88 Meaning per 100 women, 80 men in 1869 to 58 men per 100 women around 1900.
91 Gijswijk-Hofstra, 'A Sense of Gender', 40-43. In this article she gives an overview of the results of historical research on what she calls the history of illness and healing alternatives from a gender perspective.
94 During the Anglo-Dutch-German workshop on Patients Body Perceptions (Warwick University, 11-13 July 2003) only a few contributions directly aimed at the perceptions of
Even a book with the title *Feminism and the Body* implies much more than it achieves as the history of the body is studied only from a scientific point view.\(^9\)

The perceptions of women sufferers are barely highlighted in research on female health and sexuality, whereas the larger context of medical-scientific notions and achievements and the impact on socio-economic discourse is examined. These studies reflect predominantly ideas on what women were, ought to be, or how they had to behave and merely echo indirectly the bodily experiences they had.\(^6\) Historians of unorthodox medicine in the modern period, in addition, have concentrated on therapies, institutional structures and legal struggles and have largely neglected the issue of gender and lay illness experiences. Even if the history of European health and medicine is explored from a gender perspective, it focuses almost exclusively on elite culture, e.g. the female doctor or practitioner.\(^9\)

There are always exceptions to the rule and some attempts have been made to bring to life women's experiences with health, illness and suffering. *A History of Women's Bodies*, dating from the early 1980s, attempted to shed light on the impact of sex, pregnancy and delivery on a woman's life.\(^6\) It provides illuminating, imaginative examples and anecdotes about the consequences of sexual relations for a woman's body but these undermine absolutely the possible strength of the book. The presumption that 'for [peasant and working class] women in the past, sex was a burden to be dutifully, resentfully borne throughout life rather than a source of joy' turns *Women's Bodies*, at times, into a medical lamentation and an indictment of men who are depicted as insensitive, brutal and abusive.\(^6\) Women are portrayed emphatically as victims; they were

patients, sufferers and the like. Many papers dealt with bodies as the aims and means to create, for example, national/colonial identity, hygienism, medical categories or discourse and so forth. Body perceptions in a narrow sense, i.e. the way a person 'embodied' their corporal existence, received little attention.


the 'slaves' of their husbands, their children and their biology, a picture that can be put into perspective by other empirically based research. However, this study is an extensive account of the potential diseases women could develop because of their biology; a welcome overview of the conditions women suffered in the past.

Other, more recent, historical research takes more at face-value the medical circumstances of women in the past, departing from the presupposition that women were never in control of their lives, thereby, attempting to reveal their knowledge and, at times, independent behaviour. Research on the women patients of an eighteenth-century German doctor, for example, creates an understanding of individual female attitudes, knowledge and behaviour concerning the body and its afflictions. A female patients' history 'from below' has been achieved by analysing a physician's medical casebooks. The experiences of abortion from those who underwent the procedure showed that factors such as gender and class influenced a woman's options and experiences with abortion. Lower-class women in Weimar Germany who wanted an abortion turned to other women for information and preferred lower-class female abortionists, whereas men in the Hague looking for help in the early twentieth century drew on their male networks. An oral history of birth control practice in inter-war South Wales has concluded that, especially in working-class circles, abortion was widely accepted because of its practical importance.

The daily lives of women who were unwillingly pregnant have been studied by making use of infanticide cases and lying-in hospital records in

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100 As I have argued, women themselves contributed to the idea of being victims. Female venereal ill patients of Van den Berghe at times seemed rather eager to transfer responsibility onto men. Some women, thus, deliberately created the victim-role.


103 Kate Fisher, 'Didn't stop to think, I just didn't want another one': the culture of abortion in interwar South Wales', in: Eder, Hall and Hekma (eds.), Sexual Cultures in Europe. Themes in sexuality, 213-232, q.v. 213.
nineteenth-century Germany. A study of the culture of giving birth in Germany by examining the process of the medicalisation of delivery, i.e. the increasing interference of the medical profession in both childbirth and gynaecological matters, places the experiences of women at the margins. An analysis of childbirth in nineteenth-century Britain, concentrating on medical practice and perceptions regarding women suffering puerperal insanity, focuses on treatment-related developments rather than on the women enduring this ordeal. Interest in the 'milestones' in a woman's life, i.e. menstruation and menopause, has expanded considerably and contributes to an understanding of how femininity was defined and, hence, influenced the relation between the sexes. However, the history of menstruation and menopause, concentrating on prevailing medical theory, tends to ignore individual female sufferers of menstrual and menopausal related complaints, apart from an occasional personal account.

Interest in the personal illness-experience of female and male sufferers has not entered the social history of Belgian medicine. Patient history is virtually non-existent, apart from an occasional attempt to explore attitudes towards hygienics and the body. The political construction of gender and the role of women's sexuality has received more attention, mainly to determine the

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108 Cf. Liesbet Nys, 'Moderation as a Medical Moral. The Invention of the Hygienic Body in Belgium c. 1840-1914'. Unpublished paper for the Anglo-Dutch-German Workshop: Body Perceptions (University of Warwick, Coventry, 11-13 July 2003); Nys et al. (eds), De ziekte natie.
position of women in relation to the labour movement. Socialists, like liberals and Catholics, recommended strongly that women should not carry out industrial work. A woman’s proper place was at home where she could safeguard the race from degeneration and where she was protected from exhaustion as, physiologically, women were not fit for working outdoors. Labour would ‘harm their constitution, destroy their health and shorten their life’. Moreover, free contact between the sexes negatively affected a girl’s morality and would encourage promiscuous behaviour. The impact of medical discourse on sexual identities, relations between the sexes and perceptions about the susceptibility to illness largely have to be embraced still as research objects of the social history of Belgian medicine.

Medical Representations of a Woman’s Nature

Women had been considered as ‘failed’ men until the end of the eighteenth century. They had the same sexual organs as men, but only on the inside. This ‘one-sex model’ of biologically similar men and women disappeared when the reproductive organs of men and women became to be seen as completely different. Finally, women got bodies of their own and this was used to redefine the relation between the sexes. The new model ‘underlay and promoted increasing impulses to identify sex as both a biological and a political category’. A biology of hierarchy arose in which the differences of women compared to men were defined along a dichotomising line of nature versus culture, weak versus strong, body versus mind and private versus public.

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112 Laqueur, Making Sex, 149-192. There has been profound scholarly debate on Laqueur’s model, especially on the era where the switch from the one-sex model to the two-sex model would have taken place.


Depictions of how eighteenth and nineteenth century scientific and medical ideas mediated sex roles and gender differences through the study of the biomedical sciences, sees the sciences as a source of symbols and metaphors of the presumed differences between the sexes and the connective effects on the development of masculinity, femininity and, consequently, sexual identity. The notion that women were closer to nature than men held numerous elements. Women were depicted as emotional, men as analytical, and they were concretely assigned distinctive work, yet this ‘served to prescribe appropriate behaviour through metaphorical associations’.\textsuperscript{115} Medically, the sex distinction was symbolised by a woman’s sensibility. The reproductive organs not only made women highly receptive of nervous illnesses they also determined their social, physical and, thus, public limitations. The ability to carry, bear and nurse children restricted a woman’s functioning to the private domain of home and family.

The passiveness in a woman’s nature, in contrast to male public activity, and her nervousness, in contrast to male muscular strength, both resulting from her distinctive biology, was symbolised vividly in anatomical waxes developed by the medical sciences. Such images reflected women’s weakness by almost always embodying woman in a subordinate recumbent posture.\textsuperscript{116} Therefore, science and medicine represented women by emphasising the ‘otherness’ from men, resulting from the female nature and assigning specific tasks, qualities and medical conditions to women.

A woman’s specific biology determined her absent role in society because her constitution made her predisposed to affliction and illness. The idea of women falling victim to all sorts of ailments due to their nature or gender was widespread during the nineteenth century. Medical science proclaimed that, as soon as girls started menstruating, their health was at stake and caution should be applied. Moreover, their weak constitution not only made them more susceptible to illness but also contributed to an inability to easily resist or recover. One Belgian doctor wrote:

\begin{quote}
A woman is more easily influenced by disease, and her organism responds less energetically against it. On the other hand, her tasks and her genital organs are the sources of excessively common illnesses.\textsuperscript{117}
\end{quote}

\textsuperscript{115} Ludmilla Jordanova, Sexual Visions. Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries (New York etc.: Harvester Wheatsheaf, 1989), 23. The summary of Jordanova’s findings is mostly derived from chapter 1.

\textsuperscript{116} Jordanova, Sexual Visions, 58.

\textsuperscript{117} Sovet, Manuel d’hygiène publique et privée, 180. 'La femme est plus facilement influencée par les causes de maladie, et son organe reagit moins énergiquement contre elles. D’un
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The womb was given decisive power over women’s lives, thereby, determining her social status of housekeeper and caretaker. Female orgasm was no longer a necessity in procreation, thus, creating the passionless woman. The ovaries, or female testicles, determined the nature of women and were responsible for their sexual urges and other ‘deviations’ such as hysteria. The removal of the ovaries, a procedure that became popular from the 1870s, should release a woman from unladylike tendencies.\textsuperscript{118}

This medical line of reasoning turned women into helpless beings unable to guard against the urges that nature, i.e. their female body, imposed. All they could do was to restrain from all ‘unhealthy’ impulses generated by their sexual organs and nervous system. However, the view that women were more prone to suffering than men was, not so much a natural given, but a human construct and, therefore, resulted from the social cultural meaning assigned to the feminine gender.\textsuperscript{119}

\textit{The Female Body and its Vices: the Consequences of Menstruation, Pregnancy, Miscarriage and Delivery for Women}

The women who became patients of Van den Berghe were not suffering solely from typical female disorders, nor did they attribute exclusively their complaints to their sexual organs. More than ninety per cent of the women consulted him with complaints other than those specifically bound to their gender.\textsuperscript{120} However, this is not to say that these women never referred to their hard lives as mothers and wives to explain their current state of health. It indicates merely that these female urban inhabitants attributed their suffering to more than their biological state. Though female patients shared many conditions with their male counterparts, their ‘natural’ destination to reproduce contained, at times, serious repercussions on their health.\textsuperscript{121} The statement that ‘the pregnant state, is a natural state, since woman has been created for reproducing the species’ led women to suffer physically and emotionally.\textsuperscript{122}

\textsuperscript{118} Laqueur, \textit{Making Sex}, 175-177.


\textsuperscript{120} Based on the sample of 1,826 patients of which 1,056 were women: see Appendix 6. The number of women suffering sexual ailments, pregnancy, post-birth complaints, and menstrual and female disorders adds up to 90 (8.5 per cent).

\textsuperscript{121} This is in accordance with the views of Shorter.

\textsuperscript{122} Fl. Dubois, \textit{Le médecin de soi-même, moyen sur et peu couteux de se préserver et de se guérir de toutes les maladies, d’après la méthode de M.F.-V. Raspail} (Brussels: Imprimerie de la Société des Beaux-Arts; 5\textsuperscript{th} edition, 1844), 98. ‘L’état de gestation (grosesse), est un état naturel, puisque la femme a été créée pour la reproduction de l’espèce’.
In Search of a Cure

Inquiries into the course and regularity of the female patients' menstrual cycle was a normal procedure in Van den Berghe's anamnesis. It formed part of women's medical histories, whether or not changes or irregularities had taken place decades previously. Even though entirely different complaints could underlie the decision to consult Van den Berghe, a woman's gender-specific experiences of menstruation, pregnancy, delivery and the like formed an essential part of his decision on the proper treatment.

Women had to guard themselves on two fronts. There existed, on the one side, the health risks of being human, risks that women shared with men and, on the other side, there were the dangers of being a woman, diseases which had their origin in their female organs.123 Women who needed treatment for 'human' conditions had often suffered one female disorder or the other in the past. The medical histories describe many women who had lived through emotional states such as worrying about menstruation, the fear of or longing to become pregnant, apprehension during pregnancy as miscarriages occurred frequently, and anxiety about the forthcoming delivery. Perceptions of the arrival of the baby included ideas of ruptures (laceration), prolapses, extreme bleeding and even death which remained obstinately in the mind of the future mother. Forceps had been used frequently to end deliveries, causing extreme pain and uterus deformations, leaving a woman with all sorts of ailments, future delivery difficulties and, sometimes, chronic health problems. Miscarriages also seem to have been a matter of course, some occurred spontaneously, some caused by accidents or even mistreatment. Finally, multiple pregnancies, difficult deliveries and long breastfeeding in the past frequently interspersed the grievances of women about their general health and ill-health.

Jeanette Schelfaert (age 39), residing in Ledeberg bordering Ghent, was miserable because of the six miscarriages she had in two-and-a-half years. She was often losing blood during pregnancy and, especially, after having intercourse. When she consulted Van den Berghe in September 1886 she had just had her last miscarriage three months earlier. She had a foul-smelling red discharge (des pertes rouges), or a mixture of white and red, which he was unable to relieve and she was diagnosed with uterine cancer.124

123 This does not mean that men and women shared the same experiences of a disease. Moreover, current biomedical research has found unsuspected differences between men's and women's bodies resulting in a different response to drugs, different symptoms in the same disease and different degrees of suffering. Cf. Schiebinger, 'Introduction', in: Ibidem (ed.), Feminism and the Body, 3.
Dealing with Diseased Bodies

Hélène Schepens, an unspecified trader, applied for treatment for an irregular menstrual cycle that had indisposed her for one year. The amenorrhoea was a source of suffering, causing pain on her breastbone and the impossibility of sleeping on her left side as it gave her stomach-ache. Hélène was very specific about the composition of her menstrual blood and the course of her menstruation. If she had her period the blood was black, thick and normally decreased after she had been menstruating for three to four days. Van den Berghe committed to paper on the day of her first visit:

Mlle Hélène Schepens, age 20, Ghent
Nov. 29, 1900
Irreg. menses with much pain. Always late, often 2 to 2½ months. Always has pain in loins and lower belly after her menstruation has passed. The pain preceding her menses is not particularly greater. As soon as her menstruation flows [she] is much better. Abundant yellowish leucorrhoea, currently it is 7 weeks since she had her menses. Very agitated, palpitations, a little vertigo.

Hélène philosophised on the origins of her irregular menses and attributed it to a malfunctioning of the uterus as she 'believes to have gained this disturbance in the functioning of the womb after doing the laundry, having helped doing the laundry.' This seems a rather peculiar cause of menstrual problems as many women were responsible for doing the laundry for their entire family without ever having menstrual complaints. Yet, a persistent popular belief was that water posed a threat to menstruating women because it could result in personal ill health or could influence the flow of blood. Hélène, later on in the treatment, added more information about the particular event. She was in the middle of her period when she was carrying out the household chore and felt a sharp rage to which she attributed her illness (sa maladie). Whether she was angry about having to do the laundry or there was some other reason remains hidden but, ever since that emotional outburst, her period ceased to occur properly.

125 Casebook 17 (1898-1901): p. 907. DSG, Straatnamenregister 1901-1910: Onderstraat 25, district 1. Hélène Anna Francisca Maria Schepers (b. Sleijdinge, 8 December 1879, d. ?).
126 Casebook 17 (1898-1901): p. 907. 'Règles irreg. avec beau. de doul. tjs. en retard qff. 2 mois à 2½ mois a tjs. des doul. ds reins x bas ventre qd. le temps des règles est passé. Le mal avant ses règles n’est pas sensiblement plus grand. Dès que les règles coulent [elle] est beau. mieux. Leucorrhée jaunêtre abondante, actuellement il y à 7 semaines qu’elle n’a eu ses règles. très agitée, palpitations, un peu de vertiges.‘
127 Ibidem. ‘croit avoir gagné ses troubles dans le fonctionnement de la matrice après avoir lave, aider a laver’.
In Search of a Cure

Hélène Schepens considered her irregular menses to be the source of her suffering, all other ailments being side-effects, and she hoped that Van den Berghe would be able to restore her menstrual cycle. She consulted him on sixteen occasions between November 1900 and April 1901 by which time she was feeling less well. She was becoming overweight and she still had not had her menses. As there were no more consultations she had either lost faith in Van den Berghe and/or homoeopathy and suspended the treatment, or had suddenly regained her menses, thus, no longer needing treatment.

The case of Hélène is one of many telling us about the preoccupation of women with their monthly flow of blood. They knew it had to happen each month and considered irregularities as signs of something wrong. Was a suppressed menses an illness in itself or an indication that some other condition was about to break out? Were women merely worried about a possible pregnancy if they did not menstruate, or were they not at all aware of the possibility of carrying a child although their menses had ceased several months previously?

Although doctors in eighteenth-century Britain diagnosed amenorrhoea after two to three weeks, women often waited six months before seeking treatment. Many of Van den Berghe’s female patients with menstrual disorders also took their time before requesting his help. Leonie Bello had not menstruated for three months when she turned to homoeopathy in August 1876. In addition to the failing menses, she had strong leucorrhoea, lumbar pain, insomnia, headaches, an impeded respiration and was extremely tired. Leonie told Van den Berghe, after the enumeration of symptoms, that she was sexually active, having had intercourse with her lover three months ago (a fait le coit avec son amant il y a trois mois). She suspected, probably, that she was pregnant. Leonie consulted Van den Berghe three more times in August and September but then postponed further treatment until the following Spring. Van den Berghe did not confirm nor deny that she was pregnant but, in March 1877, Leonie returned with post-partum complaints of considerable uterine blood loss.

Leonie Bello considered the possibility of being pregnant as, for her, the notion of the link between being late and having sexual relations i.e. being pregnant was not unfamiliar. Not every woman appeared to have such

130 Casebook 6 (1876-1879): p. 126. DSG, Straatnamenregister 1867-1880: Nieuwe Wandeling 11, district 2. Leonia Maria Bello (1846-1878). At the time of her first consultation Leonie lived with her parents. On January 3, 1877 she married her lover Gustavus Maria Crommelinckx (b. 1847) with whom she moved to the Hovenierstraat 10, district 2. Seventeen days later their child was born: Elvira Antonia (20.02.1877-19.12.1877, bronchitis).
Dealing with Diseased Bodies

knowledge or, at least, pretended to be innocent. Eulalie Servais needed medical care for what she thought to be an abdominal ailment. She had not felt well for the previous eight-and-a-half months with nausea, vomiting and headache and a lack of her menses. Her legs were now swelling as well. Yet, she was taken by surprise when Van den Bergh told her that he was not going to prescribe anything as she was facing the consequences of pregnancy.

It will have been rather difficult for Van den Berghe, at times, to provide the right diagnosis as some women, who were unwillingly pregnant, gave quite confusing complaints. Unmarried Octavie Veekman, for example, consulted him because she had not had a period in six months and because she had belly-ache and felt a bump on the left side of her body. Van den Bergh could also feel a bump in her lower belly and noted ‘a big tumour like a child’s head’ (une tumeur grosse comme une tête d’enfant). Octavie said that she had never courted a man but, nevertheless, he observed that she was pregnant. Some women visited the doctor hoping to be with child. Nathalie VanderCruyssse will have been very confused after consulting Van den Berghe. She came to see him with, what she thought, were pregnancy-related complaints. Seven months prior to her first consultation she suffered metrorrhagia (haemorrhagic bleeding) whilst, as she thought, again being pregnant. Since she was bleeding four to five days a week, her accoucheur had assured her that she was pregnant and expected the baby to come in a month. Meanwhile, she continued to bleed and to have colic and diarrhoea. She came to see Van den Berghe as she was not at ease and he explained that she was not with child. Her belly was sonorous, not stretched and only slightly voluminous.

The women were not worried about or ignorant of being pregnant in most cases of menstrual discomfort but, instead, were concerned about the effects on their health. They thought that not menstruating or having an irregular menses could lead to other, more serious ailments which needed to be avoided. They wanted Van den Berghe to achieve one single goal, restoring their period. Women with a regular, but uncomfortable, period wanted to be freed from their suffering during those days of the month. A regular cycle, of course, facilitated avoiding pregnancy as there could be abstinence from sexual relations during the fertile period. This was the only means of protection for many women yet, even medical science was in error about a woman’s fertile period and advised that it was safest to have sex during the middle of the

131 Lidy Schoon has noted stories of women who deliberately concealed or denied their pregnant state. Cf. Schoon, *De gynaecologie*, 81-82.
menstrual cycle. However, the worries about not menstruating may have concerned also the fear of infertility and, hence, of not being able to fulfil the true feminine task of becoming a mother. British culture, for example, valued women for their ability to produce offspring, whilst menstrual irregularity posed a threat to that destiny as mothers. Menstruation, although the uppermost sign of femininity, was surrounded by connotations of illness and disorder. A regular menses was perceived as a pathological indisposition, the failure to menstruate also was considered an illness and a symptom of deficient femininity.

The casebooks reveal nothing about Ghent women feeling failed, but whether or not the anxieties of not menstruating were inspired by cultural expectations, some lived in agony because they could not conceive. A thirty-eight year old anonymous patient was zealously longing for a child and thought she was pregnant as she had a very irregular menses for four months when she consulted Van den Berghe. Yet, she still had some blood loss from time to time but other symptoms such as a swollen belly and breasts explained her expectation. The patient not being sick nor having to vomit is noted but nothing about a pregnancy. A woman of thirty who had been married for two years was near to desperation because she had not become pregnant. She longed intensely for a child and submitted herself to taking medication to become a mother.

The consequences of having a new baby, sometimes, were more than a woman could bear physically and emotionally. Van den Berghe functioned as a 'mental coach' for those who had trouble adjusting to the responsibility of caring for an innocent, dependent new baby in addition to rendering treatment to women with post-birth complaints directly related to the delivery. The nursing of a child, at times, led to mammary gland infection, sore nipples and a suppression of menstruation. The latter was welcomed as a source of contraception but was seen also as the cause of health complaints. Moreover, raging hormones resulted in a state of emotional imbalance. Five months after she had given birth Mathilde Meire (38) was afraid of dying, crying

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139 Casebook 16 (1896-1898): p. 116. '... se soumet à prendre des remèdes, dans le but de devenir mère'.
140 Cf. G. Van den Berghe, 'L'Arnica Montana dans les suites des couches', J.B. 2 (1895), 204-207; AVB, Notes on the application of arnica during pregnancy, inv. no. 47, 5 cases, from 1870.
141 Cf. Nelly Oudshoorn, 'The Birth of Sex Hormones', in: Schiebing (ed.), Feminism and the Body, 87-117. At this time, not known about or, of course, used as an explanation of behaviour.
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inexplicably, and was constantly trembling. Marie VanHelder (28), a butcher’s wife, consulted Van den Berghe with complaints of anxiety and fear of dying. She felt very weak and, furthermore, was unable to sleep except at the beginning of the night. She had given birth recently to a daughter and, perhaps, Marie would be diagnosed, nowadays, as suffering from post-natal depression.

Older female patients with failing menses often were confronted with the forebodings of menopause, the ‘âge critique’. The casebooks reveal little about the psychological consequences for women who saw that day of older age rapidly coming nearer. It was a period of anxiety as the hot flushes and palpitations followed each other in quick succession. Some historical studies provide insight into women’s menopausal perceptions, but with opposite conclusions. Menopause was perceived in general as a serious danger to health as, in the view of many women, menstruation served the evacuation of poisonous humours. Women feared that, with the cessation of menstruation, bad fluids would accumulate in their bodies causing great suffering. However, the one study claims that post-menopausal women had lost their femininity and, therefore, ceased to be socially valuable. The other concludes, conversely, that a ‘positive re-evaluation of the postmenopausal body’ took place at the beginning of the nineteenth century. Women broke loose from the chains of their reproductive organs with the passing of menopause to become physically stronger. The womb’s decline in dominance led to female stability.

It is a pity that the casebooks keep quiet about the ideas women held regarding the social, biological or even physical meaning of the cessation of menstruation. They do not answer interesting questions on what post-menopausal women thought about their social status; whether they were regarded as older, ‘wiser’ and stronger women or, if they were looked upon as women without femininity. Neither do they give evidence on if women would

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144 E.g. Stolberg, ‘A Woman’s Hell’; Strange, ‘Menstrual Fictions’.
146 Strange, ‘Menstrual Fictions’, 612.
have welcomed eventually the loss of fertility as they did not have to worry any longer about the consequences of sexual relations. Nor is anything learnt about whether these women truly pitied their new status as older women and feared the loss of beauty.

Van den Bergh frequently attended to 'disturbances' of leucorrhoea and vaginal itch or pains. Non-menstrual vaginal discharge was of great concern to women. Such complaints were described in the casebooks with the medical term 'leucorrhoea' (leucorrhoea) or the lay-term 'pertes blanches' or 'fleurs blanches'. Women reported in detail the smell, density, colour and structure. The discharge was mentioned, at times, as a secondary symptom to other conditions but, it could be also a primary cause of suffering. Women were able to make a distinction between ordinary, yet unwanted, vaginal discharge ('the whites') and other abnormal vaginal emissions. The term 'leucorrhoea' was never employed in the latter case but the emissions were referred to as 'pertes' (loss) or 'écoulement' (discharge). Camille V., for example, wanted Van den Bergh to free her from abundant purulent vaginal pertes. Nathalie B. described her vaginal ailment as purulent écoulement. She told Van den Bergh, when asked, that her husband had nothing abnormal on his 'male member' (verge). Clearly, the physician thought that a venereal disease might have affected Nathalie. She developed a swollen, grazed and callous left labium during the treatment and she began to bring along her husband as now he had developed also an abrasion, a superficial ulceration on his prepuce. Van den Bergh had been right.

Nathalie's worst nightmare probably came true. The discharge was a venereal affliction, a disorder that most women received unknowingly from their husbands. Women, although it rarely represented life-threatening diseases, therefore, dreaded vaginal discharge. The causes could be multiple, venereal disease, post-delivery infection, or damage from childbearing. The ultimate result was infertility. Thus, it made women extremely aware of their bodies. Discharge, moreover, affected the relationship between the sexes. The foul smell and pain during intercourse obstructed the joy of the sexual act and, at the same time, revealed a spouse's infidelity as well as his dishonesty if the discharge signalled the presence of venereal disease. Vaginal secretion also upset many women as it could indicate that the body's reproductive functions were in danger.

Although a few women actually complained that the leucorrhoea limited sexual relations as it caused pain, none of the women grumbled that they had been refused sex because their husbands considered it unhygienic or

149 Ibidem: p. 981.
150 Shorter, Women's Bodies, 256-260.
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inappropriate. Thus, women hardly used the vaginal emission as an excuse to avoid sex and men were not held back by a little discharge. Moreover, although men consulted Van den Berghe because of sexual impotence, virtually no woman visited him because of direct difficulty with the sexual act. An exceptional twenty-three year old non-paying patient let herself be treated in 1877-1878 for painful intercourse: ‘at the insertion of the male member she experiences great suffering’ (en introduisant le membre virile elle éprouve de vives souffrances).\(^{151}\) Sexual failure was directly perceptible in men because their genitals literally let them down. Women were not unable to have intercourse yet, at times, suffered unbearable pain. Moreover, it appears that, even if a woman knew that sex would result in suffering, the thought of abstaining from intercourse barely crossed her mind.\(^{152}\)

The typical female disorders suffered by Ghent women and the consequences for their health and life, at times, becomes abundantly clear from the casebooks. Yet, how women looked upon their bodies, their perceptions of bodily functions and of their role in relations with men is rather less obvious. The vivid depiction of the movements of the uterus and ovaries means that, for women, the functioning and health of these organs were connected closely with perceptions on causes of illness. However, not all women related their suffering to their reproductive organs but, instead, held different opinions on the origins of their ailments. Women thought also that their bodies were more than vehicles for reproduction. Sexuality was an integral part of life, inside and outside of wedlock, and not only to satisfy the needs of men. Leucorrhoea might have hindered normal sexual relations. The presence of a serious ailment, at times, was indicated by too strong or deviant-coloured discharge, perhaps unknowingly transmitted from a partner, but was considered also as a sign of impurity.

Women tended to explain their suffering differently from men but why?\(^{153}\) The answer partly can be reduced to the nature that society had assigned to women and the emphasis that medical representatives put on a woman’s sensibility. In 1883 a male doctor formulated it as follows:

General differences exist bound by a larger dosage of sensibility in women. Impressions are more vivid, habits are weaker, and, consequently, less energy exists to resist moral causes that ceaselessly affect us. In women, furthermore, much more nervous disorders are seen, and these complications always have more vile

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\(^{151}\) Casebook 6 (1876-1879): p. 914.

\(^{152}\) Whether women continued to have sex because they wanted to or out of obligation cannot be determined by the present research.

\(^{153}\) See the first paragraph.
consequences than in men. In her, the genital apparatus plays a much larger role than in us, and the aberrations in sensibility manifested in here result in a mass of lesions that are entirely unknown to us.\textsuperscript{154}

A woman’s nature made her not only increasingly susceptible to physical suffering but also implied that she was vulnerable to the slightest emotional event, thereby, causing even more suffering. This notion of female emotional weakness as a cause for disease seeped through to the perception of ordinary women who used it as a means of explaining what was happening to them. Men, as sensible beings less influenced by emotional matters, were more likely to justify their affliction by rational causes. All of this is linked with social backgrounds and, correspondingly, the level of education. As men were generally more literate than women, their chances of grasping and reading medical topics was greater. Moreover, an occupied working-class mother would not have had the luxury, in terms of time and money, of becoming as emotionally affected as an upper-class woman with private means. Women from the lower classes had less time to let their menses interfere with their daily routine than their more well-to-do sisters who could afford restricted activity during menstruation.\textsuperscript{155}

Was the presumed mildness of homoeopathic treatment an important factor in a woman’s decision to consult Van den Berghe and/or to try homoeopathy?\textsuperscript{156} The casebooks do not provide absolute evidence for such an assumption. Men and women complained about the negative consequences of

\textsuperscript{154} Becquerel, \textit{Traité élémentaire}, 851. ‘Il y a des différences générales tenant à une plus grande dose de sensibilité chez les femmes. Les impressions sont plus vives, les habitudes plus molles, et, par conséquent, il y a moins d’énergie pour résister aux causes morales qui nous affectant sans cesse. Aussi voit-on beaucoup plus de désordres nerveux chez les femmes, et ces accidents ont toujours de plus fâcheux [sic] résultats que chez les hommes. L’appareil génital joue chez elles un bien plus grand rôle que chez nous, et les aberrations de sensibilité qui se manifestent de ce cote entraînent une foule de lésions qui nous sont entièrement inconnues.’

\textsuperscript{155} Strange, ‘Menstrual Etiquette’, 257. However, this assertion cannot be substantiated by data from Van den Berghe’s women patients with menstrual and other gender-related disorders, because of only a few of them the social background could be assessed. More than half of the twenty who suffered from menstrual and sexual complaints came from the lower middle and working classes.

orthodox medicine which made them more ill than they had felt before. The wish for humane, or holistic or ‘soft’ treatment, in a sense, was expressed by both sexes. This homoeopathic physician hardly, if at all, exposed his patients to a physical examination which could have appealed to women with very intimate conditions. However, the greater part of the women consulted Van den Berghe with non-gender-related complaints. Personal explanations for becoming one of his patients are rather scarce. If they are available, the patient usually said that there was a recommendation from an acquaintance, friend etc. or that they had tried unsuccessfully other healing options and now wanted, whether confident or not, to try Van den Berghe and his homoeopathic treatment. Moreover, during the treatment, women and men did not see the need to abstain from their purging habit. So, even if they liked the near-absent side effects of homoeopathic medication, patients continued to submit themselves to harsh treatment.

Is there no indication at all for a preference for the holistic aspects of homoeopathy? There is still the fact that his practice, in the course of time, became a predominantly female business, with the new clientele including more women and fewer men. If, at the end of the nineteenth century, orthodox practitioners managed largely male clienteles then it is conceivable that the choice between orthodox and unorthodox healing methods was gender-related. Indications have been found that men attached less value to the psychological/emotional backgrounds of their suffering. Their primary focus was the eventual elimination of the conditions. However, women (51 out of 101) offered twice as often than men (18 out of 80) emotional explanations for their hardship. The holistic approach of homoeopathy, its basic assumption that physical suffering is symptomatic of psychological distress, the interconnection between body and mind, may have made them feel more comfortable.

7.4 Recapitulation

First, a sufferer's sex influenced perceptions about the nature and causes of the suffering and illness. Second, a discrepancy existed between knowledge and actual sexual behaviour. Men and women expressed their awareness of the possibly negative impact of excessive sexual behaviour and so-called immoral sex, not aiming at procreation, on their body and health. However, knowing and acting upon this awareness were not the same. Third, male and female patients equally enjoyed sexual relations but feared the potential consequences. However, men and women experienced and elucidated such adverse effects differently because of their distinctive body perceptions.

Illness could result from three different circumstances in the experience of Van den Berghe’s patients. It could be caused by emotional factors, the
illness could result from natural or medical factors, or the suffering could originate from personal conduct. These emotional, natural/medical and behavioural observations were not always separated sharply from each other; some patients explained that they had been confronted at the same time with several of these 'ill-making' factors. Although these types of explanations were given for all types of conditions and, as such, were not 'ailment-specific', men and women did not mention them equally. Women were more inclined to explain illness from a psychological point of view, stating that emotional events had caused the complaints, whereas men tended to explain their conditions from a medical/natural or behavioural perspective. The fact that women considered themselves, more than men, susceptible to the 'ill-making' effects of emotional changes was related to contemporary notions of woman's nature. Her weak and highly sensible natural constitution, resulting from the specifics of her female body, made a woman particularly vulnerable and susceptible to suffering. Men, as subjects of rationality, were influenced far less easily by emotions.

Men were aware particularly of the possibly 'ill-making' consequences of masturbation and unbridled sex. They expressed, for example, medical conceptions of sex-related disease and were aware very much of the condition of their semen. Yet, they hardly ever decided to abstain deliberately from sexual relations and neither did they feel the need to elucidate or to excuse this continuance. However, at the same time, they could never fool themselves as ulcers, grazes and impotency formed clear, visible bodily signs that something was wrong. Men were rather anxious about these conditions, not only because they feared the loss of manliness as their body could not engage in the blessings of intercourse, but also because of the uncertainty about whether the venereal condition had disappeared. It would have been very unpleasant to discover that a loved one had been infected unintentionally and unconsciously. The invisible, still infected male body, thus, at times, seemed a time bomb waiting to explode by revealing its ailment on another body.

Women also did not abstain from sexual indulgence, in spite of the medical and social views depicting women as weak, vulnerable and a-sexual. Stories about intercourse without being married and pregnancies and children outside of wedlock, indicate that unmarried women were sexual creatures to whom physical pleasures were alluring. Married women were, according to the casebooks, faithful to their tasks of beloved wives and mothers, putting their bodies at procreation's disposal but, thereby, risking becoming venereally infected by their unfaithful husbands. Women worried about their bodies disguising the true nature of their abdominal suffering from syphilis or gonorrhoea. Such ailments were visible in men but not in women. Therefore, it was not uncommon that women unknowingly had numerous miscarriages.
because of venereal disease or gave birth to syphilitic children, one of medicine’s great concerns as this was considered to lead to the degeneration of the human race.

Finally, although it was generally accepted that sexual excesses could lead to premature deterioration of a man’s body, it was not thought realistic for men to abstain. However, women should never undertake any form of excess as her irritable nature, resulting from her female biology i.e. uterus and ovaries, would be ruined by over-excitement. A woman’s biological body dictated her well-being. The state of a woman’s sexual organs and the features of femininity such as menstruation, bearing children and menopause already posed such a burden on her body that any other excitement would lead inevitably to more physical and psychological suffering.

These notions of masculinity and femininity, men having an animalistic urge, women having no such need for sexual gratification, become abundantly clear in the stories about masturbation. Men and women were aware of the possible dangers arising from masturbation, i.e. numerous bodily and mental signs of ill health, yet, their narratives on the origins of such behaviour clearly differed. Men never excused their masturbating activities, apparently considering it as a logical outcome of the male sexual urge. Women, on the other hand, always claimed that a physical sensation had forced them to touch themselves. Self-gratification resulted from the specifics of their bodies, usually a fit of vaginal itch, and, as such, women renounced all responsibility by claiming that they were biologically impelled.

Women and men had a natural, physical propensity for masturbation although women never justified that behaviour in sexual terms. Male explanations for venereal disease and masturbation considered it a matter of personal responsibility and an outcome of their natural passions. The female patients claimed that it was out of their control and, thus, they took the role of victims. Men had visited prostitutes, thereby risking venereal infections. Women blamed their husbands for infecting them. Men just simply masturbated whilst women, instead of being sexually aroused, were forced by their bodies to do so. However, although, at times, women suffered greatly from the consequences of menstruation, pregnancy, delivery, menopause and other gender-related conditions, they did not complain constantly about the ‘burdens’ of their body. The vast majority of Van den Berghe’s women patients consulted him with other than gender-related ailments. Thus, women attributed their suffering to more than their biological state and not all of them considered themselves to be the victims of their husbands, their own bodies or their femininity. The stories of Van den Berghe’s female patients reveal histories of suffering as well as accounts of joy.