Body Language: Instrumentalization of the Female Body In Nineteenth-Century Western Europe

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Development of capitalism in the nineteenth century coincided with a reformulation of the female body consistent with the needs of new economic, and thus superstructural, forms. This reformulation interposed discontinuity between male and female bodies. This discontinuity can also be understood as alienation in the Marxist sense and as a root cause of repression in Freudian terms.

This discontinuity/alienation/repression revealed itself in the discourse of science with regard to women's bodies in childbirth, hysterical paralysis, and female prostitution. Analysis of these issues reveals a "silenced" female body which persists in trying to speak.

Background

The development of representations of male and female bodies as incommensurate or discontinuous arose with theories of equality and the formulation of discourse on the dignity of man in the late eighteenth century. This reinterpretation of the body, according to Laqueur, served at first to support liberal political notions of male and female sexuality:

In striking contrast to the old teleology of the body as male, liberal theory begins with a neuter body, sexed but without gender, and of no consequence to cultural discourse. The body is regarded simply as the bearer of the rational subject, which itself constitutes the person.

Representations of the body in the eighteenth century had interpreted the female body as a homologue of the male body, granting, however, to that female body the "permission" to need and experience sexuality on a basis almost equivalent to that of men. Women were recognized in the eighteenth century, in other words, to have sexual needs, to be entitled to obtain release for them, and, indeed, to procreate only when such sexual fulfillment was


present. Sexual need and sexual pleasure were thus integrated into the fabric of women's personal and social lives, and into the medical discourse of the time.

Compared to the previous century, the nineteenth-century interpretation of the body as "neuter" in the wake of egalitarian political theories gaining momentum in Western Europe, did not create a method of representation and discourse more advantageous to women. Instead, the "neutrality" of the body was transformed into its discontinuity, as more precise information about the female reproductive cycle was obtained. Discovery of this biological discontinuity was providential, occurring in an era when political and social theorists sought to reconcile obvious inequities in social and political practices with the egalitarianism of the enlightenment. This discontinuity gained force at a time when "such differences became politically important."4 Laqueur notes that liberal theorists who were troubled by the obvious inequality of women were able to ground "the social and cultural differentiation of the sexes in a biology of incommensurability that liberal theory itself helped bring into being. A novel construal of nature [comes] to serve as the foundation of otherwise indefensible social practices."5

In this representation of women's bodies a new twist was added: the discontinuous representation of females and their sexual selves. The "moral superiority of women," which constituted their main access to social of political power under nineteenth century liberalism, could be obtained only at the expense of access to their sexual selves. The sexual participation of women became the sexual indifference of the virtuous wife and mother, accepting sex without accepting sexual desire. This dichotomy of self then entered the discourse of medicine and science, convincing women themselves that "the sexual instinct and the reproductive capacity remain distinct; there is no longer any necessary association."6

In Marxist terms, an alienation of women on a number of levels had occurred. First, the subordination of women inevitably resulted from the accumulation of capital in a patriarchal society. As Engels observed, "monogamy arose from the concentration of considerable wealth in the hands of a single individual -- a man -- and from the need to bequeath this wealth to the children of that man and of no other."7 Subordination of women

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4Ibid., 4.
5Ibid., 19.
6Mary Jacobi in 1886, quoted in ibid., 34.
arose with this need to control their sexual behavior and this formed the prototypical instrumentalization of the human body, in this case, the female body, to serve economic needs. Such instrumentalization, separating the body of woman from her control, resulted in a basic alienation of women from their bodies. The instrumentalized female body could then serve as a conduit for patrimony under capitalism.

In Capital, Marx argued that all social and political institutions are formed by the forces of production.\(^8\) Enlargement of capitalism in the nineteenth century formed a superstructure consistent with its needs; this superstructure rendered women economically, socially and politically alienated. The discovery that women did not need to experience orgasm ("venery") in order to conceive led to the identification of female sexuality as synonymous with reproductive capability. Only the prostitute possessed a sexual self; this sexuality was also instrumentalized to serve as a "drain" for the sexual needs of bourgeois men.\(^9\)

**Childbirth and Midwifery**

Changes in childbirth both reflected and hastened an instrumentalized view of the female body in the nineteenth century. The introduction of anaesthetics in childbirth provoked a discourse of the "silenced" body, a body to which male physicians now had access and the freedom to redefine that body in terms convenient for the medical establishment. Childbirth was transformed from the most uniquely female of endeavors to a quasi-disease in which medical intervention was essential.

In this new system of male medical attendance upon the woman in childbirth, the physician could "interpret" the bodies of women to themselves and their husbands, as well as to the medical profession and society at large.\(^10\) Such intervention and interpretation was not entered into without controversy. Poovey notes that two inherent difficulties presented themselves: "First, does the woman in labor properly belong to the realm of nature, which is governed by God, or to culture, where nature submits to man? Second, how can a man know -- so as to master -- the female body, which is always other to its own?"\(^11\)

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\(^10\)Poovey, "Scenes of an Indelicate Character," 141.

\(^11\)Ibid., 139.
The introduction of chloroform and other anaesthetics into the delivery room marked the point of departure at which the medical profession examined these two difficulties. This application of anaesthesia, producing a "silenced" female body during childbirth, constituted an innovation which brought into play an entire complex of discourse and representation regarding the female body, and the increasing utility of medical discourse to provide scientific rationales for its subordination within the context of nineteenth century bourgeois society. Poovey notes that the debate over use of anaesthetic in childbirth was:

Inevitably...bound up with the representation of reality as with material social relations and practices. As the arena for negotiating values, meanings, and identities, representation authorizes ethics and social practices; it stages the workings through of the dominant ideology.12

The debate over the use of anaesthesia focused primarily on its social and religious implications, although Poovey cites statistics to show that chloroform, in being administered by unskilled or inexperienced practitioners, caused hundreds of death in its early applications.13 Within the "conservative" segment of the medical profession, childbirth was still viewed as an arena in which the feelings of the patient were "worth a thousand dogmas and precepts." This view "privileged the patient's own experience of the body over any abstract theories the doctor might possess and thus argued for the non-instrumentalized body."14 This same conservative element tended also to conceptualize labor as a form of religious experience accessible properly only to women. Perhaps this constituted a more subtle form of instrumentalism.

The "reformist" element dismissed the religious issue out of hand, citing biblical interpretations to argue that whatever medical science could devise to relieve suffering was pleasing to God, for otherwise men would not have been allowed to invent it. Religious considerations were entirely secondary in this view, however, which dealt primarily with the practical problems of how to interpret the bodies of women.

Poovey argues that the introduction of chloroform in obstetrical applications served as both a practical means to facilitate male knowledge of the female body (as opposed to an illicit and private sense), and a means to bring that female body into the control and discourse of medicine. Poovey points out that anaesthesia "silences the patients and

12Ibid., 138.
13Ibid., 137.
14Ibid., 140.
subjects them to a doctor's interpretive control."15 The significance of anaesthesia lay not in its elimination of the physical spasms and movements causing pain -- these were an inseparable part of non-Caesarian deliveries -- but the elimination of the female's "feelings or sensations of pain." Chloroform "transfers to the doctor the knowledge of pain, as it renders the woman's body merely a sign, which he can read more accurately than she can." Under chloroform, the female body is "silenced," to use Poovey's term, and this "silenced" body "offers no impediment to the doctor's interpretation."16

For the sensibilities, as well as the expertise of the medical profession, physicians felt it important to "silence" the woman in childbirth. This was an essential element of the larger process of silencing the sexuality of the bourgeois woman. The "Scenes of an Indelicate Character" which Poovey refers to, relates to the frequency with which women in labor appeared in the eyes of their attending physicians to derive orgasmic "pleasure" as a byproduct of the childbirth process, although these same bodies may have been "silenced" in the marital bed. Poovey cites instances of the disquiet induced in physicians by the spectacle of "respectable" women who, under ether or chloroform, were not "silent" but rather vocal and explicit in sexual terms utterly inconsistent with the realm of social discourse and representation regarding the non-sexual nature of "respectable" women. Indeed, such spectacles were ultimately persuasive in causing obstetricians to formulate theories about feminine "hysteria," which located sexual energy in a disease model in which such sexual excitability did not occur in "normal" i.e., "good" women of the bourgeois class.

The use of anaesthesia thus achieved a dual purpose for the medical profession: it "silenced" the female patient, allowing the physician to "interpret" her body, and thus instrumentalize it; it also eradicated what physicians regarded as an "inappropriate" level of sexual feeling in childbirth. In both ways the medical profession was free to conceptualize the female body in any way it wished. In addition, the use of anaesthetics (and forceps) in delivery provided the primary entree of the male physician into the non-surgical treatment of women; this extended the range of the medical profession, in economic terms, into the formerly female-dominated profession of midwifery.

The profession of midwifery in the 1800s came under increasing attack from male physicians who were attempting to "professionalize" the fields of gynecology and obstetrics and to obtain entree into these lucrative, and female-dominated, specialities.

15Ibid.
16Ibid., 140-141.
Preliminary attacks castigated midwives as "untrained" (although training was later to be denied to them) and "primitive," effectively characterizing male physicians as the appropriate professionals in childbirthing. The association of childbirth and gynecology with female professionals (nurses and midwives) not only limited the economic access of male physicians, but also caused these specialties to be identified with their female practitioners, thus lowering their status. The lack of access of male physicians to female patients in these areas would of course prevent these physicians from "interpreting" the female body as they were later to do when entree had been gained.

Donnison demonstrates the significance of the issues in the controversy over midwifery and the determination of the male medical establishment to abolish midwifery in England. The nineteenth century saw determined efforts by the male medical establishment to force women out of medicine altogether, allowing them the clearly subordinate field of nursing by way of compensation. In 1865 the formation of a "Ladies' Medical College" in London brought into the open what had become a war of attrition by the male medical establishment against the midwifery profession. The Female Medical Society had formed the Ladies' Medical College to professionalize and extend the field of midwifery both as a means of offering competent medical care by women to other women and, of equal importance, to increase the access of educated and trained women to the lucrative field of midwifery.

Attendance at childbirth by midwives had produced a significantly lower incidence of puerperal fevers and maternal death, than attendance by male physicians. Most physicians were either unaware of the discoveries of the German physician Semmelweis regarding the importance of cleanliness in childbirth attendance, or assigned no credence to such theories. Thus, male physicians caused much of the high maternal death rate due to puerperal disorder (ranging from puerperal insanity to infections in mother and child) by attending a childbirth and going on to another without washing their hands or disinfecting their instrument.

Male supporters of female midwifery, such as Dr. James Edmunds, sponsor of the Ladies' Medical College, acknowledged the higher risk of physician-attended births, and also, using the discourse of the time, wished to "spare 'delicate-minded' women the 'ordeal' of male attendance." Unfortunately, such supporters also used economic arguments relating to the desirability of having a field in which women could earn a decent

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18 Ibid., 231.
19 Ibid.
living, and in which women could have childbirth attendance by professionals without having to pay the "prohibitive" fees charged by male physicians. This was the wrong justification to use, given the determination of the male medical establishment to penetrate this new "market" area and gain greater access to women as patients. The male medical establishment: counterattacked by defining women as "weak" and prone to illness, thus medicalizing female biology and gaining access to female patients -- a superb example of the utility of discourse and its compatibility with economic motivators.

Donnison details the success with which the male medical establishment ignored its own rules and standards which prohibited entry of women into either midwifery or medical schools. Although some medical examining boards resigned to avoid testing qualified female medical candidates, they were less reluctant in theory to license midwives to work with low-income rural women. Medical boards attempted to reformulate midwifery for the rural poor as a cross between nurse and laundress, calling for such "poor" midwives to "serve the poor...[to] wash, and mend, and cook and scrub as well, if necessary." Such midwives did not "need" training, since they were merely midwifery "assistants."20 Their purpose was, clearly, to "serve" poor people who in any case could not pay a male physician sufficiently to compensate him for his efforts. The intent to limit the earning power of women educated to be midwives and physicians was a persistent element in the opposition to midwifery.

Despite the determination of the medical profession to exclude women as unfit even to treat other women, the agitation of women for entry into the medical profession had its effect. The London School of Medicine for Women opened in 1874 and qualified its female graduates through the Irish College of Physicians, the Queen's University and the University of London. Other barriers to female midwifery and female physicians began to fall culminating in the Registration Act of 1902 which legalized midwifery. Donnison summarizes the midwifery controversy as illustrating the determination of the male medical establishment to breach the previous barriers to access of the female patient and to economically control those specialties pertaining to women's health care. This controversy provided a rallying point for a new breed of educated, career-seeking women, however, whereby "educated women could more readily unite to protect their interests -- something which for the past hundred and fifty years midwives had been unable to do."21 The result

20 Ibid., 240.
21 Ibid., 245.
was a reinstatement of midwifery as a medical option for women and also as a career field for them.

**Prostitution**

As women became de-sexualized in a special sense in the nineteenth century, prostitution did not become more highly "sexed" by way of compensation. Several discourses operated to alter the sexual signification of prostitution. Corbin, in his study of sexuality in nineteenth-century France, discusses the reconfiguration of prostitution into an institution controlled by the state as facet of its legitimate concern for public health. Prostitution came under increasing state control in France in order to protect public morality, safeguard reproductive health through the control of disease, and to foster the transmission of bourgeois capital and patrimony along socially acceptable lines. As Corbin points out: "Commercial sexuality can devastate patrimonies; it can hasten and pervert the accepted stages of social mobility...and can thwart the most cleverly contrived patrimonial strategies." The popular novel by Balzac, *Nana*, was an object lesson to the bourgeois of the nineteenth century, providing a context in which regulation of prostitution could be seen as an essential form of public safety.22

In his study of the history of sexuality, Foucault notes that the increasing regulation of prostitution also served to bring sexuality further under the control of the state: "It was essential that the state knew what was happening with its citizens' sex, and the use that they made of it...between the state and the individual, sex became an issue...a whole web of discourses."23 That the state might from time to time sanction "campaigns" against prostitution was perfectly logical according to Emma Goldman: "It is significant that whenever the public mind is to be diverted from a great social wrong, a crusade is inaugurated against indecency." Indeed, social reform was one of the few public arenas in which the "silenced" women of the bourgeois family could participate, and they took advantage of this fact.24

The social utility of prostitution aside, the male regulation of the body of the prostitute is entirely consistent with nineteenth-century capitalism and its instrumentalization

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22Corbin, "Commercial Sexuality," 209.
(commoditization in Marxist terms) of the female body. Indeed, it has been seen as a development of nineteenth-century capitalism: "Although prostitution has existed in all ages, it was left to the nineteenth century to develop it into a gigantic social institution."25 Previously, according to Goldman, although prostitution had been taxed by the Catholic church, and indirectly taxed by other religious organizations, it had remained a female enclave. Goldman also assigns primary importance to economic motives in women leaving factory or domestic service jobs to become prostitutes.26 In this sense, prostitution represented one means by which women could control their own means of production: it was less alienating than the condition of the bourgeois women who had to submit to the control of another and to an ongoing discontinuity between her body and what it produced.

Hysteria

Medical discourses reflected increasing emphasis on sexuality as inherently "abnormal," prone to expression in degenerative practices, with the extension of medicine into sexuality ever-widening the scope of what practices were "degenerate." Sexual practices frowned on by society were no longer viewed as behaviors or acts which one could do or not do, but rather as "diseases" which had infected the individual who practiced them. This medicalization of sex and sexuality along "disease model" lines, was accompanied by a heightened interest in the political implications of sexuality and in the equating of sexuality with criminality. These dual forces exerted particularly negative effects on women's sexuality. Foucault identifies hysteria as a discourse originating in the bourgeois family, which itself formed the locus of both control and sexuality in the 19th century:

It was in the 'bourgeois' or 'aristocratic' family that...feminine sexuality [was] medicalized; it was the first to be alerted to the potential pathology of sex, the urgent need to keep it under close watch and to devise a rational technology of correction. . . .

. . . It is worth remembering that the first figure to be invested by the deployment of sexuality...was the 'idle' woman....Thus there emerged the 'nervous' woman, the woman afflicted with 'vapors'; in this figure, the hysterization of woman found its anchorage point.27

26Goldman, The Traffic in Women, 20-28; see also Donnison, Medical Women, 227-236.
27Foucault, The History of Sexuality, 120-121.
For Foucault, the abnormalization of sex fulfilled a variety of needs. Alienation from production, in Marxist terms, the "idle," bourgeois woman could be made to internalize the alienation of sexual pleasure from reproduction and to substitute symptoms of hysteria in place of overt sexual behaviors. She could serve as the entry point for the "psychiatrization" of the bourgeois family of which Foucault speaks.

Edward Shorter depicts a nineteenth-century Europe in which hysterical paralysis presented a symptomology in which the sexual disorders caused by socially and culturally sanctioned repression, could exhibit themselves. Shorter discusses the hysterical symptoms exhibited as,

molded by the surrounding culture...with hysteria we enter a gray zone in which the underlying incidence of the disorder may well be constant across the ages but its form changeable, in accordance with such cultural influences as what is deemed to be 'feminine' behavior.28

Shorter's study charts a rise in hysterical paralysis (which he defines as gait disorders for which no discernable organic basis existed) throughout the century, with the Belle Epoque witnessing an epidemic of the malady. Shorter distinguishes the hysterical manifestations of the disorder as non-somatic, situated in the voluntary musculature, and perceived of by the patient as uncontrollable. Shorter further isolates this hysterical paralysis from personality or mood disorders, and does not follow a Freudian definition of such hysterical gait disorders as "conversion disorders." The psychosocial implications of these disorders are complex, manifesting a number of discourses of nineteenth-century medicine and sexual behavior. A primary element in hysterical disorders was the opportunity for exerting control they offered females, who, lacking sanctioned methods of sexual expression or the exercise of dominance in their bourgeois environments, could use their maladies to exert such control and to "punish" family members. Shorter cites a German neurologist of the era who described: "the familiar figure of the 'suffering' lady, who from bed, wheelchair or sofa tortures and tyrannizes over her partner, her husband, her children and her doctor."29

Manifestations of hysteria as an outlet for repressed sexuality declined after their peak in the late 1800s. Shorter views this decline as arising from social and cultural factors which caused changes in the tendency of women to adopt hysteria as a coping mechanism:

29Ibid., 583.
"I am convinced that the apparent decline in 'paralysis' among the young was real, and not an artifact of changes in reporting."30 One of the most significant changes in this era's view of hysteria resulted from Freudian psychoanalytic theory and discourse.

Hysterical disorders in women, Freud implied, arose out of their very biology—the "conflict" between the eroticism of the clitoris and the sexual "anesthesia" caused when the stimulation of the clitoris does not become translated into vaginal orgasm, which was thought to the the "mature" orgasm. The sexual instincts cannot be satisfied in a wholesome or "normal" way except through vaginal orgasm and certain other aspects of "normal" womanhood, such as breast feeding. Women are caught in a double bind between their socialization at puberty into "womanhood," a process Freud acknowledged involved "repression of their clitoral eroticism," and their abandonment of clitoral sexuality, which Freud termed "childish masculinity."31 Freud also ascribed the proneness to hysterical symptomology in women versus men, as arising from the tendency of women to repress their instincts toward perversion versus the tendency of men to act out such instincts.32 The discourse of Freudian psychology is mechanistic, with energy being generated by the sexual drives and either acted out in socially responsible ways, or repressed into the stuff of which psychoneurosis is made.33

The Freudian viewpoint is, as Foucault points out, also a discourse which "normalizes" sexuality, however much it may focus on how sexuality goes wrong.34 The underpinning of Freudian discourse is the importance of the instinctual sexual drives and the importance of expressing them in the context of "loving and working." Freud's own work assigned importance to the integration of mind and body, i.e., sexual pleasure and reproduction; in effect, this gave "permission" to women to be sexual again, although "sexual" in a Freudian sense (i.e., the vaginal orgasm). Hysteria in women thus became a symptom of sexual dysfunction as opposed to anatomic destiny.

Conclusion

Nineteenth-century discourse reformulated the image of woman into forms and behaviors consistent with its social, political and economic dynamics. Paramount to this

30Ibid., 565.
32Ibid., 102.
33Ibid., 29-31.
34Foucault, The History of Sexuality, 119.