



WOJCIECH MACKIEWICZ¹

UNIwersytet Medyczny we Wrocławiu

JAROSŁAW BARAŃSKI²

UNIwersytet Medyczny we Wrocławiu

HETEROTOPY OF THE HYSTERICAL BODY

1. Introduction

Utopian thinking ignites the human imagination, making it possible to abandon imperfect matter and, on the wings of speculation, move towards an alternative, more perfect reality, one from which evil is excluded. Utopian thinking, according to Michel Foucault, has its origin in the organic body. After all, are not the immortal bodies of heroes, endowed with unimaginable power and extraordinary abilities, brimming with vitality, often brutal, but always powerful?

¹ <https://orcid.org/0000-0002-9827-8443>

² <https://orcid.org/0000-0001-5670-9391>

The particular opposite of the utopian body, the exception to the rule, is heterotopia and the body that it creates - the heterotopic body: as Foucault put it in *Le Corps utopique*: “My body, it’s the opposite of a utopia: that which is never under different skies. It is the absolute place, the little fragment of space where I am, literally, embodied (*faire corps*)” (Foucault 2006/7, 229). Heterotopia is a concept of physical space in which already established meanings gain new shape. Foucault's philosophy was a response to structuralism, where the diversity of being is reduced to the dimension of meaning and signification. In this perspective, the human body, living or deceased, is the same recording medium as books, social praxis or cultural symbolism. Heterotopology abandons the dimension of time, allowing us to examine spaces of meaning in their "rupture" to timelessness and/or infinity. After all, both the mythical bodies of heroes, which for millennia have inspired us toward perfection, as well as the Egyptian mummies of ancient pharaohs, which seem to mock the passage of time, function as "manuscripts" of a certain meaning, rendering thinking heterogeneous, beyond the horizon, infinite.

Thanks to certain attributes, the body becomes a medium of invisible and unknown forces that shape our culture and tradition. Masks, tattoos and make-up not only add colour to our bodies, but above all, they communicate with “spaces of difference”, a system of signs and symbols, a secret language, a combination of codes, desires expressed in sanctity and vitality (Foucault 2006/7, 231). Thus, body can thus transcend the corporal dimension not only by way of mythical deification and ancient mummification.

However, are we correct in believing that only tradition and culture can stimulate heterotopic thinking? Is it not possible for a disease to fulfil a similar function? This text attempts to apply Foucault's heterotopology

to the mysterious phenomenon that escapes all precise definitions — hysteria. Structuralism compels Foucault to understand the problem of heterotopia in the context of “surfaces” on which we overwrite certain codes (hence, the reference to the mask, tattooing and make-up). However, for this purpose, we should take advantage of other, much richer possibilities offered by the human body: its deep physiology, connection with consciousness and subconsciousness, i.e., rather than to settle on the “outer” part of the body, we should penetrate it like a surgeon, physiologist or a psychiatrist. However, before doing so, we need to familiarize ourselves with the general definition of heterotopology, which will be later adopted as a methodological framework for research in the case of hysteria.

Heterotopia makes possible thinking about space in its anti-ontological terms. This is done by means of the theory of “absolutely different places”, “counter-sites” in which we live every day. Heterotopology draws attention to the ambiguity of space, and to notice them one requires not so much patience as courage:

Heterotopias are disturbing, probably because they secretly undermine language, because they make it impossible to name this *and* that, because they shutter or tangle common names, because they destroy ‘syntax’ in advance and not only the syntax with which we construct sentences but also that less apparent syntax which causes words and things (next to and also opposite one another) to ‘hold together’ (Foucault 2005, XIX).

Heterotopias bring meanings to life and allow us to explore a space that has been, in a certain way, “prepared”. They do not claim to be objective, because in their mediation they tend towards the primacy of geography, cartography and architecture, rather than towards the history and tradition of a place, thereby “distorting” the familiar

sense of security, rendering the place strange and alien. However, it is not only language that is at stake here, as anxiety quickly transferred to other areas. Heterotopias are born in our thoughts, which is why what by some would be considered inconspicuous space will for others be “counter-space”. The situation here is relative and labile; heterotopology makes it clear that we never occupy neutral, unintermediate, transparent space. Foucault mentions only a few heterotopic paradigms, suggesting that the very act of thinking creates their endless procession: a cemetery that allows us to “open” the present moment and look into eternity, a garden that symbolizes the order of the cosmos in its geometry; lazy seaside resorts that disrupt our perception of time; seventeenth and eighteenth century colonies in the New World, where social and political order can be re-established; museums and libraries where there is an astonishing, infinite accumulation of time in a relatively small and finite area, theatres and cinemas which take the viewer on a journey through time and space, American roadside motels, to which one travels with one's lover and where "illicit sex is both absolutely sheltered and absolutely hidden, kept isolated without however being allowed out in the open". (Foucault 2019, 8), and finally the heterotopia of all heterotopias - a naval ship, which, while travelling between different lands, carries ideas, inventions, unknown plants and on which, due to its isolation, life takes place according to its own laws.

The association of thus understood heterotopias of space with the utopia-heterotopia of the body is not entirely accidental. In 1966 Foucault devoted two radio speeches to these two phenomena, which were later transcribed and published. Although in his first speech, *Le corps utopique*, Foucault makes no mention of heterotopia, the context itself encourages such an interpretation. On this basis, Foucault's thoughts can be injected into the philosophy of medicine by way

of the heterotopia of a sickly body. But there is another important reason why this attempt is worthwhile. Foucault does not mention anywhere that the very concept of “heterotopia” had to have been borrowed from medical sciences (he himself came from a family with medical traditions — his father and grandfather were surgeons). When Michel Foucault was working on the concept of heterotopy his works dealing with the “archaeology” of medicine were published, which were characterised by a strong antipsychiatric movement (*Madness and Civilization: History of Insanity in the Age of Reason* was published in 1961, *The Birth of the Clinic* in 1963). All these circumstances lead us to attempt to undertake a study of the heterotopy of the patient's body.

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In medicine, the term “heterotopia” refers to the presence of a specific type of tissue in a non-physiological site which, nonetheless, coexists with the original tissue in its correct anatomical location. A classic example of heterotopia is the gray matter within the cerebral white matter in the brain or diverticula of the ileum (the so-called Meckel diverticulum), which is partially made up of gastric or pancreatic tissue¹. Heterotopia is not a pathological phenomenon, yet it is also not a desirable phenomenon. Heterotopia may or may not disturb the functioning of the organs in which it occurs. A similar case is the growth of cancer cells, although that is an undesirable phenomenon. This process has an aberrant quality, violating the hitherto permanent physiological and anatomical order, spreading and, at the same time, building a new space - an anomaly, a certain counter-space. Heterotopia of cancer does not mean that the pathological process finds its place in a previously healthy human body, but that it makes the already existing place radically

different from what it used to be. “Etymologically, heterotopia denotes the concentration of ‘hetero’ (another, different) and ‘topos’ (place)” (Sohn 2008, 41); it is considered simultaneously as space and a morphological anomaly. In this way, heterotopias transform a living body, indicating that its forms and possibilities are relative. The pathological process reveals the extraordinary plasticity of the human body: “Heterotopia comes to existence only when set against parameters of normalcy and correct orders” (Sohn 2008, 44). Glossaries of medical terms also record the phenomenon of heterotopia in biological sciences and explain it as a change in the expression of certain typical features. These changes have an evolutionary basis. In botany, heterotopia is defined as a situation in which the light pigment of flower petals of earlier generations is transferred to the leaves, which on as a result roll up and become similar to petals (Sohn 2008, 41).

The concept of heterotopia may, therefore, refer to pathologies. Transferring this premise on philosophical grounds, one can ask about the extent to which disease in general at all indicates a heterotopia of the body. In other words, this article aims to explain the phenomenon of heterotopia of the body suffering from hysterical disorders. This choice, in terms of Foucault’s theories, is not accidental: the historically changing issue of madness is an important part of his philosophy, but he has also devoted a great deal of attention to the problem of hysteria. Madness and Reason are two sides of the same coin; when we think of madness, we think of ourselves, the limits of our cognitive abilities, the conditions of human existence, the traps of language, the conditions of human existence (Foucault 1988, 95). This is what heterotopology sets to illustrate.

2. Genealogy of Hysteria

Hysteria seems to be an extremely complicated issue. For thousands of years it has been shrouded in mystery. An extremely difficult phenomenon to grasp, it poses a considerable problem for the philosophy of medicine. Back in 1935, Władysław Szumowski² noted down in his *History of Philosophy of Medicine* the following:

Hysteria is a functional disease that does not have a uniform clinical account; on the contrary, according to current scientific knowledge, the fact that it has a variety of symptoms is one of its characteristic features. It is, therefore, difficult to find a formula that precisely defines it. A characteristic feature of hysteria is the fact that its somatic symptoms, which are extremely varied, have a psychological origin and are “psychogenic”. (Szumowski 2005, 275)

Only twenty years earlier, Ernest Dupré gives voice to the same ignorance in the clinical account of hysteria, emphasizing this time the important element of simulation. He describes hysteria as a “state”, in which the power of the imagination and suggestion in connection with the particular synergy of body and mind, which he calls psychoplasticity, culminates in the more or less conscious simulation of pathological symptoms, in the mythic organization of functional disorders, which are indistinguishable from simulators (Foucault 1987, 4): The Polish psychiatrist, Antoni Kępiński, adds the following:

What is most irritating about symptoms of hysterical conversion are their untruthfulness, inauthenticity. The patient has a paralysed hand or leg, but this is not real paralysis, i.e. caused by damage to certain anatomical structures. The patient cannot move his or her hand or leg, as in physical paralysis, but the cause is different, “frivolous”, some mysterious emotional mechanisms, subconscious. Someone feels very strong pain, but it is hard to believe that this pain is real, authentic, when it does not have a physiological basis. In reality,

however, such a patient may suffer even more than one who is affected by a physiological disease. (Kepiński 1988, 43)

Before we can critically approach this problem, we should first construct a “genealogy” of this enigmatic phenomenon, as attempts to understand this mysterious phenomenon have been made already in antiquity. Hippocrates explains the essence of this phenomenon with the concept of “dyspnea” and links it to female diseases (the concept of “hysteria” does not appear in his work — it was added by later editors). Here is one of the images he referred to:

When the uterus is on the liver and in the subcostal area, causing dyspnea, eye proteins collapse, the woman becomes cold and even sometimes sina. She gnashes her teeth; saliva flows into her mouth and the woman resembles an epileptic. If the uterus stays on the liver and in the lower abdomen for a long time, the woman dies suffocated. (Hippocrates 1839/81, 33-34)

According to Plato, the mortal human body is composed of the same elements that make up the cosmos, and they include water, air, fire and earth. The human body is constructed according to the divine order: the top parts are the noblest and, as we descend gradually downwards, the body parts lose their “nobility”. The areas of the stomach and downward make up the “animalistic” sphere. This is where the uterus is located, which is not subject to the power of the soul, and which is thus susceptible to animalistic predation:

Wherefore also in men the organ of generation becoming rebellious and masterful, like an animal disobedient to reason, and maddened with the sting of lust, seeks to gain absolute sway; and the same is the case with the so-called womb or matrix of women; the animal within them is desirous of procreating children, and when remaining unfruitful long beyond its proper time, gets

discontented and angry, and wandering in every direction through the body, closes up the passages of the breath, and, by obstructing respiration, drives them to extremity, causing all varieties of disease, until at length the desire and love of the man and the woman bringing them together and as it were plucking the fruit from the tree.... (Plato 1931, 514)

Plato's diagnosis is consistent with the Hippocrates' conclusions. Therefore, the antidote to "the wandering uterus" seemed obvious. Hippocrates recommended that young girls should get married, married women should have sexual intercourse that would improve the degree of hydration in the uterus and its correct placement, whereas widows should get remarry and get pregnant (Hippocrate 1839/81, 271-273).

Hippocrates' and Plato's research on hysteria was clearly associated with the female body. In later centuries, under the influence of Christian doctrine, hysteria developed an intimate relationship with everything demonic, wherein suffering women were thought to have sexual contact with the Devil himself. With reference to this methodology, Szumowski writes about imagined pregnancy of hysterics, their extraordinary strength (especially, but not only, during hysterical attacks), "stigmata" appearing in moments of remembering the Passion of Christ, anxiety lasting for days or even months, or the suspension of pulse (Szumowski 2005, 280-285).

The first person to notice that hysteria is not a disease like any other, that it is much more mysterious and ambiguous, and that it is not located in the uterus was a British doctor, Thomas Sydenham. He wrote: "To simply enumerate all the symptoms of hysteria would be the work of a long day; so numerous are they. Yet not less numerous than varied, proteiform and chameleon-like" (Sydenham 1843, 89). The chameleon deceives the observer, adapts to the environmental conditions, pretending to be the background. Even if the perceptive eye spots it,

its final shape will remain uncertain. In this way, the heterotopic face of hysteria gains new features. It is no longer the “animal character”, but the “cunning” stemming from the ability to simulate a number of illnesses other than itself, that becomes accepted as an important attribute of hysteria. Henceforth, each medical diagnosis begins with the inclusion and exclusion of a number of other diseases and disorders which take the form of hysteria (Trillat 1993, 56). Sydenham rejects the Platonic-Cartesian dualism, adopting a monistic perspective: he emphasizes the role of body fluids (humours), blood, entrails, fermentation processes, which are not without influence on the sphere of feelings, and vice versa: a bad state of mind spoils the humours. The very circumstances of hysterical symptoms appearing and disappearing add an aura of mystery:

There are numerous motor and sensory disorders connected to hysteria. Motor disorders appear in the form of paralysis, stiffness, cramps, and convulsions. Injuries can affect half of the body or one limb, they occur suddenly, usually after some emotional experience, they last for a long time, months and years, and they can also suddenly subside under the influence of a new affect. For example, a sick person, who was paralysed a few years ago and could not walk at all and suddenly regains power in his legs during the outbreak of a fire or as a result of taking in the waters from some famous spring miracles. (Szumowski 2005, 277)

Until the end of the eighteenth century, it was difficult to talk about hospital and clinical conditions in the treatment of hysteria, which was not even then distinguished from other mental and social disorders. The literature on the history and philosophy of medicine provides endless descriptions of this state of affairs. In the Bethlehem asylum, restless women were chained to the walls by their ankles; in Bethnal

Green there was a woman who underwent frequent attacks of violent excitement. The standard practice in this case was to bind her hands and legs and to throw her into in the pigsty. Otherwise, she was tied to the bed without proper cover, or, when she was allowed to move, she was put on an iron bar between her legs, which was attached to the ankles and connected to the handcuffs by a short chain (Foucault 1998, 71-72). As we can see, these were incredible stories; if not for the fact that they are reliable historical messages, they could be regarded as literary fiction. It is impossible to find in them an account of hysteria, as “madness” was then defined as any behavioural, social, and even political maladjustment.

Nineteenth and twentieth century provide other, somewhat mysterious and disturbing, terms such as: melancholy, hysterical ailments, dyspnoea and epilepsy, maternal disease (the effect of a medical diagnosis of childbirth as a traumatic experience for a woman), vapors, etc. Accompanying symptoms were stupor, convulsions, stiffness, migraines, numbness, loss of consciousness, and Freud did not even rule out “dissociated consciousness”. The multitude of new terms did not bring researchers closer to solving the mystery of hysteria, but rather created a theoretical field, which perhaps more fully reflected the complex network of social reactions to hysterical theatricalization.

An important moment in the history of hysteria is connected to medical practice, specifically when Professor of the Sorbonne, Jean-Martin Charcot, neurologist and neuropathologist, became the head of the Paris Salpêtrière hospital. He was one of the first neurologists, which is why his close relationship in psychiatry should come as no surprise. It was he, writes Georges Didi-Huberman, who rediscovered hysteria, separated it from the “convulsive body

of the epileptic” and other mental disorders and gave it its name. In this way hysteria finally became a “pure nosological object” (Didi-Huberman 2003, 19), which enabled it to develop in the realm of science. Charcot’s medical practice was the first to be based on a methodological approach, i.e. meticulous collection of facts in an effort to combine them into a complete image of the disease, experimentation, and attention to detail. Such conditions required “transcending” the account of the disease and delving deep into the body - towards the nervous system and physiology. Since it is not possible to open the brain and observe how it functions, it should be assessed on the basis of the effects of stimulation. Charcot described the Salpêtrière research method as “practising nosography” (Szasz 1974, 19). Nosography made it possible to create a “map of neurological diseases” in their spatial context. In so doing, it revealed the “geological-geographical” and heteroto-pathological character of human thinking about diseases in general: “As a geologist must distinguish gold from copper and these two from other precious metals, so a neurological-nosograph must differentiate multiple sclerosis, tabes and hysteria” (Szasz 1974, 19). The medicalisation of hysteria was once again transformed. Examining the problem ceased to evoke fear of dark powers in favour of patient, endless description of subsequent symptoms. This gave rise to a new sensitivity and a new ethics, thereby allowing hysteria to separate itself from other diseases and disorders.

Out of the womb of Charcot’s new medical science, neurology, a new concept was born, one that shed new light on the problem of hysteria. It was based on the anatomo-clinical method developed earlier and was another attempt, perhaps following the example of ancient aspirations, to localize the organic source of hysteria. Neurology was based on collecting “surface” data, i.e. it examined unconditional reflexes. The key characteristic for this group of reflexes

is that they take place without one's awareness of them. Reflexes, which most often include muscle stimulation (although not only, it is worth remembering about the pupil dilation), take place *before* the impulse is sent to the brain. Neurological practice is, therefore, of significant epistemological significance: it now allows us to see the "simulation of madness" from a completely different, unintended perspective. The "neurological body" is a new form of response to the clinician's procedures, a study based on a new schema, expressed in the following form: "stimulation – effect" (Foucault 2006, 299).

Neurology (including neuropathology) distinguished from the image of hysteria the field of paralytic disorders, discovered the influence of the sense of balance and spatial orientation on the sense of body position in space, and defined the area of motor and visual-motor coordination, vision disorders, speech disorders, muscle cramps, limb trembling, dizziness, etc. The "Neurological Body" redefined the hysterical patient's behaviour in the field of peripheral nervous system stimulation, separating the will from the patient's real physical capabilities. Neurology defined the constant symptoms of hysteria and determined the range of common disorders of hysteria and epilepsy, namely convulsions (Charcot spoke in this case of "hystero-epilepsia" emphasizing the "hybrid" character of the first one), the Hippocratic-platonic "wild animal" raging beyond the power of reason was reconstructed anew by nineteenth century neurologists (Foucault 2006, 307). The neurological clinic also erased the negative moral assessment of its patients. A paralyzed, epilepticist or a patient with neurological disorders of the speech apparatus was no longer placed within the framework of disorders causing social anxiety.

The psychological-philosophical effect of separating neurological symptoms from hysterical disorders was a return to sexuality. Even

in the nineteenth century, Sigmund Freud took this approach and assumed that the aetiology of hysteria should be sought in the different development of female sexuality (the key role here would be played by the unconscious fantasy of one's own castration and the associated feeling of inferiority of women towards men). In this way, writes Paweł Dybel, the mythology of "wandering uterus" and demonic obsession is replaced by the mythology of castration of women and their attendant inferior status in culture" (Dybel 2006, 128). Freud noticed that a hysterical attack can be triggered in three ways:

a) by association, if the (sufficiently established) content of the complex is triggered by reference to conscious life; b) organically, if the libidinal cast reaches a value above a certain threshold due to certain internal somatic causes and under the influence of external psychological influence; c) in the service of secondary tendencies to which the condition has been associated, provided that only by triggering the attack can the useful goal of the patient be achieved. (Freud 2010, 1983)

The mysterious connection between the spiritual and the affective with the organic and the physiological turns out to be a key point. It enables Freud to make the first diagnosis, which assumes that a hysterical attack is "translated into motor language, designed for mobility, pantonymically depicted fantasies" (Freud 2010, 1983). The same contents, which can become the subject of a dream, lead to an attack due to, as the author explains, their "condensation", i.e. intensification, mutual overlapping, accumulation. The attack, Freud continues, becomes opaque due to the "fact that the patient tries to carry out the actions of both people in the fantasy, and thus due to their *multiple identities*" (Freud 2010, 1983).

That hysteria functions beyond the soul-body dualism is crucial. Freud gives an example of trauma that turns into a hysterical attack: it must be serious, i.e. it must involve a high risk of losing one's life (although not strong enough to paralyse mental activities), it must also be associated with a more specific area of the body, e.g. a heavy block of wood hits a worker's shoulder, the worker falls down, but, realizing that nothing has happened, returns home peacefully. After a few weeks he wakes up to find his arm limp. This is how psychoanalysis explains this situation:

If the case is typical one, it may happen that peculiar attacks set in – that, after an aura, the subject suddenly collapses, raves and becomes delirious; and, if he speaks in his delirium, what he says may show that the scene of his accident is being repeated in him, embellished, perhaps, with various imaginary pictures. (Freud 2010, 288)

An important conclusion to this “psychoanalytical heterotopia” is that mental trauma has a kind of “physical properties”, because “acts as a foreign body which long after its entry must continue to be regarded as an agent that is still at work” (Freud 2010, 9). On the other hand, however, it is Freud, who writes about the revolutionary discoveries of Charcot, who was forced to note his empirical insights on the margins of logical thinking. He noted that not everyone who considers himself sick, who looks sick, and even who is somehow incapacitated because of illness, must show a physical and chemical disintegration of the organism (Szasz 1974, 25). For Breuer and Freud, therefore, the relationship between the psychological and the organic has a symbolic dimension:

It consist only in what might be called 'symbolic' relations between the precipitating cause and the pathological phenomenon – relations such as healthy people form in dreams. For instance, neuralgia may follow upon mental pain or vomiting upon feeling moral disgust. We have studied patients who used to make the most copious use of this sort of symbolization. (Freud 2010, 8)

Associations that, like Foucault's heterotopy, disrupt chronology, logic and language. In Freud's work prompt hysterical attacks no matter how long the patient has been away from traumatic events; they also equally strongly shape feelings, elicit anxiety, take control over memories, dictate certain behaviours. Heterotopia of the hysterical body can equally resist the chronology of time. Freud writes:

for half a year, one of our patients under hypnosis reconstructed everything that stimulated her on the same days of the previous year (...); according to the mother's diary - the patient was not aware of its existence - it could be said that she reconstructed all these memories perfectly and without any mistakes. Another patient, not fully hypnotized, in spontaneous attacks experienced with hallucinatory clarity all the events that occurred to her ten years ago, when she suffered from hysterical psychosis - events that up to that moment were, to a large extent, under a blanket of amnesia. (Freud 2010, 15)

The cultural conditions in the therapy of hysteria are also worth considering. In the case of somatic disease, say the flu, we can count on the same methods and therapeutic agents in every culture while going to the doctor. In the case of mental disorders (or even hysteria, which we consider to be a psychosomatic disorder), the situation is not so obvious (Szasz 1974, 48-49). The practices of exclusion, corporal "discipline", therapeutic conversations, pharmacology or alternative medicine,

in a word, the heterotopology of a given socio-political tradition, are beginning to be considered.

3. Heterotopology of Hysteria

In its complicated history, hysteria has taken many forms: in Greek-Roman medicine, its cause was the “wandering uterus”, in the Middle Ages it was explained by “demonic possession”, in the seventeenth century, the first, what today we would call “neurological”, interpretations appeared, the era of enlightenment returns for a short time to the theory of “wandering uterus”, Charcot seeks its causes in pathological changes in the brain, and finally Freud points to the unconscious mechanisms of sexual exclusion. In addition, these explanations have always gone beyond medical discourse, where the naivety (and often uncanniness) of its practices yields much about our fears, complexes, dreams and fantasies. In spite of this, hysteria, or more generally, mental illness was pushed aside in the short term — those suffering were chased away, closed down, deprived of their lives.

The difficulty in tracing hysteria, until the end of the eighteenth century, was that it functioned contrary to Aristotelian logic, which in this case assumed only two possibilities: illness or health. Meanwhile, hysteria as a “simulation of disease” revealed a terrifying spectacle of the body, which “deceives its soul”. Medical questions about hysteria are in fact questions about the foundations of Western thinking — dialectical thinking. Jacques Derrida’s deconstruction defines this dialectic as thinking based on binary oppositions, which gave rise to a theoretical consciousness and with it the “metaphysics of presence”, i.e. the hierarchy of values on which cognition is based (Derrida 1972, 56). The kind of binary oppositions that we would be dealing with here are,

e.g. "health – illness", "able to work - unable to work", "obvious – unclear", etc., and so on. In each of these pairs there is valuation (the first members are privileged, the second are negatively valorized); therefore, as French philosophical thought explains, the multitude of subtle differences is subject to totalization and - ultimately - neutralized in the Totality and Identity.

Hysteria disturbs this order, i.e. the division into "ours" and "others", i.e. Good and Evil, Culture and Nature, theory and practice. It shows a lack of regularity, unprecedented anywhere else, which is why it was impossible to include it in the game of binary oppositions. Its mythologization resulted from a systematic, cultural lack, after all, it should be noted that a precise nozological definition was never worked out in this case (Didi-Huberman 2003, 74). However, the matter should be approached differently: this lack is only one side of the coin, on the other hand we are dealing with an alarming excess of images and events. At the same time, hysteria as a lack gave rise to a dangerous phenomenon of "hysterization of language", "hysterization of reaction" or "hysterization of culture".

Today, we can observe a change in this strategy. Mainly due to psychoanalysis, madness no longer refers to non-existence, but conversely, it gives significant features to a human being. As for Freud, unconscious content is of key importance, which is why madness is an irreplaceable mirror for rationality, one in which it has to constantly review itself (Foucault 1988, 278). This change is crucial, because in this way heterotopology is constituted. Heterotopy of the hysterical body therefore arises from all these fantastic descriptions of its states, with the reservation, however, that it is now necessary to understand them. The images themselves still bear witness to some kind of simulation. They are: The "apparent" retention of the function

of life (which has been accompanied by tragic mistakes since ancient times); the multiplication of power in fragile girls who could not be restrained even by men; the maintenance of the body position for many hours without the slightest signs of fatigue; the position of the arch, in which the head touches the heels of women who are not gymnasts or acrobats; the adoption of incredible body positions, which made it possible to move even more strangely from place to place; the lack of sensory reaction to the needles driven in at the mouth of the needle, the disappearance of senses transferring from one side of the body to the other, etc. (Trillat 1993, 240). Hysteria stimulated the imagination towards the uncanny and ghostly, and its psychiatricisation and penalisation only fuelled its ghostly character. A hysterical body is an impenetrable body, mysterious, infinitely deep and despite its finiteness - to some extent impossible to read. Heterotopology of such a body places it in a new dimension: by interpreting the symbolism of hysteria it tears them away from the dimension of time, makes spatial metaphorizations, makes human existence strange, paradoxical, degraded or exceptionally sanctified. For centuries it has not even been known whether we are dealing with a somatic or mental illness — it is only Charcot's nozography that places hysteria among the somatic diseases, transforming its understanding from “mental illness” to “instinctual disorders” (Foucault 2003, 244). Finally, we should not forget the ethical dimension, for which imitation of other diseases, deception of the doctor, “cunning” and “tricks” were clearly pejorative in nature. Szumowski writes:

Hysterics are often endowed with great insight, cunning and dexterity, which they use successfully when they want to mislead the doctor or the environment, e.g. they vomit and expel some improbable objects from their mouths and only after careful observation we can see that the patient had everything she wanted

to vomit hidden in her dress. Their memory is sometimes unreliable and their imagination rich, so that one can never rely on the testimony of hysterics. (Szumowski 1961, 174)

Hysteria revised the possibility of medical diagnosis of the disease. Thomas Szasz proposes to adopt it as a method of examining the boundary between the “normal” and the “abnormal” in psychiatry:

Logically, hysteria brings into focus the need to distinguish bodily illness from the imitations of such illness. It confronts the physician – and others as well — with the task of distinguishing “real” or genuine illness from “imaginary” or faked illness. This distinction – between fact and facsimile, object and sign, physics and psychology, medicine and morals – remains the core problem of contemporary psychiatric epistemology. (Szasz 1974, 10)

If we were to accept this proposal, then it would follow that hysteria as a disease brings to bear a multitude of different disciplines of knowledge: history, economics, ethics and morality, politics, philosophy, demography, education and communication, theology and demonology, feminism; and through criticism strengthens the foundations of medical knowledge, connects psychology with technology and tradition with modernity. For Szasz, the historical differences between hysteria, paranoia, depression, schizophrenia, etc. can be seen as parallel to the differences giving form to modern languages. For example, similarities between English, German and Danish clearly separate them from, for example, Hungarian. A similar analogy can be seen between hysteria and dreams, which use the same iconic signs and which are definitely different from paranoia (Szasz 1974, 11). In this way, the heterotopia of hysteria gives new forms

of understanding to other mental disorders and diseases, reveals an innovative methodology and ethics of working with the patient, and revises the definition of “disease” in general.

Today, most hysterical disorders have been read, classified and categorized into the order of knowledge appropriate to specific medical sciences (neurology, physiology, psychiatry, etc.). What remains is referred to by psychology as “hysterical personality”, which, after all, accompanied hysteria from the beginning. Trillat notes that “it was first a witch, then a creature suffering from vapors, a sensitive, delicate and dreamlike creature, but also a capricious, odd and an incalculable person, and, if necessary, a pathological liar, a lecher and a perverse creature” (Trillat 1993, 238).

4. Conclusions

Charcot wrote that hysteria has always accompanied mankind, and so, like any other disease, it will remain with us until the end. Modernity, however, saw the disappearance of hysteria, *as if* in response to the declining interest of doctors and therapists. Perhaps this is the result of changes in social mentality that took place in the twentieth century, when the emancipation of women ended the hegemony of power over them. This would coincide with the concept of hysteria as a “barometer” of discourse tension in relation to sexuality, gender, feminism (Gilman 1993, 107). For Hippocrates and Freud, hysteria is tied to the difference between the sexes, with the one distinction, perhaps, being that Freud made the process of individual sexual identity formation dependent on psychological-social phenomena of power and domination. Dybel explains:

The domination of one sex over the other cannot be separated from the process by which the concept of gender itself is shaped; it is an integral part of it! In other words, it is not the case that the privileged position that men occupy in culture stems solely from the patriarchal model of that culture as such, but is the result of certain historical factors, which, as it were, build upon the category of gender. On the contrary, this position is already implied by the way in which the very concepts of male and female sex are shaped. (Dybel 2006, 128)

As we know, many unclear accounts of hysteria were explained by neurology, which developed in the nineteenth century. But perhaps, the author adds, hysteria is a thing of the past, because it was actually the result of a mutual fascination with the uncanny nature of its symptoms, to which both doctors and hysterics themselves succumbed, and a reconstruction of a latent and inbriddled life instinct. In the Cartesian order of cognition, madness is a priori excluded, expelled from the order of Reason. Exiled, perhaps in response to an unconscious fear, it took on the features of monstrosity and began to once again affect the imagination. Thus, when specialists abandoned their belief in the omnipotence of medical knowledge and began to give the relationship with the patient a more symmetrical form, which intentionally strengthened the position of the sick as subjects; as a result, hysteria as such ceased to pose such a challenge (Trillat 1993, 240). This issue seems to be extremely important, as it testifies to the strong influence of the illusion that all generations of physicians have succumbed to since the earliest times until the second half of the twentieth century. This illusion had incredible power, one that, contrary to the anatomy and physiology of bodies, influenced legislation (e.g., cast hysterics to burn at the stake), eroticised culture and shaped trends in art (painting and romantic lyricism, fin de siècle, antipsychiatric movement, etc.), strongly

inspired popular culture. Georges Didi-Huberman particularly emphasizes this thought when writing about the image of hysteria as a disease in its “extreme visibility” and the physical pain it entailed. We can take the Salpêtrière Hospital in Paris, where the deconstruction of the dialectic of Identity and Difference was carried out, as a “laboratory” for the study of this visibility and observation of the effects of hysteria

However, heterotopology seems to say something more. If we assume, after Michel Foucault, that psychiatry and medicine (as well as criminology and criminal law) provide a framework for the socio-political “production” of truth (Foucault 2006, 86), then the disappearance of the phenomenon of hysteria in the twentieth century would be another example of the advantage hysteria has over the therapist. Since it was never possible to fully penetrate the “dark stone of the hysterical body”, it can be said that the researchers failed in their struggle with this phenomenon. Taming the symptoms and distinguishing detailed diseases from such a strange phenomenon before the final, equally mysterious, disappearance of hysteria probably should be associated with a crowning achievement of medicine. Hysteria turned out to be an illusion, a dreamy dream, a cultural fear of what was irrational. The clarity of Reason allowed contemporary people to solve its riddle. But can we be certain? Is not the conviction that hysteria has been overcome just another imitation of it? If we accept the concept of hysteria as a distorting mirror of European rationality and heterotopia of the body, is it certain that we have overcome the panicked reaction to the possibility of imitating certain diseases by others? (Gilman 1993, 106). Psychoanalysis shed light on the darkness of hysteria, but at the same time broke its close connection with medicine and brought it into a broader philosophical and cultural context. From this perspective,

we can ask new questions: is not the fear of mental illness actually based on a hysterical reaction? Does not the taboo of infectious diseases (once leprosy and tuberculosis, AIDS in the twentieth century) in a sense refer to this terrible heterotopia of the female body? Is not hysteria, therefore, the second, today ossified, side of Reason?

The next stage of the struggle with disease simulation appears along with the return of a phenomenon already known in antiquity, namely the practice of hypnosis. Hypnosis is “a state that occurs when appropriate suggestions evoke hypnotic phenomena. Hypnotic phenomena are then defined as positive reactions to test-suggestions, and these reactions are always associated with suggested changes in perception and memory” (Orne 1998, 19). A hypnosis session works on the same level as hysteria. The underlying epistemological assumptions suggest that, like hysteria, hypnosis is a certain kind of pretence, suggestion, an induction of certain forms of behaviour and experience. For this reason, it can be claimed that in hypnosis these experiences are somehow devoid of a source, with the difference being that here the person responsible for the induction is the hypnotist. A perfect example of this unusual similarity is Antoni Kępiński’s description stating that in hypnosis as in hysteria,

one often has the impression that someone else is controlling our actions, some mysterious force, some demon, which resides inside, a mysterious id and superego, etc. One has no power over oneself. Under the influence of the hypnotist's orders the eyelids drop, the hand becomes inert, one loses the perception of pain or, on the contrary, pain becomes extremely severe; there are various kinds of vegetative changes, normally inaccessible by the action of our will, e.g. acceleration or deceleration of the heartbeat, contraction of blood vessels, so that the skin can be pierced, not a drop of blood, or vice versa, their enlargement, so that they occur as in saints stigmata, etc. A hypnotist can elicit various emotional states, such as love, admiration,

disgust, anxiety, despair, etc. He can elicit behaviours typical for other people or even animals. The hypnotised person can behave like a great scientist, saint, villain, etc., or like a dog, lion, cat, like a child, in love, etc. Under the influence of the hypnotist's suggestion, a modest woman can behave like an indulgent curtizan, a venerable citizen like a hooligan, an adult like a small child, etc. Acting, which is characteristic of hysteria, is brought here to its zenith. (Kepiński 1988, 49-50)

This is another, though certainly not the last, strategy in the fight against hysteria: since it is a natural “simulation of diseases other than itself”, perhaps the only way to heal it is to try to “falsify lies”, “outsmart cunning” and “deceive deception”.

NOTES

¹ Cf. dictionary of medical terms <https://medical-dictionary.thefreedictionary.com/> (accessed: 01.17.2019).

² Representative of Polish School of Medical Philosophy (Löwy 1990).

³ The institution of the clinic gave birth to a new perspection of time. Inside its walls observation could be carried out indefinitely, which made it possible to accumulate countless facts about a given illness. It also made possible for the clinic to realize another one of its functions, i.e. experimenting (Foucault 1994).

⁴ Małgorzata Kowalska aptly expresses this intuition, when she writes that: “the spectral totality is always understood as a triumph of identity over difference, which can also be described as a triumph of onness over multitude” (Kowalska 2000, 25). We cannot here forget about the mutual, historically relative conditioning of health and illness, understanding illness as an “aberration of health” or latent, incredible adaptive abilities of the organism, which are unleashed a result of the illness (Canguilhem 1991).

⁵ Post-Freudian psychoanalysis allows this phenomenon to migrate from the medical field to culture studies. It can be noticed that in the contemporary research in this field there is considerable effort devoted to surmounting the cultural differences expressed

in the inferior status of women (Karen Horney), the question of conflict as a result of the experienced lack from women as well as men (Melanie Klein), the attempt to develop a feminine “hysterical rationality” (Luce Irigaray, Hélène Cixous) or the topic of language as a structure distinguishing gender (Jacques Lacan) (Hutfless, <https://queeringpsychoanalysis.wordpress.com/2016/02/22/hysteria-perversion-subversion-some-remarks-from-a-queer-perspective>).

⁶ In 1935, Władysław Szumowski wrote: “The course of hysteria is egocentric, i.e. it revolves around the experiences and desires of the afflicted. The symptoms develop always for someone, for someone’s eyes; they have a purpose. If no one were to take interest in the histeric, the symptoms would have no reason to exist (Szumowski1961, 174).

⁷ In specialist literature, we can find research revealing that in neurological treatment the percentage of hysterical events is comparable to that which was documented 120 ago in Charcot’s clinic, with the one difference being that, instead of writing about “hysteria”, today we write about “psychoneurosis” or “functional disorders”. It is, however, certain, as noticed by the authors, that there are fewer works devoted to this problem (Stone 2008, 12-18).

<https://www.researchgate.net/publication/5588056> The 'disappearance' of hysteria Historical mystery or illusion (accessed: 01.12.2019).

⁸ *Historia medycyny* edited by T. Brzeziński from 1988 is far from announcing the end of hysteria. “In the second half of the twentieth century, it assumed another form and, as a result, is even more difficult to diagnose” (Brzeziński 1988, 416).

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Heterotopy of the Hysterical Body

Abstract: Heterotopia is the space of otherness, a counter-space. A very specific type of heterotopia is a human's body, especially in its illness and sickness. Hysteria, the disease which can imitate many other diseases, is here a crucial example. From its ancient beginnings until today hysteria makes us reflect on the essence of illness and disease, on the definition of the human condition, on the social role of a healthy and ill human body, etc. The archeology of hysteria explains how disorders shape medical standards.

Key words: hysteria, madness, epistemology, philosophy of medicine