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Hysteria as a Shape-Shifting Forensic Psychiatric Diagnosis in the Netherlands ca. 1885–1960

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ABSTRACT

Based on criminal court cases found in archives and newspapers, this article traces how the diagnosis of hysteria functioned in trials and Dutch forensic psychiatric practice ca. 1885–1960. Informed by Science and Technology Studies and praxiography, hysteria is studied as a 'fire object'. It can make multiple relations with gender, which can be absent or present. This approach asks *whether* and *how* gender is important regarding hysteria. Gender only 'stuck' to hysteria in certain situations. In rape cases, hysteria took the form of lying and was connected to women. Although a woman's hysteria could be used as a reason to exonerate the male perpetrator's crime of murder, a man's hysteria never served to exculpate a female perpetrator of a crime. Signs on the body appeared to be very significant but did not suffice for a clear diagnosis. Inconsistencies during the psychiatric examination of the body therefore needed to be coordinated by pointing to other bodily symptoms, personal life stories, academic literature or logical reasoning. To analyse the ways hysteria functioned as a versatile fire object in the courtroom and pre-trial investigation alerts us to hysteria's shapeshifting potential that might explain the power of the hysteria label in twentieth-century medicine and culture.

Introduction

Hysteria has received ample attention in medical and gender history. Historians of medicine and psychiatry have extensively outlined how the concept of hysteria changed throughout the centuries, contemporary doctors debating the origins of the disease (body or mind) and its connections with gender.[1] One of the main questions of historical research has been whether hysteria was a 'real' disease or a cultural construction. Feminist historians have moreover been interested in the potential function of hysteria as a way of female protest against strict gender roles, a passive form of resistance against patriarchy's limitation of women's possibilities.[2] Gender historians have shown how cultural discourses on hysteria related to gender and how hysteria could be used as an 'extraordinarily plastic label', not necessarily only referring to a disease.[3] Scholars have, moreover, pointed out that hysteria as a medical diagnosis seemed to disappear in the twentieth century, specifically after the First World War.[4] Dutch historians, however, have found evidence that the diagnosis was still used, for example in asylums, throughout the twentieth century.[5] The notion of hysteria seems

to have remained tenacious in other social and cultural domains as well. This article shows how hysteria continued to function as a serious diagnosis and concept in criminal trials and forensic psychiatry in the Netherlands in the late-nineteenth century and first half of the twentieth century. The analysis is based on a total of forty-one (nearly all criminal) court cases from lower courts and courts of appeal, dating from the period 1885 to 1957, in which hysteria was mentioned in relation to the suspect, victim or witness.[6] These cases were found in Dutch court archives, newspapers and legal journals. Although medical historians have focused on the classification of disease, I explore the ways hysteria was enacted in the courtroom and the pre-trial expert examination, and the effects these enactments had on the prosecution and sentencing of perpetrators, and on the treatment of witnesses and victims. I thereby shift the focus from the hospital and the doctor's private practice to the criminal investigation and the courtroom. So far, historians have hardly paid any attention to the role of hysteria in the practice of forensic psychiatry. The two existing studies, from Karen Nolte and Ruth Harris, focus on Germany and France around 1900.[7] The forensic appropriation of hysteria is relevant since it can inform us about its shifting shapes and the ways it gets attached to gender.

In order to study the courtroom dynamics of hysteria, I use insights from praxiography and Science and Technology Studies (STS), which have demonstrated how entities such as gender and race are shaped in practices, encounters and specific situations and contexts, thus underlining how these entities are not only discursively but also materially formed and enacted. This 'ontology of relationality' rejects the idea of an entity as singular and instead emphasises its multiple enactments.[8] For my analysis of the functions of hysteria in the practice of forensic psychiatry, I use three elements inspired by these studies. First, the idea that hysteria gains meaning *in relation to* other entities such as gender, body and mind. Second, that hysteria is made in messy, ongoing processes. Several STS scholars have underlined that objects change as they move across practices.[9] Here, I study how hysteria moves between a medical and a legal context and on its way shifts shape. Third, I will apply the notion of the 'fire object', coined by STS scholars John Law and Vicky Singleton in their study on alcoholic liver disease, which often slipped into cirrhosis, liver disease, alcohol abuse or alcoholism. Law and Singleton proposed to understand complex objects 'as sets of present dynamics generated in, and generative of, realities that are necessarily absent', taking 'the form of jumps and discontinuities'.[10] When the body of a patient with alcoholic liver disease, for example, is an object of the medical gaze in the hospital, mental issues accompanying the disease are othered and absent; the same is true when mental issues are studied, with bodily issues othered.[11] Moreover, for Law and Singleton, 'fires are energetic and transformative'.[12] The notion of the fire object thus helps to highlight how enactments can be discontinuous and the importance of the dynamics of absence and presence.[13] Specifically, the absent presence of gender, or the ways it 'sticks' to hysteria, will be discussed in this article.[14]

Applying these three insights from STS and praxiography (relationality; objects changing as they move across practices; the fire object and its dynamics of absence and presence) implies studying the forms of hysteria as it moves through several phases of a criminal investigation and trial. Thus, I aim to go beyond historical studies of medical discourses on hysteria, which mostly focus on aetiology, manifestation and treatment,

thereby presenting a static and closed definition of hysteria. This approach can also inform us about the question whether and how gender is important regarding hysteria, instead of merely replicating contemporary doctors' views on the difference between male and female hysterical patients. As I will demonstrate, whether gender becomes a significant aspect of the hysteria diagnosis depends on the contextual relationships between hysteria and other concepts, such as perpetrator or victim. Moreover, only certain elements of the clinical psychiatric definition of hysteria were particularly relevant to the criminal trial, such as lying, making false accusations, suggestibility and amnesia. I aim to show the difficulties in diagnosing hysteria in the forensic medical examination: signs on the body appeared to be very significant but did not suffice for a clear diagnosis. Inconsistencies during the examination of the body therefore needed to be coordinated by pointing to other bodily symptoms, personal life stories, academic literature or logical reasoning. Thus, we can see how the unruly and versatile object of hysteria was disciplined in the courtroom and pre-trial investigation.

Hysteria and Dutch forensic psychiatry

Until the late-1960s, hysteria remained an important diagnosis, taken seriously by Dutch psychiatrists, psychologists and criminologists.[15] It was often used in asylums and mostly considered a woman's disease, although a significant minority of patients were men. In forensic psychiatric texts, hysteria functioned to explain why and how people commit crimes. The label also served to assess the reliability of witnesses and to pronounce a suspect unaccountable. Between 1910 and 1914, the topic of hysteria in connection with forensic psychiatry was explicitly taken up by Dutch psychiatrists in forensic textbooks and lectures. As I will show, the connections made in clinical medicine and psychiatry between hysteria, suggestibility and lying offered space for forensic psychiatrists to put forward their theories on the relationship between crime and (un)accountability. Moreover, these forensic psychiatric texts testify to the different methods scientists explored to establish the presence of hysteria. These methods corresponded to the two main approaches to hysteria, exemplified by French neurologist Jean-Martin Charcot (1825–93) and psychoanalyst Sigmund Freud (1856–1939).

Charcot's 'clinicoanatomic' method, grounded in visual observation and experimentation, implied that medical practice in the late-nineteenth century located hysteria first and foremost in the body, albeit with differences in regard to its exact physical localisation.[16] The most conspicuous hallmarks of hysteria were the aberrations of sensibility: the hysterical stigmata, like anaesthesias (lack of sensitivity) and hyperaesthesias (exaggerations of sensibility), and abnormalities of the five senses (mostly visual disturbances). For Charcot, hysteria was a real and somatic disorder of the nervous system that allowed for both female and male expressions of the disease. Generally, Charcot underlined similarities rather than differences between male and female hysterical patients.[17] Charcot's model of hysteria was accepted by the mainstream medical world in Europe in the 1870s and 1880s. In the first half of the twentieth century, the medical and clinical explanations provided by Charcot were mainly replaced by psychological theories. From the publication of *Studies on Hysteria* in 1895, psychoanalysts Freud and Josef Breuer (1842–1925) laid the groundwork for a shift from a physical to a psychological model, forwarding hysteria's mental genesis, which then caused physical symptoms. In contrast to Charcot's clinicoanatomic approach, Freud

proposed a 'clinical-investigative' method based on listening to patients' subjective accounts and taking these into consideration while constructing his understanding of the disease.[18]

Academic work on the most important Dutch twentieth-century psychiatric theories on hysteria showed the influence of psychoanalysis, neurology and phenomenology.[19] These texts included two elements of hysteria that would prove to be vital to forensic psychiatry: lying and suggestibility. The textbook on neurology by professor Leendert Bouman et al. from 1930, for instance, noted that many scholars still emphasised the hysterical character: women who are two-faced, lying, simulating and fickle.[20] The hysterical personality was a much-debated term, sometimes seen as distinct from hysteria, referring to the patient's suggestibility and lying according to some, and to degeneration according to most. Hysterical lies were thought to be uttered in a condition that hovered between consciousness and dreaming.[21] Moreover, the authors regarded hysteria's fundamental symptom to be suggestibility.[22]

The symptoms of suggestibility and lying as presented in clinical medicine and psychiatry were integrated into forensic psychiatry's theorising on hysteria's relationship to crime and (un)accountability. Professor Cornelis Winker (1855–1941), who defined the discipline of psychiatry as a natural science and disapproved of psychoanalysis, gave a presentation in 1910 on the forensic meaning of hysteria. Applying his insights to suspects, Winkler defined a hysteric as someone who could unexpectedly get into a changed condition of consciousness.[23] In a non-hysteric state, the hallmarks of the hysterical person were pathological lying and the utterance of false accusations.[24] Winkler also discussed the issue of suggestibility, stating that most hysterics are directly suggestible, although some resisted suggestion and were 'only auto-suggestible'.[25] Winkler thus related hysteria to lying, making false accusations and suggestibility.

When hysteria was connected to specific crimes in these early works on forensic psychiatry, it was mostly to rape. In the first textbook of forensic psychiatry, written by psychiatrist Dr Henri van der Hoeven for legal scholars in 1913, and reprinted several times, a chapter was devoted to hysteria, which was part of the category of degeneration. As Freud had also claimed, van der Hoeven stated that hysterics make false accusations of sexual assault.[26] Similarly, Dr H. F. Roll, in his textbook of forensic medicine dating from 1912, argued that it is a fact that most rape cases involve hysterical women who wrongly indict men. He added that doctors have to do 'objective research' themselves and examine whether these women are hysterical, which is best done during menstruation. Via observation, the doctor could research 'malfunctioning in sensibility'.[27]

In addition to rape, forensic psychiatry connected hysterical women to murder by poison. In 1935, the authoritative professor Gerbrandus Jelgersma (1859–1942), the most important Dutch psychiatrist working on hysteria, who, during his career, shifted from a neurological to a psychoanalytical perspective and came to regard hysteria as a women's disease caused by their more emotional and impulsive character, wrote about a prevailing stereotype: the predisposition of degenerated, hysterical women to kill by use of arsenic or other types of poison. Jelgersma regarded these murders as the female form of the lust murder and grouped their perpetrators under the heading of 'perverse psychopaths'.[28]

These ideas in regard to hysterical women and poisoning were still influential in forensic psychiatry in the 1950s and 1960s. In his 1956 textbook on criminal psychology and forensic psychiatry, professor Dr D. Wiersma devoted a chapter to hysteria and the pathology of the nervous temperament. According to Wiersma, psychiatrists regarded malingering as one of the main symptoms of hysteria. When discussing 'hysterical criminality', Wiersma not only referred to female serial killers using poison and arsonists but also to a male hysterical car thief, who was found to be hysterical on the basis of examinations and observations which had shown him to be passive and highly emotional, and from the way he told his life story, since it was clear that he had difficulty imagining previous periods. The diagnosis of hysteria was confirmed by the research with the tachistoscope, a device with a shutter that displays an image for a specific amount of time, and by the physical examination, together demonstrating a serious concentric narrowing of vision as well as several 'hyperaesthetic' zones. The car thief's hysteria had caused a narrowing of consciousness and a pathologically increased suggestibility, leading to the car theft. Therefore, he should be considered unaccountable.[29] Wiersma's discussion underlines the persistence of hysteria in forensic psychiatry and the continuing importance of the body as an indicator of hysteria.

Thus, in both forensic psychiatric texts and clinical literature, hysteria was enacted as lying and suggestibility but also some new features (solely relevant to the trial and investigation) were added in forensic psychiatric literature: making false accusations and unaccountability. Hysteria thus shifted shape in the new medico-legal environment. Moreover, the dynamics of presence and absence are relevant to approaching hysteria as a fire object. Gender only became pointedly present when hysterical women were connected to rape and murder by poison. Last, these texts also inform us on the methods forensic psychiatrists proposed to ascertain the hallmarks of hysteria, referring to 'objective' research that could indicate impaired sensibility. These methods dovetailed with Charcot's clinicoanatomic approach. As we will see, however, in practice, Dutch forensic doctors and psychiatrists often had to resort to the interpretation of subjective narratives on hysteria provided by suspects or witnesses.

Hysteria enters the courtroom: forensic examinations in practice

In the following, I will analyse the ways in which hysteria was used as a diagnosis or label in the courtroom and pre-trial investigation, focusing on medical and legal *practices*. I will address the ways hysteria entered the court cases, and how it was linked to other concepts throughout a trial, in connection with the techniques and practices with which hysteria was examined.

In contrast to the Anglo-American accusatorial jury system, in which prosecution and defence can each hire their own experts, the inquisitorial legal system used in the Netherlands implied that the investigating judge steered the judicial proceedings, including the request for expert witnesses. Therefore, hysteria was nearly always mentioned as part of a (pre-trial) psychiatric examination ordered by the court. Sometimes psychiatrists or doctors answered questions about their reports during the trial in the courtroom. In a few cases, lawyers suggested the presence of hysteria, as in a case from 1907, in which a nineteen-year-old servant girl was accused of poisoning her employers. Her lawyer called for a psychiatric examination, basing his request on medical literature that found a correlation between hysteria and poisoning. The request

was not allowed by the court.[30] The psychiatric examination consisted of either a general investigation of the mental faculties of the suspect or witness, or specific research into the suspect's or witness's accountability. Sometimes psychiatrists were asked to answer the question of whether a specific claim of the suspect or witness (e.g., suffering from amnesia, having a psychosis) could be explained by hysteria. In some cases, hysteria was a central, independent notion; in most other cases, it was connected to psychopathy, epilepsy, *insania moralis* or psychosis. Generally, looking for signs of hysteria was a standard part of the psychiatric examination, for both men and women, even if it was not the main instigation for the tests.

From the total of forty-one criminal cases, dating from the period between 1885 and 1957, in which hysteria was mentioned in relation to the suspect, victim or witness, in twenty-four cases, the diagnosis of hysteria was applied to women and in seventeen cases to men. Nearly all of the men were perpetrators in cases of murder (or attempted homicide, one case concerned physical abuse); six of the twenty-four women were perpetrators of murder (one of them murder by poison), six were victims of rape, three victims of (attempted) murder and a few cases related to female perpetrators of arson and theft. Hysteria thus stuck powerfully to gender when the label was applied to female victims (mostly of rape); since the label of hysteria could be employed for both female and male suspected perpetrators of a crime, the combination of gender and hysteria was less telling or combustible when it related to perpetrators.

Diagnosing hysteria: a case of sexual assault, 1911

The following case study shows how hysteria could enter the courtroom, how it was examined and diagnosed in practice, how it related to gender and the notion of accountability, and what the effects of this diagnosis were. Overall, rape cases demonstrate that the body was an important site of analysis to testify to the presence of hysteria in women, but doctors could be selective in choosing which bodily phenomena were vital to certify its manifestation. Ultimately, the body never provided sufficient signs to diagnose hysteria. In this case of sexual assault dating from 1911, one hallmark of hysteria – lying – became so forceful when it was placed in relation to the question of whether the female witness or victim was reliable, that it outshone any contradicting (bodily) elements.

After the sexual assault claim of a nineteen-year-old girl, who worked in a factory, a lower court sentenced the perpetrator, a shoemaker, to nine months' imprisonment, and both public prosecutor and the defendant appealed the verdict. The higher court (the Gerechtshof Arnhem) ordered the alleged victim's psychiatric examination by three psychiatrists: E. D. Wiersma, professor at Groningen University; Dr M. J. van Erp Taalman Kip, medical director of the asylum in Arnhem; and Dr J. L. C. G. L. le Rütte, medical director of the asylum in Deventer. Their psychiatric examination was informed by the question of whether or not the girl's physical condition during the assault and during her interrogation made her statements reliable. The psychiatric examination began with an interview with the girl's mother, her schoolteachers and a friend. The girl's medical history, character traits and intellectual abilities were discussed. The girl had initially refused to talk about the sexual assault, but later ashamed told her friend and her mother about the event, who confirmed that she had become quiet,

jittery and tearful. This change in character, a clear indication of trauma, was mentioned in many nineteenth-century cases of sexual assault of children and young girls.[31]

The physical examination was clearly informed by Charcot's theory on 'hysterogenic zones', pressure points that could lead to a hysterical aura and then a hysterical fit. These pressure points could be found anywhere on the male or female body, including in the groin or genitalia. In this case, the three psychiatrists tested the power in the muscles of arms, legs and hands, and did not encounter any pressure points on the girl's back or breasts. On the left side of her abdomen, they perceived one of the hysterical stigmata: 'ovarie' (putting pressure on the ovaries was thought to trigger or stop 'grande hysterie').[32] No clavus – a shooting pain in the head – was detected. Her pupils were similar and responded well to light and accommodation; her left eye showed no limitation of vision for white but did for red and blue, and her right eye did not show limitations for any of these colours. Both eyes showed a cornea reflex, there was a weak pharynx reflex (gag reflex), lively reflexes of the tendons and no clonus (alternate extension and flexion of the foot). The 'globus hystericus' (sensation of lump in the throat) and 'meteorismus' (accumulation of intestinal gas) were absent. No aberrations in her sense of touch were found. Typical cuff-shaped analgesic zones were encountered on the lower legs and arms and above the wrist and ankle. The report mentioned that these analgesic zones were 'characteristic stigmata for hysteria'. Furthermore, the girl was able to differentiate between different weights and could hear the ticking of a watch at half a meter distance, proving that her other senses showed no aberrations. It was added that her 'vasomotor and secretory' disorders were not conspicuous.

The expert report concluded that no 'hereditary moments of nervous disease' were encountered, nor any intellectual defects. Dysfunctions were only found in an irregular menstruation and difficulty in falling asleep. Regarding the main question on the girl's reliability, the psychiatrists concluded:

> The objective examination has not found any sickly deformation, which can lead to doubt H.K.'s subjective reliability. However, there are reasons to doubt her objective reliability. The presence of certain aberrations (the insensitive spots on arms and legs, the ovarie, the very weak pharynx reflex) are characteristic of hysteria. Therefore it is possible that this girl has some of the mental characteristics so often found with hysterical persons, such as a tendency to exaggerate, a strong fantasy, and confusing what has happened with her thoughts. A hysterical person thus often becomes so unreliable in her statements, not in the sense of purposely stating falsehoods, but in the sense of exaggeration, so that there is a kernel of truth in her statements, but it is difficult to indicate the size of this kernel. Such an unreliability that leads to incorrect or exaggerated statements but that are made in good faith; an objective unreliability therefore […] is often encountered in hysterical persons, so one should carefully consider their statements.[33]

The conclusion continued to prove the probability of this 'objective reliability' because H. K.'s statement could not be considered completely true. The girl, after all, had stated that she had not resisted the perpetrator's actions, even though she had shown aversion. The psychiatrists found this lack of resistance improbable, since even a minor resistance, they alleged, would have been enough to withstand her attacker. Here, the doctors repeated the well-known rape myth that stated that adult women had the power to physically resist an attack.[34] They furthermore suggested the girl either had lied on purpose, which they did not find probable considering her good character,

or believed herself that this was the way the events had taken place, even if they had not. The latter might be explained, the experts stated, by female hysterics' ('hystericae') tendency to exaggerate and fantasise, especially when it came to very emotional events in which they played the main role. Even though nothing from H. K.'s previous history pointed to this unreliability, the possibility of exaggeration could not be ruled out. In short, the psychiatrists felt it was very probable that H. K.'s statements were not entirely accurate, even if she herself was convinced she was telling the truth, because she was suffering from hysteria. Although indicators of mental illness were not found during the examination, their existence could not be excluded. The question of whether the hysterical stigmata only arose after the assault, when the girl grew quiet and melancholic, could not be answered with certainty. The psychiatrists added that 'even if the weak person only started suffering from hysteria from the mental shock during the assault, then still this points to mental weakness and inferiority'.[35]

Thus, the expert examination started with the question of reliability, looking at the girl's personal history, her character and her body. Hysteria was not originally part of the research question, but it was immediately put centre stage by the doctors. As a fire object, hysteria thus had the power to eclipse the original question. It was especially the girl's body that supposedly revealed indicators of hysteria, even though it did not show all possible signs. The latter absences, however, easily disappeared as soon as the word hysteria was mentioned. The conclusion that the girl suffered from hysteria was sufficient ground for supposing her statements to be unreliable, as this fickleness was the presumed hallmark of hysterical patients. Here, no physical evidence was necessary. The possibility of the girl becoming hysterical because of the shock of the assault was dismissed, and even if this were the case, the doctors argued, she was already regarded as receptive to hysteria because of mental weakness. This latter conclusion is strange, since the psychiatrists explicitly stated that they had found no evidence of mental illness (except for the hysteria itself).

Analysing hysteria as a fire object implies looking at how it is enacted, how it shifts shape and how it becomes attached to gender. In this case, hysteria is enacted as a number of physical signs, but in the end, their (lack of) meaning is determined by the hallmark of unreliability. During the girl's bodily examination, the doctors continually referred to 'the hysterical person' in general. But when the hallmark of lying was discussed, female hysterics' tendency to exaggerate and fantasise, especially regarding emotional events, came to the fore. Gender is initially the absent presence here but is triggered by it being linked to lying. When femininity was connected to lying in the diagnosis of hysteria, the connection between the two eclipsed any bodily signs that might contradict the verdict of unreliability. Even if the evidence for hysteria seemed inconclusive, in the conclusion of the psychiatric report, the label 'hysteria' became a stable attribute which was then converted back to 'unreliability'. In this case of the female victim being examined for signs of hysteria, the aspect of 'lying' was the most important element of hysteria that was highlighted. It is clear from this, and many other cases of sexual assault, that the stereotype of the lying hysterical woman was prevalent and could potentially work to the disadvantage of female witnesses or victims.[36] However, judges did not always concur with psychiatrists. In this case, the higher court confirmed the original sentence of nine months' imprisonment.

Objectivity and subjectivity

Although hysteria had always been hard to diagnose in clinical medicine, due to difficulty in reading bodily symptoms and connecting them to underlying lesions, the aforementioned rape case showed that this task was even more difficult for forensic psychiatrists. This was mostly due to the lapse of time: it was impossible to reconstruct the exact mental state of the witness or suspect during the crime. In addition to the problem of retrospection, we have seen that bodily signs of hysteria could be absent or ambiguous. Sometimes, moreover, doctors could not observe the perpetrators or witnesses personally, but had to rely on written files from other doctors. How, then, did they come to the diagnosis of hysteria?

Charcot's ideal was to demonstrate hysteria's presence objectively by making it visible through experimentation and observation. As Paolo Savoia argues, Charcot's epistemic values can be seen to belong to what Lorraine Daston and Peter Galison have called the regime of 'mechanical objectivity', in which the doctor's eye, but also photography, were the means to attain objective knowledge. The patients' subjective and ambiguous narratives should therefore be eliminated.[37] Yet, in the forensic context, as well as in Freud's treatment of his patients, the subjective story was vital to reconstructing the mental state of the witness or perpetrator during the crime. However, as we have seen in the 1911 rape case, 'the tendency of 'hysterics' to lie ran the risk of disqualifying their subjective stories. How, then, to steer between the lack of objective bodily symptoms and the unreliable subjective narratives? The solutions found by doctors were to resort to academic literature and to logical reasoning in order to attain a final diagnosis or conclusion.

The case of S. D., a thirty-two-year-old servant, who was tried in 1896 for theft and as a 'degenerated specimen' sent to an asylum, shows both the importance of subjectivity and of academic literature to solving the problems that accompanied the physical examination. Since the scientific experts who examined this woman for the court found her to be suffering from 'pseudologica phantastica', they stated a 'subjective examination' (that is, interrogating the woman) was not possible. The doctors needed to interview the defendant's family and friends to conclude that her 'hysterical character' had already surfaced in adolescence, when she demonstrated instable emotions, perversities, insensitivity to the suffering of others and immoral behaviour, including lying and stealing. During S. D.'s physical examination, the experts concluded that several aberrations belonging to hysteria could not be found. Yet, this woman's past experiences, as related by others, testified to the presence of hysteria in their opinion.[38] The doctors, additionally, compared these data to the academic literature, stating that hysteria was hard to define, yet eventually sided with the diagnosis of the hysterical character. Hysteria could therefore be proved by bodily symptoms, the life story of the patient and by academic literature. Often, these three sources of evidence pointed to each other.[39]

This cross-referencing can also be seen in the case of A. B., a twenty-nine-year-old woman accused of having poisoned her husband, possibly under the influence of her lover, in 1919. She was sentenced to eight years' imprisonment for homicide. R. A. Mees, physician at the Provincial Hospital 'Duin en Bosch', who examined her mind, concluded that 'objectively' no pressure points, increased or decreased pain or insensitivity could be demonstrated. Neither had he found any limitation of vision; A. B.'s

pupils responded normally. She could not be hypnotised at the first attempt and hence was not found to be immediately susceptible to the influence of others. This 'absence of objective symptoms', which Mees stated were always changing and insecure in the medical opinion, did not preclude the expert from being certain the accused was a hysteric. Her anamnesis and the statements of her doctors, added to the headache located on the head, the tinglings and the sense of weakness in arm and leg, mostly on the right, her sometimes swollen belly, her easy crying and her nervous shaking with every interview, made the diagnosis of hysteria 'completely just', according to Mees. Besides referring to the body and to her personal history, Mees quoted Professor Jelgersma's textbook to back up his argument that the prime hallmark of hysteria was the (female) hysteric's lack of rationalisation: she was irrational and impulsive. The physician argued this textbook definition dovetailed perfectly with the crime committed in this particular case: the woman was arguing with her husband and had held a grudge against him for a long time. Acting 'impulsively', A. B. had grabbed the bottle of poison and had not considered the consequences. Mees added that since hysteria should be regarded as a broad spectrum, every case should be considered on its own; in this case, the term 'diminished capacity' could be applied to the hysterical patient.[40] Here the 'absence of objective symptoms' did not preclude the 'certainty' of hysteria, since bodily symptoms could be connected to personal history and to academic literature.

In addition to personal history and academic literature, a resort to logical reasoning could be used to make sense of ambiguous mental and physical symptoms and address the lapse of time since the crime. This can be observed in the case of H. v. d. B., a man accused of murdering his baby in 1919. During the first investigations in 1919, H. v. d. B initially confessed to his crime and was sentenced to five years' imprisonment for murder, but he later withdrew his confession, and in the meantime, was declared insane and unfit for trial. Eventually the court acquitted him. During both trials, H. v. d. B.'s mental health was examined by psychiatrists, especially in relation to questions of whether his confession had been based on unmotivated self-accusations and whether he was feigning a prison psychosis. Hysterical stigmata were only brought up as a symptom of insanity, which was equated with psychosis. The suspect underwent physical examination and psychiatric observation, during which he had hysterical fits.

Here, not only insanity at the time of the crime was investigated but also the suspect's state of mind afterwards when he uttered self-accusations. Besides the body, the testimony of relatives and the letters written by H. v. d. B. formed another source of information to establish the presence of hysteria. Dr Hendrik Stenvers wrote an extensive psychiatric report on the suspect in 1922, which was based on data from the file sent by the investigating judge, information gained from the wife and family of the accused, reports provided by mental institutions where the suspect had previously been treated, and data gained by his examination and observation in the Psychiatric-Neurologic Clinic in Utrecht. Stenvers stated that he 'relied on the information provided by the accused, in which we cannot find any argument that the accused was already in a psychosis at the time of the crime'. Although the doctor was convinced of the suspect's prison psychosis, he also regarded this mental state as 'mostly a demonstration, just like hysterical persons, where the actor often goes so far that it gets out of control'.

Specifically, Stenvers was asked to research the possibility that the confession was based on unmotivated self-accusations. He explicitly elaborated on his method which he described as 'trying to clarify under which circumstances and how the suspect has uttered his self-accusations at different times, which motives probably played a role during these self-accusations and then to conclude if these self-accusations can indeed be considered to be pathological'.[41] In this way, Stenvers scrutinised several moments in which H. v. d. B. accused himself of murdering his child, wondering if his susceptibility to other people or his 'calculated' behaviour could explain the self-accusations. Applying this more hermeneutic method, which he himself called 'psychological', and which was in fact a manner of logical reasoning by placing himself in the suspect's position, Stenvers dismissed the idea of pathological self-accusations, since these accusations remained the same in all moments, whereas if pathological, they would have varied according to mood. Thus, the observation of 'objective' bodily symptoms did not suffice in this case, a 'subjective' personal history was needed as well, and eventually using logical reasoning led to the final conclusion on the suspect's mental state.

To summarise, in none of these cases, a bodily examination was sufficient to diagnose hysteria, due in part to the lapse of time since the crime had been committed. A resort to 'subjective' personal narratives, academic literature or logical reasoning supplemented the techniques of medical examination. In these three cases, hysteria was enacted as lying, irrational behaviour and, connected to insanity and psychosis, as pathological self-accusations. Lying and irrational behaviour were of course associated with femininity, and thus gender formed the absent presence here, since it was not mentioned explicitly. The different enactments of hysteria, as well as the insufficiency of the medical examination of the body leading to other methods of reasoning, testify to the shifting shapes of hysteria, which was hard to pin down.

Hysteria and the position of perpetrator and witness

In addition to being enacted multiply, hysteria also gained meaning in relation to the position of either perpetrator or witness/victim. In contrast to rape cases, in which femininity and unreliability were related to hysteria and together ignited a powerful diagnosis to the detriment of the female victim of sexual assault, hysteria was less powerful as an excuse when it came to male and female *perpetrators*. Here, hysteria could be part of the examination into insanity and unaccountability, but could not eclipse other elements. Rather it was a compound object: it was often attached to insanity, psychosis or psychopathy. It was not always or primarily connected to lying, but to amnesia, simulation or pathological self-accusations.

The notion of hysteria could amplify the opinion of the prosecution or the defence. Strikingly, the connection between hysteria and women as victims was sometimes stretched to remarkable lengths. Women were characterised as hysterics even when this characterisation did not seem relevant to the case at all. In a number of murder/manslaughter cases, in which the husband was accused of killing or attempting to kill his wife, the wife was said to be a hysteric (either by a psychiatrist, a lawyer or the prosecution). Here, hysteria was connected to depression and it was suggested that perhaps these women had committed suicide. In a case from 1931, an elderly man was exonerated for the attempted murder of his wife with a razor because of a lack of

evidence. It is unclear if the psychiatrist's opinion that his wife, a hysteric, could also have attempted suicide played a role in the outcome of the trial.[42] In 1932, a forty-two-year-old woodworker was accused of having strangled and then murdered his wife by turning on the gas of the stove. His lawyer claimed his wife had committed suicide and that she was suffering from paranoia. The female physician who had treated the deceased told the court that her patient was nervous, and that she (the doctor) had asked her if her husband was going to kill her. The doctor added that she was convinced this woman was 'a hysteric, who related everything to herself'.[43] The Rotterdam lower court sentenced the husband to ten years' imprisonment for manslaughter and physical abuse, but during the trial at the higher court in the Hague, the defendant's lawyer argued again that his wife had been a hysteric and had blamed her husband for what she had done herself. The public prosecutor however retorted that there was no medical evidence for her being a hysteric.[44] In appeal, the suspect was sentenced to fifteen years' imprisonment.[45]

In all of these cases, the woman's presumed hysteria only gained meaning in relation to the man's position as perpetrator. This association seems to have continued until at least the late 1950s.[46] In addition to the woman's alleged hysteria functioning as a possible reason for suicide to have taken place, instead of murder, in a few cases, it was used to indicate a bad marital life and thus a potential excuse for manslaughter.[47] Although a woman's hysteria could be presented as a reason to exonerate the male perpetrator's crime of murder or manslaughter, a man's hysteria never served to exculpate a female perpetrator. Hysteria and gender thus seem to have worked asymmetrically, when taking into account how hysteria is related to the position of perpetrator and victim.

Diagnoses of hysteria and the final verdict

In the final verdict, part of the case file in which the whole case was wrapped up, hysteria was assessed and compared to other evidence; sometimes it disappeared, sometimes it was rejected and sometimes it was converted into another term (for instance, unaccountability). The final verdict thus served as a means of coordination.[48] Clearly, in the courtroom, there was a hierarchy: the judge could overrule scientific expertise.

While several studies of forensic medicine and psychiatry in Europe in the later nineteenth and first half of the twentieth century have attested to the increasing role of doctors and psychiatrists as expert witnesses, the exact influence of this scientific expertise on sentencing and treatment seems to have varied.[49] In regard to the specific diagnosis of hysteria, Nolte has argued that in Germany around 1900, the psychiatric diagnosis of hysteria and especially the hysterical character highlighted lying and worked to the detriment of female victims and witnesses in cases of sexual assault.[50] For English cases of sexual assault from 1850 to 1914, Victoria Bates found that defence teams shrewdly used the perceived link between hysteria and false allegations to cast doubt on the female victim's credibility, even though she also noted that it is difficult to gauge the impact of evidence regarding emotions and hysteria on the outcome of trials. In any case, Bates argues that the late-nineteenth-century shift in medical theory on hysteria from a focus on the 'hysterical fit' towards the hysterical personality type reinforced the tendency to distrust over-emotional or nervous women.[51] In the French courtroom during the *fin de siècle*, as Harris argues, the hysteria diagnosis

mostly worked to the advantage of female perpetrators of murder, but the few male hysterics were less likely to benefit from medical or judicial leniency, with doctors and the judiciary often mutually enforcing each other's statements.[52]

Generally, in the Dutch courtroom in the late-nineteenth and first decades of the twentieth century, judges mostly agreed with scientific experts.[53] In the cases in which hysteria played a role, judges often accepted the psychiatric expertise, but that does not necessarily mean this expertise had a large impact on the verdict. In fifteen out of the forty-one cases analysed, it is unclear whether the hysteria diagnosis influenced the sentencing. The strongest correlations can be seen, first, when female victims were labelled hysterics. These were rape and murder cases, and the label of hysteria was always accompanied with the symptom of lying, which obviously worked to the woman's disadvantage. Still, the male suspects in rape cases were not acquitted because their victims were classified as lying hysterics. This lack of impact of expertise can sometimes be explained by the disagreement among doctors but also by the fact that the cases that made it to court were always ones in which there was other evidence (e.g., witnesses) and this evidence mostly overruled any expertise.[54] It is very probable, however, that in the many rape cases that were dismissed by the police or the investigating judge in the pre-trial phase, the image of the lying hysterical woman played a role.

The second pattern which clarifies the correlation between hysteria and the outcome of the trial regards male and female perpetrators, mostly in cases of murder. From the sample of forty-one cases, eight male and six female perpetrators who were diagnosed with hysteria (sometimes in combination with other psychiatric labels) received either a lower sentence, were sent to an asylum instead of being sentenced to prison or were acquitted.[55] Here, the label of hysteria led to mitigation of the sentence. A third pattern regarding the correlation between hysteria and the outcome of the trial is seen in five cases (three male and two female perpetrators), in which hysteria was established but the suspects were nevertheless regarded as fully accountable by the judge. In a few of the cases, the judiciary explicitly disagreed with the medical or psychiatric experts.[56] This lack of consensus dovetailed with a debate, held in newspapers and legal journals in the first decades of the twentieth century, on the question of whether hysteria could lead to unaccountability.[57] In any case, in these two latter patterns, the effect of the perpetrator's presumed hysteria did not differ according to gender.

To summarise, the fact that lawyers used the concept of hysteria strategically, either to exonerate their clients or to put blame on other witnesses, shows that it had the potential to lead to the verdicts of acquittal or unaccountability. The label of hysteria in court could work to the disadvantage of female victims in rape and murder cases (even though not all judges accepted the medical expert's diagnosis), and mostly to the advantage of male and female perpetrators of murder and other crimes. This can be explained by the multiple enactments of hysteria: in the case of female victims, the element of lying was emphasised, whereas in the case of perpetrators (both male and female), the hysterical symptoms of subconsciousness, amnesia, suggestibility and false accusations were explanatory and potentially extenuating factors for the crime. Interestingly, the power of hysteria as a fire object is ignited mostly in combination with the relationship between gender and the position of perpetrator or victim.

Conclusion

This article has approached hysteria as a 'fire object', following its shifting shape as it moves through several phases of a criminal investigation and trial, taking note of its different enactments, of how it becomes entangled with other medical and legal concepts, how gender sticks to it and the real effects hysteria could have in trials. To analyse hysteria as a fire object in the legal context demonstrates the presence of different enactments of hysteria in different relations. Certain elements of the psychiatric definition of hysteria were particularly relevant to the criminal trial, including lying, making false accusations, suggestibility and amnesia. Whether these elements were associated with a perpetrator, victim or witness made a difference and gender became most visible when hysteria was connected to the female victim. In rape cases, the hysterical element of women's lying came to the surface; in cases of murder, the female victim's depression and potential suicide were highlighted as hallmarks of hysteria. At the same time, hysteria was used for both male and female perpetrators to advocate a lower sentence or unaccountability. The meaning of hysteria was thus not fixed according to gender: whether gender became significant depends on the contextual relationships between hysteria and other notions. Although a woman's hysteria could be used as a reason to exculpate the male perpetrator's crime of murder or manslaughter, a man's hysteria never served to exonerate a female perpetrator of a crime. Hysteria and gender therefore seem to work both relationally and asymmetrically.

Hysteria's versatility in the legal context is striking. Yet its content is not empty. Hysteria could not mean just anything, but was a very flexible notion. If hysteria can be regarded as a fire object, then the body functions as a smoke screen. The body at first sight seemed to be very significant in the psychiatric examination, but turned out to be only one enactment of hysteria and often insufficient for a clear diagnosis. A solution to the puzzle posed by inconsistencies in bodily symptoms could be found in alluding to other corporeal indicators, autobiographical narratives, academic literature or logical reasoning. A first step towards closure was the psychiatric report, in which hysteria was confirmed, rejected or absorbed into another psychiatric concept or into the legal term of (un)accountability. Final closure was provided through the judge's verdict, in which hysteria could be accepted, rejected or connected to other concepts. In the medical report and the judicial verdict, the messy practice of diagnosing hysteria was (temporarily) solved.

Regarding hysteria as a fire object implies focusing on the different enactments of hysteria and its entanglement with other notions, which highlights the problems of forensic diagnosis and the necessary forms of coordination to solve these problems, which often remain hidden in (studies of) academic psychiatric textbooks. In the courtroom, the unruly object of hysteria had to be pinned down multiple times in order for it to function within cultural and legal parameters. Finally, studying the ways hysteria functioned as fire object in spaces outside of the clinic or private medical practice may alert us to hysteria's potential to shift shape and the multiple relations it can make with gender, which can be absent or present. This approach asks *whether* and *how* gender is important regarding hysteria, instead of merely replicating contemporary doctors' views on the difference between male and female hysterical patients. Hysteria was a dynamic and versatile object that easily adapted to the judicial context, demonstrating how hysteria survived into the mid-twentieth century.

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Notes

1. Ilza Veith, *Hysteria. The History of a Disease* (Chicago: University of Chicago Press, 1965); Andrew Scull, *Hysteria. The Disturbing History* (2009; repr. Oxford: Oxford University Press, 2011); Mark S. Micale, *Approaching Hysteria. Disease and its Interpretations* (Princeton: Princeton University Press, 1995); Sander L. Gilman, Helen King, Roy Porter, G. S. Rousseau and Elaine Showalter, *Hysteria Beyond Freud* (Berkeley: University of California Press, 1993); Sabine Arnaud, *On Hysteria: The Invention of a Medical Category* (Chicago: University of Chicago Press, 2015); Jan Goldstein, *Hysteria Complicated by Ecstasy. The Case of Nanette Leroux* (Princeton and Oxford: Princeton University Press, 2010).
2. Carroll Smith-Rosenberg, 'The Hysterical Woman: Sex Roles and the Role Conflict in Nineteenth Century America', *Social Research* 39 (1972), pp. 652–78.
3. Lisa Downing, 'Murder in the Feminine: Marie Lafarge and the Sexualization of the Nineteenth-Century Woman', *Journal of the History of Sexuality* 18 (2009), pp. 121–37, here p. 127. See also, Elaine Showalter, *Hystories: Hysterical Epidemics and Modern Culture* (New York: Columbia University Press, 1997); Jan Goldstein, 'The Uses of Male Hysteria: Medical and Literary Discourse in Late Nineteenth-Century France', *Representations* 34 (1991), pp. 134–65; Paul Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma, 1890–1930* (Ithaca: Cornell University Press, 2003).
4. Mark Micale, 'On the "Disappearance" of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis', *Isis* 84 (1993), pp. 496–526.
5. Giel Hutschemaekers, *Neurosen in Nederland: Vijfentachtig jaar psychisch en maatschappelijk onbehagen* (Nijmegen: Socialistische Uitgeverij, 1990), pp. 198–9; Harry Oosterhuis and Marijke Gijswijt-Hofstra, *Verward van geest en ander ongerief: psychiatrie en geestelijke gezondheidzorg in Nederland, 1870–2005*. Part I (Houten: Bohn Stafleu van Logchum, 2008), p. 167.
6. The sample cannot be considered representative, since the source material is necessarily scattered, but it does offer an impression of the different types of criminal cases and variable ways in which the notion of hysteria could be (strategically) used. The cases were evenly spread over the period, except for the 1950s, when only one case was found. This might, however, be due to the different sources. For the period before the 1930s, Dutch newspapers hardly wrote about crime extensively: the legal journal *Weekblad van het Regt* only ran from 1839 to 1943, and court files in archives are not all kept or inaccessible after the period 1944. It is therefore difficult to present a solid, quantitative, chronological distribution of these cases.The late-nineteenth and first decades of the twentieth century are generally regarded as the 'heyday' of hysteria. My research has taken circa 1960 as an endpoint since the last references to hysteria were found in forensic psychiatric textbooks from the late 1950s and since Hutschemakers concludes, in his sociological study of the relationship between neuroses, culture and modernity in the Netherlands (in 1900–1985), based on interviews with psychiatrists and data from patient files, that the frequency of the diagnosis of hysteria decreased especially after 1960. See, Hutschemaekers, *Neurosen in Nederland*, pp. 198–9.
7. Karen Nolte, *Gelebte Hysterie. Erfahrung, Eigensinn und psychiatrische Diskurse im Anstaltsalltag um 1900* (Frankfurt/New York: Campus Verlag, 2003), mostly focuses on the hysteria diagnosis in asylums as part of forensic examinations. Ruth Harris, *Murders and Madness. Medicine, Law, and Society in the Fin de Siècle* (Oxford: Clarendon Press, 1989), primarily discusses hysteria in relation to hypnosis in France in 1880–1914.
8. John Law, 'Enacting Naturecultures: A Note from STS', the Centre for Science Studies, Lancaster University (2004), https://www.lancaster.ac.uk/fass/resources/sociology-online-papers/papers/law-enacting-naturecultures.pdf. Annemarie Mol, *The Body Multiple: Ontology in Medical Practice* (Durham: Duke University Press, 2003); Geertje Mak, *Doubting Sex. Inscriptions, Bodies and Selves in Nineteenth Century Hermaphrodite Case Histories* (Manchester: Manchester University Press, 2012); J. R. Latham,

'(Re)making Sex: A Praxiography of the Gender Clinic', *Feminist Theory* 18 (2017), pp. 177–204; Amade M'charek, 'Beyond Fact or Fiction: On the Materiality of Race in Practice', *Current Anthropology* 28 (2013), pp. 420–42. For a general overview of Law and Social Science Literature that draws on STS, see, Simon A. Cole and Alyse Bertenthal, 'Science, Technology, Society, and Law', *The Annual Review of Law and Social Science* 13 (2017), pp. 351–71.

9. John Law and Vicky Singleton, 'Object Lessons', *Organization* 12 (2005), pp. 331–55.
10. Law and Singleton, 'Object Lessons', pp. 343–4.
11. Law and Singleton, 'Object Lessons', p. 345.
12. Law and Singleton, 'Object Lessons', p. 344.
13. See also, Lisette Jong and Amade M'charek, 'The High-Profile Case as "Fire Object": Following the Marianne Vaatstra Murder Case Through the Media', *Crime, Media, Culture* 14 (2018), pp. 347–63.
14. Sara Ahmed notes how the 'work of emotion involves the "sticking" of signs to bodies'. Sara Ahmed, *The Cultural Politics of Emotion* (New York: Routledge, 2004), p. 13.
15. D. Wiersma, *Moord en sensatie in de negentiende eeuw* (Leiden: A.W. Sijthoff, 1969), pp. 146–52.
16. Daphne de Marneffe, 'Looking and Listening: The Construction of Clinical Knowledge in Charcot and Freud', *Signs* 17 (1991), pp. 71–111, here p. 77.
17. Mark Micale, 'Charcot and the Idea of Hysteria in the Male: Gender, Mental Science, and Medical Diagnosis in Late Nineteenth-Century France', *Medical History* 34 (1990), pp. 363–411, here pp. 406–8; see also, Mark Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge: Harvard University Press, 2008).
18. De Marneffe, 'Looking and Listening', pp. 91–104.
19. L. Bouman, 'Hysteria', *Psychiatrische en Neurologische Bladen* 39 (1935), pp. 445–86; Dr E. L. K. Zeldenrust, *Over het wezen der hysterie* (Utrecht: Bijleveld, 1954).
20. L. Bouman, B. Brouwer, M. A. de Kock, E. de Vries, F. H. Quix, *Specieele leer der zenuwziekten*. Deel II, 2e gedeelte (Haarlem: De Erven F. Bohn, 1930) pp. 527, 532.
21. Nolte, *Gelebte Hysterie*, pp. 272–73.
22. Bouman et al, *Specieele leer*, p. 533.
23. Prof. Dr. C. Winkler, '*Over de forensische betekenis van hysterie*', lecture for het Psychiatrisch-Juridisch gezelschap 5 February 1910 (Amsterdam: F. van Rossen, 1910), pp. 10–32, here p. 11.
24. Winkler, '*Over de forensische betekenis van hysterie*', p. 13. See also, Dr J. Kat, '*De pathologische leugen in foro*', lecture for het Psychiatrisch-Juridisch Gezelschap 14 February 1914 (Amsterdam: F. van Rossen, 1914), pp. 21–9.
25. Winkler, '*Over de forensische betekenis van hysterie*', p. 26.
26. Dr Henri van der Hoeven, *Psychiatrie. Een handleiding voor juristen* (Rotterdam: Brusse, 1913), pp. 17, 267.
27. Dr H. F. Roll, *Leerboek der gerechtelijke geneeskunde*, Part III (The Hague: Algemeene Landsdrukkerij, 1912), pp. 286–92.
28. Dr H. C. Jelgersma, 'Vrouwen die met vergif werkten. Slechts 30 pct. op naam der mannen', *De Telegraaf*, 22 June 1935. Wenneke Meerstadt, 'Het ligt geheel in het vrouwelijk karakter. Gerbrandus Jelgersma over hysterie', *Gender en gekte. Jaarboek voor Vrouwengeschiedenis* 30 (2010), pp. 159–72, here p. 160. Jelgersma's works on hysteria include *Het hysterisch stigma* (Amsterdam: Scheltema & Holkema, 1903) and *Een geval van hysterie psycho-analytisch behandeld* (Leiden: S.C. van Doesburgh, 1915).
29. Prof. Dr D. Wiersma, *Persoonlijkheid en rechtspraak. Leerboek der criminele psychologie en forensische psychiatrie*, deel I (Haarlem: H.D. Tjeenk Willink & zoon N.V., 1956), pp. 75–98.
30. *Weekblad van het Regt* no. 8470 (14 January 1907), p. 4.
31. Willemijn Ruberg, 'Trauma, Body and Mind: Forensic Medicine in Nineteenth-Century Dutch Rape Cases', *Journal of the History of Sexuality* 22 (2013), pp. 85–104, here pp. 102–03.
32. Elisabeth Bronfen, *The Knotted Subject. Hysteria and Its Discontents* (Princeton: Princeton University Press, 1988), p. 179.
33. *Weekblad van het Regt* 9329 (10 July 1912), pp. 2–3, here p. 3.
34. Joanna Bourke, *Rape: A History from 1860 to the Present* (London: Virago, 2007), pp. 21–49.
35. *Weekblad van het Regt* 9329 (10 July 1912), p. 3.
36. Willemijn Ruberg, 'Onzekere kennis. De rol van forensische geneeskunde en psychiatrie in Nederlandse verkrachtingszaken (1811–1920)', *Tijdschrift voor Sociale en Economische Geschiedenis* 9 (2012), pp. 87–110.
37. Paolo Savoia, 'Seeing and Hearing: Charcot, Freud and the Objectivity of Hysteria', in lavia Padovani, Alan Richardson and Jonathan Y. Tsou (eds), *Objectivity in Science: New Perspectives*

from Science and Technology Studies (Cham: Springer, 2015), pp. 123–44, here pp. 131–3. Also see, Lorraine Daston and Peter Galison, *Objectivity* (New York: Zone Books, 2010).

38. Dr P. Wellenbergh, 'Pathologische Fantaisieen. Een forensisch geval', *Tijdschrift voor Strafrecht* 11 (1898), pp. 220–37, here p. 231.
39. Similarly to sex, as demonstrated by Geertje Mak, hysteria has no final physical signifiers; its signifiers refer to each other, not to a final truth. Geertje Mak, 'Doubting Sex from Within: A Praxiographic Approach to a Late Nineteenth-Century Case of Hermaphroditism', *Gender & History* 18 (2006), pp. 360–88, here p. 341.
40. Noord-Hollands Archief (NHA), Archief Gerechtshof Amsterdam (GA), inv. no. 374, case no. 747, case of A. B., 1919.
41. NHA, GA, inv. no 86, case no. 2018, case H. v. d. B., 1919–1922.
42. 'Een verrassende vrijspraak', *De Telegraaf*, 30 September 1931.
43. 'Moord te Rotterdam. Houtbewerker staat terecht', *Bredasche Courant*, 20 April 1933.
44. *Haagsche Courant*, 24 August 1933.
45. *Telegraaf*, 6 September 1933.
46. *Het Parool*, 22 November 1957.
47. In addition to the wife's presumed hysteria functioning as a possible reason for suicide to have taken place, instead of murder, in one 1940 case, the wife's hysteria was used to indicate a bad marital life, and thus an excuse for manslaughter (in this case not of the wife): *Rotterdamsch Nieuwsblad*, 14 August 1940. See also, a case of robbery of an old woman from 1933, which, instead of focusing on the male perpetrator, revolved around the question whether this woman was a lying hysteric: 'Aanslag op een oude vrouw', *Haagsche Courant*, 11 January 1933.
48. Mol, *The Body Multiple*, p. 49, pp. 60–64.
49. Harry Oosterhuis, 'Introduction: Madness and Crime. Historical Perspectives on Forensic Psychiatry', *International Journal of Law and Psychiatry* 37 (2014), pp. 1–16.
50. Nolte, *Gelebte Hysterie*, pp. 279–80.
51. Victoria Bates, *Sexual Forensics in Victorian and Edwardian England: Age, Crime and Consent in the Courts* (Basingstoke: Palgrave Macmillan, 2016) pp. 133, 146–47.
52. Harris, *Murders and Madness*, p. 325.
53. Willemijn Ruberg, 'Expertise in gerechtsdossiers. De praktijk van de forensische psychiatrie in Nederland, 1811–1930', *De Moderne Tijd 3* (2019), pp. 28–50; Harry Oosterhuis, 'Treatment as Punishment: Forensic Psychiatry in The Netherlands (1870–2005)', *International Journal of Law and Psychiatry* 37 (2014), pp. 37–49.
54. Ruberg, 'Onzekere kennis', pp. 87–110.
55. In the Netherlands, from 1886, suspects could be found either accountable or unaccountable (partial unaccountability was not an option) and those found unaccountable were committed to an asylum. From 1928, 'TBR' (Ter Beschikkingstelling van de Regering, or detention on behalf of the government) was implemented, as part of the so-called 'Psychopath Laws', meaning the judge could compose a verdict that both included a prison sentence and treatment in a psychiatric institution. Partial unaccountability then became an option.
56. Mick de Vries, 'De Zaak-Führmann', *Het Nieuws van den Dag in Nederlandsch-Indië*, 16 April 1931.
57. *Weekblad van het Regt* no. 8769 (11 December 1908), p. 4; de Vries, 'De Zaak-Führmann'.

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