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Through My Narrative I Was Born,  
My Narrative Sustains Me  

*Women Authoring Selves*

Through my dream I was born  
My dream sustains me  
—Rosario Castellanos

On September 28, 1911, Luz D. and her husband arrived at the Admissions Office of La Castañeda General Insane Asylum, the largest state institution dedicated to treating insane men, women, and children in early twentieth-century Mexico. According to the rules of the establishment, the Ds provided general identification information before a hospital resident completed a routine physical and psychological exam designed to determine the patient’s mental condition. Because her affliction did not prevent her from understanding and answering questions, Luz D. participated actively in the institutional psychiatric interview, a ritual structured around the questions on an official medical questionnaire that would determine her admission status. Later, when Luz D. became an inmate, she opted to write her narrative of her illness herself, on a separate sheet of paper:

I was born in ’74. When I was six, I had scarlet fever; after that I grew up healthy and robust and at thirteen I started my period without any disturbance; at fifteen I became nervous and I got married at seventeen; I was cured of nerves and I was like that for four years and because of moral troubles and physical losses, as I was nursing a very robust little girl, my nervous state came back from February to August. After that I was perfectly fine and at five years I had puerperal fever and I was in an acute nervous state
and I got relief from distractions and travel. At that time one could say that I used alcohol by medical prescription and perhaps unknowingly abused it.

In 1900 I had an attack of dipsomania and Dr. Liceaga convinced me to check in to La Quinta de Tlalpan, then I had this attack because of the life change morally and physically since my respected husband brought another woman and from that time on I have not been living intimately with him and the emptiness of my soul was reflected in the physical part; I never drank another glass of wine, until 1901 when I drank for a few days, I checked in to La Canoa and stayed there three months, I left and I was perfectly fine until 1906, when because of having excessive work and moral troubles and terrible unpleasantness I went back to drinking for a few days, I went back to La Canoa I left and I got intestinal fever and I went back to La Canoa where I stayed for a year and five months, I left and I was perfectly well until September 29th, 1911, when I went to visit someone and I drank cognac and pulque and then I kept drinking for a day and a half; noting that I never have the habit of drinking a single glass of wine, nor pulque, nor beer, only when nervousness and moral troubles, physical losses, and especially the emptiness of my soul reflected in a physical part, like I said, do I drink the first glass; in full use of my reason I withstand big things and it doesn’t take away the great control that I must have given my difficult situation and my exaggerated way of feeling and being and I get carried away with passion and the most complete excitement.

As Luz D.’s personal version of her life concluded, the diagnosis written by medical resident Agustín Torres began:

The information transcribed above was given and written by the patient herself, showing her clear talent for expressing her feelings and thoughts through writing. Except for her outbreaks of dipsomania, which she always relates to her moral pain, she seems to be a moral person. However, a more detailed study reveals a chronic state of manic excitement, which is more mental than physical (a background of moral insanity).

She has new ideas every day, whether it is leaving the psychiatric hospital or following a specific behavior with her husband, whom she blames for her condition. Every day, too, she complains about her health, whether it is a pain in her leg or her arm, a certain dizziness that gives her nausea, pain in her left ovary, or even hiccups. These symptoms make me think of a case of hysteria, which undoubtedly is present, but they are the results of her chronic mental excitement.
We have seen her write poems or letters for entire days describing her horrible situation to her relatives. Other days she spends doing manual work. What is pleasant today becomes bothersome tomorrow. The patient is aware of her situation and attempts to correct herself. She compares herself to a horse that is difficult to break, a horse that does not stop once it starts to run.

We have examined her carefully and we have not noted any other detail except for the pain in the left ovary which speaks in favor of hysteria. There are no signs of alcohol intoxication. To conclude this diagnosis, I will point out that she eats and sleeps well and suffers only slight constipation. Her prodigious memory is also noteworthy.

These two different, although not completely antithetical, interpretations of an experience with or within the universe of mental illness constitute a Mexican example of what Arthur Kleinman has called illness narratives: the series of “plot lines, core metaphors, and rhetorical devices that structure illness [which] are drawn from cultural and personal modes for arranging experiences in meaningful ways and for effectively expressing those meanings.”

While divergent indeed, the insanity narratives that gave shape to Luz D.’s physical and spiritual suffering seem to arise from an implicit agreement: both patient and psychiatrist (in this case more precisely, a female inmate and a male doctor) discussed mental illness as a real experience. Without this tacit yet pervasive agreement, the dialogue between Luz D. and Torres could not have taken place. The shifting and sometimes oppositional devices used to describe her illness, however, indicate that the agreement had its limits, which were as real as the unified effort to give her condition a name. These limits developed in the specific experiences and meanings that allowed both actors to interpret the medical notion of mental illness. These experiences and meanings developed outside the asylum walls, in a Mexico City that was growing exponentially under the leadership of a president obsessed with the idea of transforming it into a showcase of modernity—in a society of stark social contrasts where men and women were asked to create idealized versions of themselves as domestic angels and productive, austere workers, and in a time of great volatility that witnessed the fall of a thirty-year regime and the ignition of the armed phase of a social revolution that mobilized peasants, workers, and members of the middle class across the country’s rugged geography. Therefore, debates about class, gender, and nation that informed the existences of people living in these dramatic times of transition transcended the asylum walls and contributed in large part to the
identification of what became, at least in the specific example of Luz D.’s diagnosis, a case of moral insanity.

Defined, as I have mentioned, by James Prichard in 1835 as “a form of monomania in which people recognized the difference between right and wrong, yet lacked the willpower to resist evil impulses,” this diagnosis opened the door to definitions of “good” and “evil” that very clearly led to the use of nonmedical phrases in interpretations of mental disturbance, an opportunity that neither Luz D. nor Dr. Torres passed up. In developing a profile of this disorder, the two of them deployed their own observations, captured in their own metaphors, in narratives that emerged as they entered into contact with one another. This was not the case, then, of two ready-made discourses annihilating one another in sheer opposition, a view that is often linked to antipsychiatric notions of madness. Rather, a more mobile yet just as relentless strategy of displacement occurred.

Luz D., for example, brought interpretations of her life with mental illness that she generated in her contact with doctors and family members during her long career as a psychiatric patient in various state and private institutions, most notably La Canoa and La Quinta de Tlalpan. She also brought her long hair and those wild, piercing eyes that still gaze at her observer from the static reality of her official photograph, an image in which she appeared wearing the straight-jacket that on at least one occasion reined in what she called her “exaggerated way of feeling.”

Medical resident Torres, who five years later would become the director of the institution, brought with him the education that he received in Porfírian schools, more specifically the School of Medicine, as well as the professional ambition that contributed to his promotion. He also brought the intellectual curiosity that prompted him to lend an ear, sometimes a generous one, to Luz D.’s stories.

Suspicion and seduction must have played equal roles as their multiple encounters unfolded: the suspicion of two people who considered themselves utterly different, and the seduction of two people who saw themselves engaged in working for a common, yet not altogether clearly defined, purpose. Simultaneously clashing and negotiating, asylum inmates and their doctors produced tense, volatile narratives of mental illness, texts of multiple voices in which both actors deployed and intertwined their own relational understandings of the body, mind, and society.

Psychiatric hospital narratives are hardly free-flowing constructions of life stories. Constrained by an institutional setting that emphasized doctors’ authority,
and by a medical questionnaire that left little space for inmates’ answers, these narrations were based on, and in turn reproduced, the bureaucratic, medical, and social hierarchies of the psychiatric hospital itself. Yet even in that inequality, the mad, pained narratives that emerged on the hospital grounds necessarily incorporated the perspectives of doctors and inmates in the very friction that characterized their making.

The fact that such perspectives were not isolated entities became clear in Luz D.’s free use of rhetorical devices, a strategy more often associated with medical, not popular, interpretations of illness. Luz D. showed little hesitation to employ, for example, a narrative line linking her mental disturbance with stages of her life roughly based on a sexual interpretation of the female condition. This connection was common in Porfírian medical circles, obsessed with their supposed lack of knowledge of the female sex. Thus, although she noted that menarche did not cause later complications, she linked the onset of her “nervousness” with important transitions in her sexual life, most notably with marriage and later with conflicts in her marital life. However, even when Luz D. referred to her nervous condition as a phenomenon clearly rooted in the reality of her body, and more specifically, in her development and her sexual behavior, she also quickly proceeded to place that body within the charged context of daily life through concrete stories of childbirth, troubled family relationships, domestic violence, and often, suffering and loss. Thus, Luz D. conceded to medical discourse even as she maintained her own version of a life with mental suffering. She was not alone. Signs of a similar negotiation emerged in resident Torres’s pensive diagnosis, seemingly nonmedical and even a bit poetic.

The word “excitement” with which Luz. D. ended her narrative, for example, appeared very early in the text appended by resident Torres, serving as a sort of bridge between the language of the two. No one knows, or will know, who said it first, and therefore, which of them borrowed it from the other, but both used it in conspicuous ways. As was to be expected of a doctor interested in psychiatric science, he referred disdainfully to “what she calls her moral pain,” discarding or downplaying the stories of his patient’s complicated married life. Moreover, in an attempt to bolster his medical status, Torres introduced the well-known psychiatric term “hysteria,” but he did it in a casual way by relating it in passing to a pain in the ovaries. It was much more interesting to him, however, that she wrote a great deal and very well, something the doctor praised in the first sentence of his diagnosis.

The fact that he yielded to Luz D.’s interpretations as much as she did to his became tellingly clear when he used a metaphor of his patient’s own making.
to describe her: “she compares herself to horse that is difficult to break.” Even when he could not help but note a “background of moral insanity,” which was, in fact, his final diagnosis, he likewise could not refrain from praising Luz D.’s “prodigious memory.”

The incorporation of pompous and/or popular adjectives in a medical diagnosis is another sign of the tenuous terrain of social and cultural exchange that both inmates and specialists created, a view that implicitly questions the totalitarianism and absolute social control often ascribed to psychiatric hospitals. In this chapter, I explore this tenuousness as it developed in other patient files related to cases of moral insanity. I argue that, by participating in the scientific definition of what was normal and abnormal in human behavior, psychiatrists attempted to link themselves actively with efforts to shape a modern, centralized state. Yet the process—and I argue this here too—was not as direct and natural as presented, then and now, in medical narratives.\(^{12}\) This chapter invites the reader to participate in the psychiatric interview in which women inmates, faced with the imposition to reveal themselves, talked about their lives in ways that both followed and evaded the institution’s official medical questionnaire. Based on a meticulous analysis of the language used by psychiatrists and female inmates, I also contend that the debate about the appropriate place for poor women in society played a fundamental role in the broader definition of normal and abnormal behaviors in society as a whole.

Male psychiatrists, most of whom received their education in Porfirian Mexico, infused their diagnoses with normative notions of gender and class and detected signs of mental illness in cases where human behavior deviated from socially approved models of feminine domesticity in a modernizing setting. Thus, their repetitive and somewhat alarmed references to women who were “capricious” and “sexually promiscuous,” who according to some, “did not respect or obey anyone.”\(^{13}\) However, when women described the complex nature of their condition—their physical and spiritual causes, its evolution and social representation—they became their own authors as legitimate, albeit disconcerting, female citizens of the new era. Indeed, the narratives that women constructed as they interacted with psychiatric hospital doctors revealed their capacity to interpret and rename the domestic and social worlds they inhabited, obliging doctors and readers alike to see those worlds through their eyes. The spirited contact between inmate Luz D. and Dr. Torres was not very common, but neither was it unique.

Through various formats, and with varying degrees of articulation, some female inmates, especially those who did not suffer from severe mental conditions,
participated actively in the creation of their medical files. This was particularly evident in a substantial number of women diagnosed with moral insanity, a condition that despite being common among diagnoses recorded in the 1910s, decreased abruptly in the following decades. By 1930, psychiatric hospital doctors no longer diagnosed this condition in men and women confined in the institution. In the second part of this chapter, which discusses cases of long-term patients who were initially diagnosed with moral insanity, I explore the set of medical, social, and cultural elements comprising the horizon where this illness vanished.

Although the international psychiatry community had questioned the scientific status of this diagnosis since at least the late nineteenth century, I argue that interest in producing a prototype of the new woman in nascent revolutionary Mexico played a primary role in this transformation. Thus, as Porfírian models of femininity were increasingly questioned, members of the middle classes, new professionals, and revolutionary authorities engaged in spirited debate to demarcate appropriate gender functions for the new nation. Psychiatric classification changes in the General Insane Asylum represent but one example of this energetic dialogue. More than simply reflecting broader trends, I argue, patients’ rhetorical strategies helped to disrupt psychiatrists’ classification efforts at La Castañeda.

**Men, Women, and Sex**

The male doctors who worked at La Castañeda were often struck by an unsettling sense of strangeness when interviewing female inmates. As in mental health institutions in Europe and the United States, doctors observed female mental patients through the lens of normative models of femininity that represented them as angels in the house, detecting signs of mental illness when female behaviors deviated from that norm. Thus, while interviews included questions seeking to reveal abnormalities in patients’ habits, doctors formulated different modes of questioning for men and women.

Indeed, psychiatric examination of women inmates clearly took a sexual route. As in Mexican jails, male experts regularly interrogated female inmates about their sexual history in an attempt to find the true source of deviance and mental disorder. Although these questions violated implicit rules of female propriety (*decencia*), doctors were relentless in their pursuit because they were striving to obtain scientific knowledge about the female sex—information to legitimize the lenses they used to view their female patients in the first place. Thus,
psychiatrists made important contributions to the creation of a science of sexuality in modern revolutionary Mexico. Informed by the findings of Porfirian sexual science, a discipline developed by gynecologists and hygienists in the late nineteenth century, psychiatric hospital doctors placed great emphasis on female sexuality because they believed that “the ovaries and the uterus are centers of action that are reflected in the female brain. They can determine fearsome illnesses and passions yet unknown.”

These views linking sex with mental illness did not come out of the blue. In a time of rapid modernization, when social rules and customs seemed to be changing quickly, anxieties about gender were developing just as fast. Not only was the population of the metropolis expanding, but women were also gaining increased access to work and education at the turn of the century, a process that gave male experts ample opportunities to fret over the influence of feminism.

Beginning in 1867, the approval of a series of controversial prostitution regulations also laid bare the impotence of federal authorities to control women of supposedly loose morals. Crude debates over syphilis allowed lawyers and doctors alike to alert the public to the possibility of contagion and social annihilation throughout the first decades of the twentieth century. However, as elite male experts and politicians fought to put women “in their place,” they discovered to their great surprise that they knew very little about that place, and even less about women themselves. As the anonymous editor of the journal *La Escuela de Medicina* succinctly expressed in 1892, “as incredible as it may seem, it is a fact that there is no real information about the moral and physical conditions of the female constitution.” Thus, driven by a distressing, urgent will to know, they threw themselves into the task of producing knowledge about that female constitution. This was hardly an irrelevant mission for doctors who believed that the preservation of the family, the stability of the country, and the survival of the nation depended on scientific and moral knowledge about sex.

However, intervention by male doctors in female bodies met constant social resistance. Although doctors applauded advances in the field, other members of society claimed that “as objects of study” women became “victims of examinations which science may be able to justify, but which feminine modesty forbids even in thought.” Thus, in their quest for information, doctors were obliged to turn to alternative sources. The bodies of prostitutes imprisoned in Hospital Morelos, a welfare institution dedicated to treating women with syphilis, became fertile ground for the development of women’s medicine in Mexico. Indeed, prostitutes became informants, despite their not infrequent resistance. It soon became evident that prostitutes did not take kindly to the fact that research
was being conducted on their bodies, and consequently, they rebelled against the hospital’s medical and disciplinary rules. Riots and other forms of organized resistance became routine at the institution. Doctors, however, found additional pathways to knowledge in other welfare establishments, most notably the General Insane Asylum.

The increasingly abundant medical literature linking sex with female illnesses informed encounters between asylum doctors and female patients. As the questions accumulated, psychiatrists demanded disclosure and induced—sometimes gradually, other times abruptly—women’s narratives. Attentive to detail, male doctors attempted to organize the information they received in diagnostic groupings, one of which was moral insanity. Although not numerous, with diagnoses of this condition totaling only about 2 percent of psychiatric hospital patient files in 1910, it was quite common as a contributing factor in other diagnoses such as alcoholism, hysteria, and cerebral syphilis, which doctors associated with a dubious “moral sense.” More importantly, the moral insanity diagnosis no longer appeared in psychiatric hospital records from 1930 onward, demonstrating that revolutionary-era psychiatrists were increasingly skeptical about the scientific status and social value of a medical category employed in Porfrian medical circles.

Moral insanity diagnosis files, which often contained long narratives, showed that this shift in psychiatric perspectives stemmed not only from medical concerns about scientific classification, but also the contested dialogues in which psychiatric hospital doctors and patients participated with equal vigor and tenacity. To be sure, these dialogues did not take place in a vacuum. Indeed, in a context that witnessed growing deliberation about the nature of the female sex and the role of women in building the new nation, it became ever more difficult for doctors to explain female mental illness solely in relation to sexual deviation.

Likewise, as the revolutionary period progressed, women diagnosed with moral insanity had increasing opportunities to participate in social discourses like feminism that emphasized the multifaceted structure of female experience.

Diagnosing Female Perversion: A Psychiatric Profile

In the early 1910s, psychiatrists at the General Insane Asylum detected symptoms of moral insanity in women who did not conform to models of feminine domesticity. Signs of the illness were especially acute in prostitutes, the sworn enemies of the angel in the house, but as in US institutions, few of them came
under their scrutiny. Perhaps that was the reason why Dr. Méndez devoted close, even fascinated attention to Modesta B., a thirty-five-year-old prostitute who arrived at the psychiatric hospital in July of 1921.

Even though most US and European psychiatrists no longer used the moral insanity diagnosis to classify their patients, Dr. Méndez decided that her case was “one of the clearest examples” of this condition. Modesta B.’s lack of modesty, use of affected terms, attempt to pass for an educated woman, and most of all, her willingness to talk about sex, to give interminable, shameless descriptions of orgies and other sexual practices considered deviant, made the diagnosis seem fitting. Moreover, as Prichard’s original definition required, she distinguished between good and bad, but was unable or unwilling to resist her evil impulses, especially those related to her body’s sexual urges. However, her proclivity for concupiscence soon fell into question when the Wassermann test, designed to detect syphilis, came back negative.

When Modesta B. became a patient at the psychiatric hospital, the doctors prescribed her mild sedatives and a treatment centered on work, an activity that she completed in the institution’s sarape workshop, where Professor Magdalena O. viuda de Álvarez praised her diligence and good temper. However, echoing the medical diagnosis, Professor Álvarez testified that the patient indeed talked, perhaps too much.

As asylum doctors soon discovered, however, single and married women also developed this condition. The case of Carmen S., a girl of undetermined age, gave psychiatrists an opportunity to analyze the initial stages of moral insanity in June of 1910. After listening to the testimony of Carmen’s mother, doctors reported that “from an early age, Carmen manifested a capricious and violent temperament. She openly disobeyed her mother’s orders. Moreover, she tended to skip school only to go out with her friends, with whom she invariably ended up quarreling.”

This capricious temperament, her mother added, had increased day by day, and had led Carmen S. to consume alcoholic beverages, and most surely, to other unmentionable vices. Displaying characteristics of that temperament, Carmen S. refused to answer the interview questions, and claimed that she “did not remember anything that was being said about her.” Besides the occasional headache, leg cramp, and swollen feet, doctors described her as a healthy individual who nevertheless required confinement.

Josefa B., an unemployed single eighteen-year-old woman, was admitted to the psychiatric hospital for the second time in December of 1910 with the same symptoms. According to Dr. Rojas, she was an “impulsive” inmate who once even hit
another patient and had attempted to untie others on various occasions. Clear signs of moral insanity surfaced in the lack of respect with which she treated her mother, disobeying or dragging her feet when obeying her orders, as well as in a tendency to argue openly with other people. However, as the resident noted, in this case, her temperament was transitory, since as soon as the excitement passed, she returned to normal: “respectful, obedient, and even submissive.”

Similar reports of a strong temperament and assertiveness appeared in the file of Teresa O., a single, unemployed twenty-six-year-old woman who lived with her mother in Mexico City. As doctors noted in her file covering the period from 1905 to 1915, Teresa O. also showed “poor character and a proclivity for leaving her house to wander the streets freely. She did not respect or obey anyone.” Although she was physically healthy, Teresa O. “had suffered from hysteria since the age of fifteen”; the condition drove her to attempt suicide on two occasions.

Teresa O. explained that “she would leave her house to avoid the bothersome comments of her sister,” but she also disclosed the fact that despite being single, she was not a virgin, having had two different lovers in the past: a man her age and a trusted doctor. After hearing the details of her sexual history, Dr. Rojas readily classified her case as moral insanity.

Sexual practices considered deviant were the clear hallmark of women suffering from moral insanity. For example, Loreto M., a twenty-five-year-old seamstress who lived in Tacubaya, “was an exhibitionist who lacked all sense of modesty and displayed a marked proclivity for obscenity and perversion.” Her case, which was first examined at the Divino Salvador hospital in 1903, was especially complicated because although she was blind, as soon as she would sense the presence of a man, “she would expose herself shamelessly.”

Adulterous women were also likely to be diagnosed with moral insanity, especially if they alluded to revenge as the cause of their behavior. Rita C. violated fundamental rules of feminine conduct when, after arriving at La Castañeda on September 19, 1911, she used obscene language to describe how “her husband had cheated on her several times . . . [and], to get revenge, she had cheated on him too.” Doctors diagnosed her with violent jealousy, a trait that they believed was related to a deficiency in her moral sense.

Although psychiatric hospital doctors did not use the term, homosexual women also belonged to this category. Soledad J., for example, a married thirty-six-year-old woman who was examined by Dr. Palacios Garfias in 1912, displayed a pronounced fondness for one of her fellow female inmates, although due to her peaceful, kind character, “she had not yet become excited.”
In May 1910, when female inmates like Margarita V., a twenty-year-old migrant from Guerrero, dared to display excessive love for other women, doctors diagnosed them as cases of “madness of two,” a mental disturbance that was especially acute in the presence of the other person. The photograph in Margarita V.’s file, which included the face of another female inmate, corroborated the information. Confined and isolated, the counterposed faces of Margarita and her companion were an all-too-human reminder of the cruel consequences suffered by women whose uncontrolled “passions” violated socially accepted sexual rules.

Although moral insanity existed within the broader category of sex, doctors also perceived intellectual activity as a sign of female mental degeneration. When Guadalupe Q.—a patient committed for the first time in 1882 and later transferred to La Castañeda due to her sexual mania, which caused “great harm not only to herself but also in her family”—began writing poems and passionate love letters, both the content and the activity itself marked her as a woman with moral insanity. Luz D.’s ability to write the narrative of her illness struck doctors as further evidence of her unstable mental condition. Likewise, Modesta B.’s remarkable skills as a storyteller instantly captivated asylum doctors’ attention.

Despite or perhaps thanks to their diagnoses, these women fought, at times successfully, to narrate their personal histories, opening an invaluable door to women’s self-interpretation in early twentieth-century Mexico.

Look at the World through My Eyes: Female Patients Speak

As asylum doctors were well aware, having the need or desire to tell their life stories was hardly an innocent urge among female inmates. As they structured narratives of their experiences with illness, female inmates emphasized aspects and topics that were often neglected in the medical questionnaire. As women attempted to describe their symptoms and explain the causes of their conditions, they became their own authors in contested interconnection with psychiatric hospital doctors. Rather than using rigid strategies of opposition, however, the women manipulated fundamental passages of their life stories that would help them elude or expand the narrow roles that doctors assigned them. In this way, even while confined by walls, women engaged experts in a tense dialogue about the medical and social boundaries of gender in revolutionary Mexico. Some, like the “capricious” girl, Carmen S., flatly refused to speak and sustained a suspicious
silence; others, however, spoke about or wrote their life stories, which given the circumstances in which they were created, lacked happy endings.

Most female inmates’ stories revolved around troubled family relationships, in particular, the mother-daughter bond. In a rapidly changing social environment, it proved difficult for mothers to transmit traditional feminine values such as modesty, obedience, and docility. After all, both work and public life represented temptations that some early twentieth-century daughters were incapable of resisting and, in fact, readily enjoyed. Such was the case of Carmen S., who took to the streets in spite of her family’s prohibition, as well as the case of Teresa O., who, for example, said she had been sent to the psychiatric hospital “because my mother doesn’t want me to go out.” In a society that increasingly associated street life with vice, Teresa O.’s mother’s fear was not ideologically unfounded. Seemingly, daughters felt constrained by their mothers’ morality. Teresa O. stated that she felt despair because “my mother didn’t want me to get married.” Likewise, Natividad O., a seventeen-year-old woman from Michoacán who arrived at the psychiatric hospital in July 1910, reacted against her mother’s restrictions by running away from home and declaring that she was “independent and absolute.”

For asylum doctors, this tense and highly ambivalent bond between mothers and daughters affected the minds of the latter to the point of numbing their “affective sense”; as moral insanity evolved, some, like Josefa B., could only feel “hatred” for their mothers—an unnatural emotion that betrayed their condition. The degree of conflict in these mother-daughter relationships was evident in the fact that at least in a couple of cases, the mothers themselves took their unruly daughters to the asylum.

Conflicts between single women and family authority figures also emerged in sibling relationships. Olga F., for example, had immigrated from Cuba to the United States in 1925, when she became an orphan at the age of fourteen. There, she lived first with a prosperous uncle who owned a cabaret, which is how she grew accustomed “to dancing, sports, travel, and driving an automobile.” Once she moved into the house of her brother, an engineer who attempted to discipline her, Olga F. found his ways too “rigid,” and after a quarrel over money, she ran away. Her brother, she said, was “a bad man.”

Likewise, Teresa O. had problems not only with her mother but also with her older sister, albeit for different reasons. The patient claimed that her sister bothered her often, a situation that, according to her explanation, was related to the fact that both of them were fighting for the attention of the same man. The
sisters’ rivalry became so unbearable that she later used it as an excuse to run away from home. Just as some mothers brought their daughters to the psychiatric hospital, sisters did the same. Guadalupe Q.’s younger sister, for example, not only committed her but also participated in the initial psychiatric interview, where she described the first manifestations of her condition.

Tense family relationships with parents and siblings developed as spirited single daughters of the modernizing age violated traditional rules for behavior. Quite often, these violations involved their relationships with men. Some, like Teresa O., had sex with men in spite of their mothers’ warnings. In an act of rebellion, she first “gave herself” to a boyfriend and, later, suffered sexual abuse by a doctor. Both events marked her as unfit for marriage and for life outside the asylum walls altogether.

Victims of societal double standards, women who openly had sex with men compromised not only their honor and that of their family but also the continuity of the relationship. As Teresa O. testified—“later, he married a cross-eyed woman and I forgot him”—most men abandoned their lovers and eventually married respectable girls. Facing the opportunities and risks that their mothers feared, the impetuous daughters of revolutionary Mexico found trouble more often than not. The case of Olga F. almost perfectly exemplified the darker side of those fears. Olga F. had lived with a man for two years while she became addicted to his vice: heroin. When she arrived at the asylum in September 1930, filthy and weighing about seventy-seven pounds, doctors attributed her condition to her drug addiction, but not without mentioning the degrading consequences of free love. Indeed, as shown in the files of the Sanitary Inspection charged with licensing prostitutes, women who acquiesced to men’s desires, or worse, their own desires, had a high probability of becoming streetwalkers for life. Marriage, however, was not exactly a peaceful sanctuary.

Violent domestic dynamics between men and women appeared as principal causes of mental illnesses in female inmates’ narratives. Indeed, most women diagnosed with moral insanity took their stories to a place that was so common it emerged as a pattern: physical abuse at the hands of lovers and husbands alike. Felipa O., a married twenty-four-year-old woman who spoke of continuous “marital disputes” when she arrived at the General Insane Asylum in June 1920, for example, developed a case of “convulsive hysteria” after receiving a hard blow to “her genital organs.” She was one month pregnant at the time, and she lost the baby as a result of the assault. Resident Iturbide Alvírez noted a conspicuous two-centimeter scar along her right brow.
Although physical abuse did not appear in Luz D.’s narrative, she too wrote about “the very difficult life I lived with the man, my husband.” In this case, as in many others, male infidelity played a primary role in the unleashing of female rage, a condition that doctors associated with a mental disturbance. According to Luz D., for example, her husband “brought a woman to live with him,” a situation that seems to have triggered “terrible fights,” “mental pain,” and “frightful disputes” when he tried to divorce her. Marital tension between the Ds became painfully clear in the efforts he made to keep her from being released, alluding to the harm Luz D. could inflict on her family and on society at large. 

Facing a similar situation, Rita C. found it impossible to forgive her husband’s infidelities. Instead of conforming to domestic models that stressed feminine sacrifice and submission, Rita C. resented “having been cheated on” by her husband, and in coarse language she described the many occasions on which she herself had cheated on him. Such scandalous behavior sent her straight to the asylum.

Other women with similar tendencies, however, ended up in Belén, the city’s prison. When journalist and amateur criminologist Carlos Roumagnac interviewed them there, they made similar claims of marital abuse. Nevertheless, both psychiatrists and journalists remained blind to this pervasive reality, attributing it instead to the intrinsic violent behavior of the uneducated poor. Although women also related poverty to violence, and provided evidence to document it, they also pointed to uneven gender relations that permitted and even invited abuse.

Loss of children and family members was another important theme in women’s narratives of mental illness. Within the context of continuous change of the Mexican Revolution and its aftermath, which resulted in more than a million recorded deaths, these personal histories offered a personal dimension of social change in telling detail. In 1920, for example, Altagracia F. de L., a married thirty-five-year-old woman from Aguascalientes, suffered a “painful impression” when she received the news that one of her children had been in an accident. Afterwards, she developed intense headaches, and eventually, delirium that brought her to the psychiatric hospital facility. Her rage was so great that doctors recommended the use of the straitjacket, in which she was photographed.

Likewise, Cresencia G., a sixty-five-year-old widow, experienced her first attack after the death of her son in July 1920. Claiming that her neighbors had poisoned her, Cresencia G. was bedridden for nine days before wandering about the countryside in search of solace, which she did not find. For this reason, Cresencia
G. responded with rage to visitors from her hometown of Capulhuac, believing that they, and society in general for that matter, were responsible for her loss. Felipa O.’s loss of her one-month-old fetus also triggered her mental disorders.

Despite how little is known about the various ways that common Mexicans coped with pain and loss during the turbulent early years of the twentieth century, these medical histories stand as vivid reminders of the centrality of these themes in life narratives in modernizing Mexico.

Women diagnosed with moral insanity also laid claim to concepts of justice and social equality galvanized by the discourse of the Mexican Revolution, revealing the manifold components of an experience that was hardly encompassed by the category of sex. This process was especially clear in the case of Modesta B., who took up writing about national politics as her clinical history accumulated over thirty-five years of continuous confinement. In her version of events, she was an employee of the Virginia Fábregas Theater Company, and after denying her favors to a group of soldiers, she was unjustly sent to jail. There, a licensed doctor diagnosed her as mentally unstable. As documented in the twenty-one pages that she wrote by hand while confined, Modesta B., the woman who, according to doctors, was obsessed with sex, blamed her condition on contemporary political dynamics and complained bitterly about the corruption and disorder plaguing the asylum and her nation alike.

The harrowing pages, which Modesta B. called “diplomatic dispatches,” belonged to a woman who did not perceive herself in terms of sex. As a concerned female member of a country in continuous turmoil, she cast off the limiting category of sex as a primary definition of her life experience. Given the blank space of a sheet of paper, she chose to draft a contorted characterization of the ills affecting her nation, which in her opinion were many. Addressing the president of the Republic or the superintendent of the General Insane Asylum, Modesta B. criticized doctors, bureaucrats, anarchists, and foreign investors alike.

Her first complaint was related to the disastrous conditions and lack of privacy prevailing within the asylum walls. In an attempt to change the situation, she wrote a public letter to expose the unjust state of affairs, and she rallied the other patients, obtaining the signatures of three additional female inmates to support her cause. Modesta B., however, not only concerned herself with asylum matters. In these missives, she also described a social world deeply disturbed by the actions of those with “red hands”—anarchists who were sparking revolutions and world wars—and those with “white gloves,” always stealing from the vulnerable and needy. In her anger, she described both groups as “vile, rude, dirty people, on the right or the left. Evil people, capricious people.” Although her
words lacked the style of political standard-bearers, they showed the wide range of concerns that informed her life as a woman and as a citizen.

Modesta B. was not alone. Members of feminist organizations of the era—journalists, teachers, and political activists—defended women’s rights and education as well as the right to fair treatment in the workplace. The two feminist congresses that took place in Yucatán in 1916 emphasized similar themes.

It was not surprising or coincidental that by voicing the language of psychiatry, male intellectuals often portrayed women concerned with “the social question” as not only ugly and masculine, but also, and more importantly, as hysterical.

When women diagnosed with moral insanity intentionally presented themselves as active agents in both domestic and social arenas, they narrated the stories of their lives, and in doing so, implicitly questioned supposedly scientific medical diagnoses. Considering that moral insanity diagnoses appeared most often in patient files dated 1910 and disappeared by 1930, this was a clear victory for patients over Porfirian psychiatry, a body of ideas espousing punitive views of mental illness in which sex and insanity were intimately linked.

Voicing their own discourse as daughters and wives, workers and neighbors, mothers and citizens, female inmates forced revolutionary-era asylum doctors to reconsider and eventually discard Porfirian medical doctrine.

Counterpoint: From Moral Insanity to Melancholia in Sixty Years

According to what has been presented so far, it would appear that most if not all women diagnosed with moral insanity were deliberately and inherently direct and expressive. Some of them clearly were, and not exactly to their own benefit, since doctors took the fact that they talked too much as an additional sign of a mental disorder. However, some women imprisoned themselves in a silence so absolute that it could not be broken, even by the indirect quotation strategy so frequently used by doctors in medical files.

As a counterpoint to the experiences of expressive women who supposedly suffered from moral insanity, I now offer the case of Rosario E., whose voice does not appear in psychiatric hospital documents. Her file is also relevant because she was confined for sixty years of her life, while psychiatric concepts of moral insanity underwent dramatic changes.

In the early 1930s, at the same time that hospital directors Samuel Ramírez and Manuel Guevara Oropeza were working on medical reform in the institution, doctors ceased to diagnose women with this illness. Although Mexican
doctors’ efforts to keep up with international classifications played an important role in this transformation, nonmedical factors should not be ignored. After all, moral insanity diagnoses disappeared at a time when the emerging revolutionary regimes of Obregón and Calles were striving to establish the economic, social, and cultural foundations of a new nation.

This period witnessed, for example, the rise of the Institutional Revolutionary Party (PRI, Partido Revolucionario Institucional), the political organization that united most of the factions in the revolutionary family. National worker organizations such as the Regional Confederation of Mexican Workers (CROM, Confederación Regional Obrera Mexicana) and peasant leagues throughout the country acquired greater relevance in the nation’s political affairs. A growing emphasis on the responsibilities of the state drew long overdue attention to public welfare institutions, including La Castañeda. However, this period also witnessed increasingly intense debates over the appropriate roles of women in this new society in diverse forums including feminist congresses, newspapers, clinics, and classrooms. Changes in psychiatric classification went hand in hand with such debates, even if there was not a direct causal link. The long and perplexing story of Rosario E., an inmate whose career as a psychiatric patient spanned six decades, thus serves as an ideal case to illustrate this point.

The story of Rosario E.’s life with mental illness began in the facilities of La Canoa Hospital in 1896 at twenty years of age. She came from a large family: she had seventeen siblings, only five of whom survived. Rosario E. was born in San Luis Potosí, and her medical file did not specify her occupation. Described by one of her brothers as “unbearable and capricious,” she remained in the institution for some ten years with a diagnosis of “intermittent insanity.” Doctors’ notes, written toward the end of the nineteenth century but copied and expanded over time, emphasized certain behavioral peculiarities that combined to coincide almost perfectly with the profile of moral insanity in 1912.

According to the brother, who returned her time and again to the psychiatric hospital, Rosario E. suffered from “hysterical outbreaks,” mostly detected when she would run away from home looking for brothels where she attempted to satisfy her “carnal instincts.” While she was an inmate in La Canoa, Rosario E. expressed unspecified “delirious ideas,” which according to an anonymous medical source, improved enough to let her go free. Just a month later, Rosario E. returned to the hospital, accompanied yet again by her brother. The list of complaints had increased, but its nature was unchanged. Not only did she continue to run away from home, she also persisted in visiting places of ill repute. Her temperament had worsened, and she was increasingly “irascible, manipulative,
crafty, and envious.” On this occasion, however, she also developed well-defined visual and auditory hallucinations. She heard distant voices, for example, and she saw faces “of monstrous men or giant monkeys.”

Dr. Ernesto Rojas’s moral insanity diagnosis appeared in notes dated 1906. Those who authorized her numerous discharges throughout 1910 based their decisions on improvements in that illness. Those who took her back regularly confirmed the verdict without further comment.

Rosario E. was one of the female inmates who were transferred from La Canoa to La Castañeda after the institution’s grand opening on September 1, 1910. As was customary, she underwent a new medical exam, and subsequently she was sent to the tranquil female inmates ward, section “A.” Noting no peculiarities in her behavior, Dr. Rafael Palacios Garfias processed her release shortly thereafter. She was taken to her brother’s house and was thrown out not long afterward.

In September 1912, Dr. Manuel Ortiz heard the customary complaints: Rosario E. went home only to run away. Once again she attempted to visit unholy areas of the city where women were sexually available. “We have observed her for several months,” wrote Ortiz, “and we have not been able to witness the supposed hysterical outbreaks she is said to suffer. However, we can say that her temperament is frankly hysterical, as she presents phobias and obsessions that characterized her condition.” The doctor concluded his report with a final diagnosis: “hysterical psychosis (moral insanity).” Dr. Tomás Valle, director of the institution at the time, affirmed this conclusion two years later.

Although Rosario E.’s behavior ostensibly changed little over the next fifteen years, Dr. Manuel Cobarrubias produced a different diagnosis in the late 1920s. In his opinion, the patient did suffer from a type of psychosis, but it was intermittent in nature rather than hysterical. Unlike Dr. Ortiz, who paid much attention to the appearance of signs of hysteria, most notably in sexual behaviors considered deviant, Cobarrubias’s examination emphasized a new set of symptoms: he noted that Rosario E. experienced long periods of “complete tranquility” and added that for this reason she was hired as a guard in the observation ward. These periods were interrupted by short but acute episodes of confusion and excitation. It was then that she became aggressive and burst into fits of tears. During these phases, she would speak aloud with no one in particular and also engaged in prayer sessions, occasionally up to three times per day.

Although Cobarrubias also stressed Rosario’s increasing attachment to a fellow patient, a woman who was confined in the female epilepsy ward who she called her daughter or niece, he made no comment about the possible sexual nature of this bond. He instead placed greater emphasis on the development of what
he called “her religious delirium.” In 1927, when the Plutarco Elías Calles regime entered the Cristeros War against supposed religious fanatics in the provinces of Mexico, closing churches and prohibiting religious services throughout the nation, this diagnosis could not have been an innocent one. Cobarrubias’s notes on the case of Rosario E. were clearly contaminated by matters that transcended the asylum walls, speaking to nonmedical factors that shaped many of the medical observations recorded in the asylum archives. As the source of irrationality shifted from sexuality to religion, Rosario E. came to embody a threat to the secular regime. However, her condition was special, even for Cobarrubias, who recommended ongoing confinement but did not prescribe any medication.

The psychiatric interpretation of Rosario E.’s condition continued to evolve. Four years later, Dr. Gómez Robleda, head of the tranquil inmates ward, signed a typewritten report with his own observations and those of his medical resident, Luis Vargas, which included notes filed in this case beginning in 1896. In 1931, Rosario E.’s physical condition was, as in the past, rather normal. Stressing her passive conduct, perennial lack of initiative, and the worry detectable in her body language—she was always seen seated, hanging her head, with a facial expression denoting sadness and depression—Dr. Gómez Robleda arrived at the conclusion that Rosario E. did not suffer from psychosis, hysterical or otherwise, but rather, melancholia.

Based on observations gathered in the psychiatric interview, both doctors believed that in terms of intelligence, she had a good sense of orientation with appropriate intervals of passive and active attention. However, after running a memory test in which they asked her to arrange simple numbers in an increasing sequence, Dr. Gómez Robleda and Dr. Vargas confirmed a deficiency in her short-and long-term memory. The fact that she manifested reproductive rather than creative imagination, which in the physicians’ opinion generally played an important role in the formulation of “delirious interpretations of the depressive type,” provided even more evidence to support a final diagnosis for Rosario E. as the victim of a melancholia syndrome. Her sexual escapades and the rebellion that had so infuriated her brother in the past were no longer emphasized. Her religious inclination that had captured the attention of Dr. Cobarrubias a few of years before did not appear either. Instead, Rosario E. now appeared motionless, even shapeless, and profoundly sad. It seemed that a life devoid of support, family care, and the ability to work had finally done her in.

However, only a month later, on June 11, 1931, a new diagnosis was added to her medical file. Despite containing the distinctive signature of Dr. Garfias, the handwriting in the document suggests the intervention of an additional expert.
Based on observations already recorded, instead of additional interviews, this document unequivocally denied that Rosario E. suffered from depression. Instead, after describing her as autistic, the anonymous doctor noted a different set of symptoms, including, once again, reports of her hysterical temperament (“crafty, stubborn, irascible, a troubled person”), sexual deviance, obsessions, and outbursts of an indeterminate nature. Auditory and visual hallucinations, frenetic prayers, a reduced attention span, angry self-criticism, and imaginative delirium that allowed her to believe that a patient with epilepsy was her daughter formed a clear picture of hysteria. However, despite his efforts, the psychiatric hospital doctor did not find physical signs of the illness, and so he only prescribed a mild laxative.

Meanwhile, Rosario E. continued to regularly leave and return to the psychiatric hospital, since although her diagnosis constantly shifted, most of the doctors reported that her observable behavior was somehow normal. In the years when medical files began to include copies of the results of laboratory tests and evaluations based on a variety of standardized measures, hers were not included. Doctors were conducting increasingly detailed interviews and paying more attention to previously recorded information, but they did not evaluate her condition with the meticulousness devoted to other inmates.

The carelessness with which most of the changing diagnoses of her condition were made was related to the clear fact that there was no one outside the psychiatric hospital waiting for or demanding news about her, a common situation for inmates who had conflicts with their families. What is certain is that asylum doctors pressured public welfare system authorities to admit her to the state nursing home for the elderly, which indeed happened. At other times, such as on August 27, 1932, Rosario E. became a domestic servant; in this specific instance, it was in the home of a man named Roberto Couttade. However, as had happened earlier with her brother, each of these people returned her to the psychiatric hospital, alleging behavioral inconsistencies that they found troubling.

In 1953, debilitated and suffering from senile dementia, Rosario E. left the medical facilities almost at will, only to return shortly thereafter. Each time, her fellow inmates declared that she appeared out of nowhere or showed up “spontaneously” at the doors of the psychiatric hospital. It was the only home she had known, albeit reluctantly, for at least forty-three years.

In contrast to victims of moral insanity who were willing to engage doctors in uncomfortable dialogues, Rosario E.’s silence during her confinement afforded physicians more opportunities to develop their medical interpretations unilaterally. For this reason, the specialists’ argumentation seems more extensive and
clear in this file, accentuating the role played by external factors, whether general social issues or more particular academic concerns, in the changing nature of their own classifications; thus we see doctors’ emphasis on the supposedly deviant sexual conduct of women during Rosario E.’s youth and the first years of the psychiatric hospital, when Porfirian gender ideology was highly influential, and the apparently subtle change in critical views on religious fervor during a strongly anticlerical period dominated by supreme leader Calles.

To be sure, psychiatric hospital doctors enjoyed a high level of authority in the institution, and they did not hesitate to use it. Nevertheless, the vertical imposition of their own verdicts was just one of many strategies utilized to adapt the language of psychiatry to international medical standards and the needs of revolutionary Mexico.

The Psychiatrization of Sex

Faced with expressive women who talked too much, often about sex, the hospital’s doctors in the early 1930s displayed remarkable restraint in their moral commentary. Instead, however uneasy or disturbed they may have felt, they noted observations in an increasingly standardized medical history, and recorded information obtained through laboratory analyses, particularly reactions to the Wassermann test, designed to detect syphilis. This emphasis on objective and systematic information, rather than subjective, unfocused speech, corresponded to psychiatric hospital doctors’ efforts during this period to elevate the scientific status of their profession, an urgent task for professionals who were anxious to shake off their previous label of “medical dilettantes” and carve out their own niche in a new society.

At a time when efforts opposing the regulation of prostitution were gaining support, and when nationalist doctors were calling syphilis an epidemic of national proportions, listening to life stories plagued with sexual details took on both medical and political relevance. Mexican psychiatrists working in the nation’s largest government-run psychiatric hospital soon understood that the use of methods considered objective, and therefore scientific, would guarantee them a privileged role in a regime that favored the secular to the point of equating it with modernity itself. In the process, women who previously had received the diagnosis of moral insanity were increasingly diagnosed with progressive general paralysis, a condition associated with syphilis—and therefore, with a licentious sex life—verifiable through the Wassermann test.
Just a couple of years after Ramírez Moreno and Guevara Oropeza took charge of reforming the General Insane Asylum, Mexican psychiatrists sharply increased their emphasis on obtaining information through objective means and precise documentation of data.

The hospital’s doctors not only were more willing to use Wassermann results to justify diagnoses, but also displayed greater discipline in recording medical histories. Unlike files from the early years of the asylum, clinical histories from the 1930s followed a standard format. Normally typed rather than handwritten, clinical histories from revolutionary Mexico began, after an observation period, with an “identification” section where doctors recorded data taken directly from the institutional questionnaire, such as name, age, place of birth, marital status, and occupation, if known.

In the second section, titled “history,” doctors recorded relevant illnesses of patients and their family members. The third section, titled “progression of the illness,” included an often-lengthy description of the possible causes and the development of the illness, according to the patients themselves and any family members present. This section, which typically incorporated the patient’s discourse through indirect quotations, revealed the life story of most inmates.

Doctors divided the fourth section, known as “current condition,” into two subsections: one dedicated to the “mental examination” and another for the “brief physical examination.” The first subsection was, in turn, divided into three large categories: intelligence, affect, and will. A later subdivision required doctors to include within the intelligence section an analysis of orientation, perception, attention span, memory, imagination, ideation, and judgement. Doctors’ descriptions of patients’ affective abilities and manifestations of will were often less precise and extensive. Under “brief physical examination,” doctors recorded results of patients’ physical exams, including head, neck, chest, abdomen, and upper and lower extremities. Here they also typed data obtained from laboratory tests. Only after detailing all of this information were doctors ready to record the diagnosis, in section five of the clinical history.

In the next section, doctors recorded the prognosis and then concluded with section seven, where they specified the recommended treatment. Thus, based on verifiable data and organized in a systematic format, psychiatric discourse produced in early revolutionary-era Mexico secured, perhaps for the first time, its status as a scientific discipline.

Like the colleagues who went before them, revolutionary psychiatrists knew that illness identification, scientific or otherwise, required patient participation.
So they paid attention and listened carefully. They incorporated these voices into medical histories through indirect quotations revealing patients’ insistence upon linking physical and spiritual symptoms with the social and domestic worlds in which they arose. Like women diagnosed with moral insanity in the past, victims of progressive paralysis in revolutionary Mexico strove to relate their illnesses to the suffering that was invading their lives, giving them pain and meaning at the same time.

Although psychiatrists’ implicit disdain for these poor women’s lifestyles was evidenced in the medical histories, it is clear that their own emphasis on objectivity restricted their personal comments. Thus, even though the occasional slippage betrayed doctors’ entrenched personal beliefs, they could not accuse women of immorality. Rather, they could only refer to them as ill. The medical and political ambivalence involved in this transformation will guide my analysis of the cases of four women whose Wassermann test reactions were reported as “intensely positive.”

On July 8, 1930, resident physician Francisco Elizarrarás examined Ángela P., a thirty-one-year-old married woman from Hidalgo. Part of a large family—she had fourteen siblings, eight of whom survived—she grew up without a father and with a mother who had epileptic seizures. Under the title of “evolution of the condition,” Elizarrarás condensed an all too familiar story. Led by an incestuous stepfather, Ángela P. migrated to Mexico City at the age of ten to work selling tortillas. Later, however, a city cousin “sold her,” and her life as a prostitute began.

She became pregnant, lost her baby, and later experienced symptoms that the medical resident immediately linked to the initial phases of syphilis. Despite her condition, Ángela P. got married on an unspecified date, but she could not “make use” of her husband because he was impotent, a situation that drove her to satisfy her “need for sexual contact” with other men. Although she mentioned many of them, she only spoke in fond detail of an Englishman who had given her a bed. At the time she was committed, however, Ángela P. was weary of her life—in fact, she had attempted suicide, but “the train stopped and did not kill her”—and she expressed her desire to settle down and get married. She kept conspicuously silent about her stay at the police facility, from which she was transferred to the General Insane Asylum that summer.

Bearing a striking resemblance to women listed under the moral insanity diagnosis twenty years earlier, Ángela P. described numerous instances of sexual abuse and domestic violence, which the medical resident included as examples
of exaggerated, delirious ideas in the section of the medical history titled “ideation.” Unlike psychiatric hospital physicians in the past, however, resident Elizarrarás refrained from assessing Ángela P.’s moral stance. Although he did note that her husband had abused her “for some reason,” his only identifiable personal comment in this file, he described her supposed sexual instinct “in the form of nymphomania” without the use of adjectives, proceeding to emphasize her “intensely positive” reaction to the Wassermann test.

Concluding the clinical exam with a succinct diagnosis, Elizarrarás used both “her mental state and laboratory results” to justify his final verdict: Ángela P. suffered from general progressive paralysis. Transferred to the newly created ward for female neurosyphilis patients, Ángela P. received the appropriate treatments. Just four months later, psychiatric hospital doctors processed her discharge. Sending copy after copy to unknown recipients, however, they discovered that, like most female patients diagnosed with moral insanity, she had no relative, friend, or husband waiting for her outside the asylum walls.

Similar cases came under the scrutiny of psychiatric hospital doctors that year. On July 9, 1930, resident Elizarrarás examined Olga I., a twenty-three-year-old woman from the northern state of Sinaloa who came to the institution from the police station. Like Ángela P., Olga I. had run away from home at a young age due to her father’s “twisted intentions.” She ended up living with a married man, who soon abandoned her. She worked as a prostitute and waitress in various cities throughout the country, eventually arriving in Mexico City in 1928, where she became a habitual drinker and cocaine user. Her life was, in her own words, “bitter,” and she felt it was like “a ditch in between two high walls.”

Three years later, after drinking a “poisoned preparation,” she experienced visual and auditory hallucinations, which continued after she was confined. Her negative attitude, evident in her selective reluctance to answer questions she considered offensive or unnecessary, could easily have identified her as a woman with moral insanity twenty years earlier. Resident Elizarrarás promptly avoided these descriptions and decided to emphasize the fact that she had previously been diagnosed with and treated for syphilis, and according to the “intensely positive” Wassermann test reaction, she still suffered from this condition. Olga I. was transferred to the ward for female neurosyphilis patients, but in her case, the stage of general progressive paralysis was very advanced, and the doctor’s prognosis was not optimistic. When Olga I. died seven years later, however, doctors linked her death to complications of tuberculosis rather than syphilis itself. In
addition to her name and place of birth, her death certificate included the word “unknown” where the names of her family or friends should have appeared.

Sandra C., a twenty-seven-year-old single woman born in Mexico City, suffered a similar fate. A former patient of the Morelos Hospital, an institution dedicated exclusively to treating women with syphilis who remained in the institution as “sequestered” patients while receiving treatment, Sandra C. arrived on the grounds of the General Insane Asylum on January 5, 1932. When medical resident Raúl González Enríquez performed the initial exam, he confirmed the concerns expressed by the doctors at Hospital Morelos. In his opinion, Sandra C. not only suffered from syphilis; her “intensely positive” reaction to the Wassermann test in conjunction with her aggressive behavior led him to believe that hers was a case of general progressive paralysis in an advanced stage.

After noting that her physical weakness prevented her from getting out of bed, and that she also suffered from kidney disease, González Enríquez did not record an optimistic prognosis. Despite receiving medication, mostly morphine injections, doses of saline solution, and a milk-based diet, she never recovered, and passed away only three months later. As was usually the case with unclaimed cadavers, her body was cremated by authorities at the Zacango cemetery, where her ashes remained for a period of seven years.

The narratives of suffering that encapsulated the lives of Ángela P., Olga I., and Sandra C. reiterated themes that psychiatric hospital doctors heard repeatedly in the early 1910s. The main details barely changed: the abused girl who ran away from family conflict, typically from the provinces to the capital; the teenager whose sexual independence and lack of education generally made her into a prostitute; the abandoned woman, destitute and sick, who was forced to remain in state institutions. Unlike doctors educated in Porfirian schools, who viewed the poor, especially women, as difficult to redeem, revolutionary psychiatrists steeped in welfare ideology promising comprehensive reform did not mark them as immoral, diagnosing them instead as ill.

Accordingly, they received treatments that typically consisted of doses of Salvarsan, the miracle cure that had been used in Mexico since 1910. The increasing medicalization, or to be more exact, “psychiatrization” of sex, in terms of both analysis and its deployment, translated into prescriptions for the appropriate medications, which occasionally alleviated some patients’ physical suffering. However, laboratory information also helped to undermine more personal, socially questionable information that patients shared with doctors in interview after interview. As the number of pompous adjectives and exaggerated adverbs
in medical files diminished, so did the emphasis on the inner world that shaped the contours of mental illness.

Lacking scientific instruments and armed only with their life experiences, women with syphilis nevertheless continued to voice the physical and spiritual suffering that formed the narrative phrases of their illnesses. Perhaps in relation to this perseverance, a minority of psychiatrists paid increasing attention to psychoanalysis, the talking cure, which most asylum doctors considered ridiculous and completely useless in large institutions dedicated to treating the poor.

Verifiable information and orderly medical histories not only allowed doctors to support scientific claims, but also helped to detect the “undeserving poor” attempting to deceive the good will of the state. Indeed, according to reformed welfare system guidelines, psychiatric hospital doctors were capable of distinguishing those who deserved state help—in this case, patients whose condition could be objectively corroborated—from those deceitful individuals who were unwilling to raise themselves up on the ascending path of the revolutionary nation.

The case of Felipa M., a former revolutionary soldadera affected by partial blindness, serves as an example to this respect. On July 18, 1930, Felipa M. came under the scrutiny of medical resident Mario Fuentes. Although Felipa M.’s mother emphasized the erratic aspects of her daughter’s life—she had run away from home and had lived a “free and agitated life,” marked by epileptic seizures and murderous outbursts directed toward her own mother—Dr. Fuentes did not note anything abnormal in Felipa M.’s behavior. Actually, the patient was somewhat confused, complaining, for example, that her husband abused her, when in fact, she was not married. Like many other asylum inmates, she also complained of a life of perpetual suffering; however, nothing about her perception, intelligence, or affect manifested a disorder justifying her confinement. Moreover, her reaction to the Wassermann test only registered “slightly positive,” which gave medical resident Mario Fuentes sufficient cause to declare in his final diagnosis that she was mentally healthy.

He was convinced, however, that Felipa M.’s “visual defect” represented financial and emotional challenges that her family that was not willing or able to endure. Nevertheless, in an aside, he also mentioned Felipa M.’s possible complicity, emphasizing her suspicious attitude. After all, she had faked attacks that a less attentive observer would have linked to a real illness with biological causes. Information from laboratory tests strengthened his argument. In this case, medical resident Fuentes argued that the prognosis should be social rather
than medical. He was not optimistic. He believed that it was likely that Felipa M. would end up a beggar or would soon enough make a new attempt to get admitted to the asylum. He processed her release in August of the same year.

A December 2, 1930, memo declining her admission soon confirmed Dr. Fuentes’s prognosis. Using modern technology to reject the “undeserving poor,” medical resident Mario Fuentes played a key role in the revolutionary state welfare system.

A Citable Past

While psychiatric interpretations of mental illness underwent dramatic changes between 1910 and 1930, the narratives that women fashioned around and with their suffering remained remarkably unchanged. Informed by modern medical technologies and a welfare discourse emphasizing the state’s responsibilities for community health, asylum doctors’ narratives clearly echoed changing social mores. Their interpretations of mental illness—as a physical affliction disturbing normal mental processes that was curable with early detection—almost perfectly reproduced a notion of a society that was (or thought it was) progressing toward ever higher levels of perfection.

Women, on the other hand, persevered in their attempt to tell the stories of their lives with illness through a logic emphasizing suffering and deterioration. In a milieu captivated by the constant discourse of progress, where emerging elites strove to create the futurist myth of historical evolution, the women’s stories struck a dissonant note. And in that note, in their insistence on retrospective reflection, in their refusal to forget the mortifying context in which their suffering began, and in thus becoming contexts of their mortified lives, the voices of these women faintly echoed the allegory and the ruin that are so fundamental to Walter Benjamin’s philosophy of history.

To defy the myth of progress, one of his fundamental endeavors, Benjamin suggested applying analytical emphasis to the ruin, which history sees encapsulated in the mortified, destroyed, ancient fragment expressing the fragile, transitory quality of modernity. Escaping the myth of progress also required, in his opinion, using an alternative thought process built on the allegoric mode: “allegories are, in the realm of thoughts, what ruins are in the realm of things.” This mode of thought figures in the ways that women shaped the narratives of their stories while confined.

Whether negotiating with the doctor on duty or yielding to his power, women clearly refused to allow their experiences to be ignored. They brought suffering,
and awareness of that suffering, to the medical domain of a profession that was increasingly interconnected with visionary state agencies. Women injected failure and agony into the narrative of an era intent on selling the endless benefits of the revolution.

To be sure, these women did not present themselves as rebellious heralds of times yet to come—they were no protofeminist heroes—but rather, as reminders of the human cost of that progress. They voiced destruction; they embodied destruction. If, as Benjamin said, “there is no document of civilization that is not at the same time a document of barbarism,” the words of these women presented the other side of the revolution. However, perhaps paradoxically, they did so through quotations and phrases in medical histories, documents meant to record acts of civilization.

Moreover, if, as Benjamin stated, “only for a redeemed [hu]mankind has its past become citable in all its moments,” then these women redeemed themselves, registering quotations of their past in documents that otherwise attempted to erase them. It is in this sense, and only in this sense, that the women confined in the General Insane Asylum participated in the creation of that “common meaningful and material framework for living through, talking about, and acting upon social orders characterized by domination.” Thus, even within the asylum walls, these women became fundamental actors in the construction of the fragile hegemony in which modern Mexico took shape.