

THE MADWOMAN IN THE CELLAR: TRAUMA AND GENDER AFTER BOTH  
WORLD WARS — A FIELD STUDY OF PSYCHIATRIC FILES

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## The Madwoman in the Cellar: Trauma and Gender After Both World Wars — A Field Study of Psychiatric Files

### Abstract

By utilizing practical examples from the Abteilung für Psychiatrie [psychiatric ward] at the Landeskrankenanstalt [province hospital] in Carinthia, Austria, in the wake of the two World Wars, this article seeks to explore the stories of hospitalized women and girls after armistices and peace treaties. Whereas the dialectics of conflict and resulting post-conflict traumas became increasingly accepted by medics for combatants during that time frame, this was not necessarily the case for comparable traumatic experiences of female civilians. Instead, for these patients, the Freudian definition of hysteria prevailed as a stereotypical ‘feminine’ symptom. Accordingly, post-war transitions from 1918 and 1945 onwards, with critical, sometimes even unstable, material and political infrastructures, consolidated a decidedly gender-related notion of trauma. This monopoly of trauma diagnoses, reserved for male patients, hence even resulted in misogyny towards institutionalized women, especially when they were refugees or displaced persons. As this study attempts to show, the mapping of mental illness or normality was heavily determined by sex, class, or ethnic background and in most instances served as an administrative tool for socio-political ends. The research for this contribution is based on archival work conducted for an ERC Advanced Grant, entitled “EIRENE — Post-War Transitions in Gendered Perspective: The Case of the North-Eastern Adriatic Region.”

True<sup>1</sup> it is that they have had toil enough to be disheartened.<sup>2</sup>

Drums in his ear, at which he starts and wakes,  
And being thus frightened swears a prayer or two  
And sleeps again.<sup>3</sup>

The phenomenon of post-trauma ailments — be they physical or psychological — is certainly nothing new under the sun, and Post-Traumatic Stress Disorder (hereafter PTSD), so far, is the most recent label for this condition.<sup>4</sup> Throughout the history of (wo)mankind, symptoms appearing after cataclysmic events for a specific person or a group of people have been witnessed and recorded for centuries, even entering eminent literary accounts, as the classic quotes above demonstrate. The onset of modern times brought about an increasing individualization of subjects as independent citizens during the age of enlightenment and revolutions mainly in many places of Europe and North America, beginning from the late eighteenth century. In tandem with evermore technologized and industrialized living conditions as well as warfare in empires and nation states, the relatively new disciplines of psychology and psychiatry also started to draw attention to emotional traumas after crises and catastrophes. The gamut of

terms was multifarious, ranging from *syndrome du vent du boulet* [cannonball wind syndrome] and soldier's heart to railway spine and *Kriegszitterer* or war shakers, shell shock, and war neurosis.

## **1\_Introduction: War, Masculinities, and Trauma**

The earliest beginnings of vaguely detecting symptoms and formulating a theory connected to mental trauma were elaborations on the so-called railway spine. This nervous condition was linked to the physiological shock of passengers on derailed locomotives in the nineteenth century. John Eric Erichsen (1818–1896), a London surgeon who treated train accident injuries, can be credited with this achievement.<sup>5</sup> Erichsen's neurological discoveries and definitions were subsequently taken up by his contemporaries, such as Sigmund Freud (1856–1939), associating them with states of either trauma or hysteria. In *Jenseits des Lustprinzips* [*Beyond the Pleasure Principle*], originally published in 1920, Freud touched rather superficially and sporadically on psychoses among Austrian and German veterans of the First World War.<sup>6</sup> Already during this war, Emil Kraepelin (1856–1926), one of the pioneers of psychiatry next to Eugen Bleuler (1857–1939), coined the term *Kriegszitterer* for soldiers who showed neurological anomalies that seemed to be related to post-combat distress, besides physical ones:

[T]he question of war neuroses was raised [...] the fact that all kinds of more or less severe psychiatric symptoms could lead to a lengthy stay in a hospital, or even to a discharge from the military with a generous disability pension, had disastrous consequences. This was compounded by the population's feeling of pity for the seemingly severely ill "war-shakers," who drew attention to themselves on street corners and used to be generously rewarded. In such circumstances, the number of those who believed that a "nervous shock," or, especially, having been buried alive, entitled them to discharge and continuous support, increased dramatically.<sup>7</sup>

In his autobiography, Kraepelin detailed this seemingly new war neurosis already in 1917, the same year he established the Deutsche Forschungsanstalt für Psychiatrie [German Research Institute for Psychiatry], which certainly was no coincidence. On the one hand, the staggeringly pragmatic and economic calibration in dispassionate language of what to do with these expensive war veterans, who might even be simulating, as is implicitly suggested, is unambiguously evident in this passage. On the other lurks the visibility and urgency of the problem, with fragile ex-combatants on the street — in broad daylight, so to speak — dangerously arousing sympathies from the public and therefore threatening to undermine the war effort, to create a crisis on the home front, and to counteract the displayed *Burgfrieden* or *union sacrée*. Moreover, 'stitching'

these shaken soldiers back together also mentally, so that they could continue to serve on the front, was utmost priority for Kraepelin, his colleagues, and military strategists. Post-war therapy then was primarily geared towards clinically treating these returning warriors and molding them into ‘functioning’ citizens of everyday life again.

This passage in Kraepelin’s *Memoirs* further anticipates future traumas, caused by evermore mechanized weaponry with the unfolding of another World War. His excerpt illuminates the potentially dangerous clinical side effects of being buried alive in rubble after air raids, a situation that developed into a reoccurring topos in succeeding scholarly analyses. Particularly during and after the Second World War, civilians in their homes or in bomb shelters were affected and traumatized accordingly, as this case study will uncover.<sup>8</sup> Historiographic goal is to capture female voices that became traditionally eroded in society and scholarship alike, with the First World War and the frequently hidden symptomatology of the “*Daheimgebliebenen*” [those who stayed at home (and did not go to war)] during the interwar years as a starting point.<sup>9</sup> Habitually eliminated from the equation of war and trauma by the medical community, the narratives of female civilians with mental problems were mostly devoid of the diagnostic terminology that was otherwise readily applied to soldiers’ anamneses. This exclusivity and bias towards male patients and their war traumata cohered with patriarchal blueprints or political intentions of demobilization and the restoration of conventional gender roles after both World Wars.

The First World War was the overture of technical and chemical armaments, never before experienced by humankind, impairing thus not simply limbs and physiognomy but also the psyche, itself just newly defined by Freud and his many and predominantly male cohorts. This modern-age warfare with destruction *ex machina*, accordingly, evoked neologisms in field hospitals, most famously perhaps ‘shell shock.’<sup>10</sup> Shell shock, a phenomenon predominantly surfacing in the roaring trench war on the Western Front, then was increasingly debated in Great Britain during and after the Great War. Alternative terms in English ranged from battle hypnosis to nervous shock or war shakers, which is a direct translation of *Kriegszitterer*.<sup>11</sup> Concerns and debates about ex-soldiers, unable to adapt to post-warfare life, even penetrated and perturbed the British parliament, as this citation substantiates:

The subject of shell-shock cannot be referred to with any pleasure. All would desire to forget it — to forget [. . .] the roll of insanity, suicide, and death; to bury

our recollections of the horrible disorder, and to keep on the surface nothing but the cherished memory of those who were the victims of this malignity. But, my Lords, we cannot do this, because a great number of cases of those who suffer from shell-shock and its allied disorders are still upon our hands and they deserve our sympathy and care.<sup>12</sup>

The First World War opened the short twentieth century as a total war with a newly emerging and as such newly defined home front, including non-combatants as both recruits and casualties behind the official military lines. This blurring of frontlines also resulted in a steadily increasing number of wounded and killed civilians, particularly on the Western, Eastern, and South-Eastern Front. Nonetheless and despite ideological, methodological, and national rivalries, what all these various contemplations explained above have in common is that they gravitate around soldiers, without reference towards war or post-war dynamics for women, either as caretakers on the home front or auxiliaries on the actual battle lines.

This article aims to remedy the historiographic marginalization of women's war traumas by elucidating implemented discourses about female patients on a Carinthian psychiatric ward in Austria after the First and Second World War.<sup>13</sup> The chosen geographic location is therefore part of the North-Eastern Adriatic region, the focus of the EIRENE project and a much-overlooked space in Europe with frequent changes of political systems, intense border redefinitions, and grave levels of interethnic violence throughout the first half of the twentieth century. The temporal scope of the EIRENE project and thus this study covers post-war transitions and transnational interrelations in this area by analyzing documents of psychiatric institutions for women as indicators of gender discrimination and socio-political agency. At the same time, this contribution also tries to incorporate and pay attention to the actual stories of these patients in question as an elemental, yet by and large institutionally and socially suppressed means to grasp and tackle traumatic pasts. It will become clear that female portrayals of mental illnesses were, at best, deprioritized or sidelined next to male patients' tales and chronicles, or, alternatively, stagnated in a state of non-narration, regularly and readily silenced through sedation or shock therapy.

## **2\_Beyond the Cuckoo's Nest: Gender and Trauma**

The first part of the title of this article paraphrases and slightly modifies Sandra M. Gilbert's and Susan Gubar's seminal volume *The Madwoman in the Attic*. Dissecting

Victorian literature, the two authors argue that “the personal was the political, the sexual was the textual,”<sup>14</sup> which, equally, bears relevance for the examination of psychiatric files. Analogously, throughout this field study, misogynistic and discriminatory jargon is scanned, because female patients during post-war times in the first half of the twentieth century overall were denied the terminology and diagnostics of traumatic effects, even then already sometimes available for or at least recognized in the medical community regarding soldiers. The ominous madwoman in the attic is, of course, featured prominently in Charlotte Brontë’s novel *Jane Eyre* (originally published in 1847). For this contribution, the trope of the supposed madwoman was placed in the basement — more precisely bombed shelters towards the end of the Second World War, which caused many female human beings, together with children and elderly men, to suffer from severe traumatic stress.

Additionally, this research also heavily borrows from Elaine Showalter’s prolific oeuvre about mental disorders and gender, first and foremost, *The Female Malady: Women, Madness and English Culture, 1830–1980*, highlighting the impact of socio-cultural expectations towards women as feminized creatures in the medical — and mainly masculinized — profession.<sup>15</sup> Accordingly, therapeutic approaches and strategies in the western world were for a long time adjusted to these clichés about femininity, reinforcing perceptions of and approaches towards female patients by hospital staff as either hysterics or sexual deviants. Ostensibly, no theoretic assessment or critical evaluation of feminine-defined illness, particularly mental illness, would be complete without mentioning Judith Butler and her ground-breaking work on the social, cultural, linguistic, and political conceptions of the female body and mind. Butler’s writings about dimensions of gender as acts of performativity indicate interfaces with the rhetoric and conceptualization of disease.<sup>16</sup> Thus, femininity is understood as a construct, determined by norms, which again filter into classifications of what is and is not ‘normal.’ One might just think of hysteria as the ‘classic’ case, stigmatized as a typically feminine sickness in patriarchal psychoanalysis, as, most notably, Hélène Cixous aptly put it in contradistinction to Jacques Lacan: “Disons que la Femme Absolue, dans la culture, celle qui vraiment représente de façon la plus efficace... la plus proche de la féminité en **proie** à la masculinité, c’est vraiment en effet l’hystérique... il lui fait son image !”<sup>17</sup>

Hence questions and parameters of sanity are intersected with gender expectations, especially in post-conflict eras, and Foucauldian power structures are flagrant in the investigated psychiatric files.<sup>18</sup> Consequently, discourses about female patients and their potential in/sanity are embedded in hierarchies, both deriving from the intrinsic institutional structures of psychiatric wards and the external layers of policies in the wake of the two World Wars. Psychiatric protocols therefore also integrate and are characterized by alienation or ‘othering’ processes that establish artificial orders or ranks, as defined by Michel Foucault.<sup>19</sup> A spectrum of taxonomies provides the basis for differentiations and polarities like ‘regular/healthy’ and ‘irregular/unhealthy’ in the clinical environments examined. In this respect, particularly Elizabeth A. Waites’s assessment and interpretation of the masculinized infrastructures of clinics as a foil for society in *Trauma and Survival: Posttraumatic and Dissociative Disorders in Women*, which appeared in 1993, is essential.<sup>20</sup> By contrasting a theoretic evaluation of psychiatric practices with a therapeutic approach that is more oriented towards female needs, Waites demonstrates the gendered patterns of these institutions. Hysteria, first and foremost, used to be the common categorization for ‘dysfunctional’ women, while, for example, personality or dissociative disorders were mainly overlooked or only gradually acknowledged.

Thus, the Freudian matrix of hysteria dominated clinical assessments of females and their mental malaises for a very long time. With his *Studien über Hysterie* [*Studies on Hysteria*] (1895), which were almost exclusively directed towards women patients, Sigmund Freud, together with Josef Breuer (1842–1925), did not simply set the tone and medical crux for his profession but also heavily influenced the extrication of post-aggression trauma concerning female clients.<sup>21</sup> As previously mentioned, Freud was rather nonchalant in his adoption of the psychiatric concept of war-affiliated trauma with his peripheral treatise in *Beyond the Pleasure Principle*. Strikingly, his remote study objects for this new symptom were war veterans, *not* female civilians, since these were conventionally and conveniently defined as hysterics, with no prerequisite for new expositions or procedures. Once firmly established as a side-effect of wars in the succeeding decades after Freud’s opus, trauma diagnoses predominantly remained the domain and prerogative of male combatants, on average not extended to the experiences of the other sex during conflict and post-conflict surroundings. This is even more unfortunate in that these civilian experiences are heavily determined by gender and

gender-specific cruelties in military or paramilitary settings, such as sexual assaults, for example.

Evidently, earlier manifestations of non-soldier trauma beyond killing fields and in the aftermaths of wars are manifold, yet heavily understudied. Psychiatric files of women and girls admitted to mental asylums during and after armed conflicts can represent a crucial and helpful source, particularly for areas with high levels of military and paramilitary violations. For the following analysis of trauma and gender after both World Wars, sample documents of a rather rural psychiatric clinic in the south of Austria have been selected according to the aforementioned parameters of the EIRENE project. The Abteilung für Psychiatrie [psychiatric ward] at the Landeskrankenanstalt [province hospital] in Klagenfurt was closely situated near the epicenter of fighting militias after the First World War as well as heavy bombings during the Second World War and experienced steady influxes of traumatized refugees and deportees after both wars. The succeeding field study of female patients demonstrates many nuances and metatexts of psycho-physical wounds, albeit undetected and untreated by their medics, who relegated and reduced incoming cases to standard and patterned diagnoses and therapies, mainly formulated in the nineteenth century and quite separate from theories about stress and trauma. Certain representative cases of disrupted or hindered (un)narratives in juxtaposition to the intersectionality of biological sex and social or migratory backgrounds are also cited to exhibit and unpack the nexus of gender, trauma, communicative modes or devices, and ellipsis.<sup>22</sup>

### **3\_Talking Cures or Clipped Tongues?: Women Patients and the *Abteilung für Psychiatrie* at the *Landeskrankenanstalt* in Klagenfurt from 1918 to 1950**

This psychiatric hospital in Klagenfurt, the capital of Austria's southernmost province Carinthia, was opened during the Habsburg rule in 1877, after plans to erect such a building for insane persons since 1840. Earlier, mental patients were kept in a former prison, the so-called Zucht- und Spinnhaus, in intolerably unhygienic and inhuman conditions. However, the new clinic was also crowded and overrun right from the start, with little staff or funding and intermittent outbreaks of typhus and tuberculosis. The largest number of patients living at once in this institution was in 1940 with 864.<sup>23</sup> In fact, there are documented cases of sterilizations, deportations to the infamous Hartheim Castle in Linz, and murders of inmates in that clinic during the Third Reich.<sup>24</sup>



For enhanced contextualization, I briefly present some basic explanations about the quantitative and qualitative parameters in the files: For this research, 2,000 records of female patients were inspected for the periods from 1918 to 1925 and 1945 to 1950, respectively. The youngest patient encountered was a six-year old refugee, G. W. (\*1942 Dyakovo), who lived in the displaced persons (DP) camp Weidmannsdorf near Klagenfurt before being admitted in December 1948 with epilepsy.<sup>25</sup> The second youngest at the time of her hospitalization was a schoolgirl of fourteen years, H. H. (\*1931 Heidelberg) and also a refugee, diagnosed with schizophrenia in January 1946 and treated with electric shocks.<sup>26</sup> The forms and questionnaires for first-time patients covered several coefficients next to date and place of birth or anamneses and diagnoses, such as occupation and religious denomination or marital status, and these, it needs to be stressed, remained the same throughout the studied periods. Hence it is quite striking that, generally, the social, economic, cultural, or religious norms by which these women and girls were assessed stayed the same for more than half a century amidst drastic changes in society and politics all over Europe. Demographically speaking, women from all strata of society can be found in the files, ranging from maids and factory workers to teachers and aristocratic ladies. Apparently, impoverished women, who obviously could not have afforded their stay in such an institution, were accepted as well, and the financial question always had to be clarified upon their admittance. This meant that the patient either became a welfare case or that the relatives or persons who brought them into the clinic — no woman, suffice it to say, voluntarily went there herself — paid the costs.

In almost all cases, immediate family members took the women to this institution; in very rare cases, it was their employer, and this happened usually with servants from farms or urban households. Regarding the topic of relatives, distinct patterns can be observed for the post-1918 and the post-1945 eras. After the First World War, the overwhelming majority of males in these women's lives — be they spouse or father — were matter-of-factly portrayed by staff on the patient sheets as prone to alcohol and violence. Interestingly enough, this scenario ran through all social milieus. For instance, B. K. M. (\*1886 Tarvisio), who stayed in the clinic in November of 1922, was married to a high bureaucratic official, who was described in extremely frank words as a “callous drunk,” while she herself, quite fittingly, was diagnosed with a psychopathic constitution with hysterical traits.<sup>27</sup> One of the most cruel samples of domestic violence

could be pinpointed after the Second World War: Twenty-one-year old V. S. (\*1925 Chernivtsi), also a refugee in the DP camp Weidmannsdorf and six months pregnant, arrived on the ward, “beaten and punched by her husband.”<sup>28</sup> According to the doctors, V. S. spoke German badly, but acted completely normal. She was admitted to the clinic in January of 1947 for anxiety, and then picked up six days later — by the same husband.

As a general rule, passages about battering stay in the records after the Second World War, yet there can be noticed slight alterations in the depictions of partner profiles: Instead of alcoholism, traits like womanizing and adultery are listed. Hence, at this point, it can already be concluded that the notetaking and comments in patients’ files were also a mirror of their staff’s attitudes towards the world, plus the staff’s adherence to orders by their superiors. Additionally, in post-1945 times, incidents of sexual assaults by perpetrators outside of the family circle are addressed, which is not at all the case for post-1918 records and perhaps more conservative protocolling. Incest, again, as *the* taboo par excellence is never mentioned at all, except for one incident: A. B. (\*1933 Klagenfurt), abused by her uncle in 1945 and taken to the clinic by her mother in 1948 for psychogenic attacks.<sup>29</sup>

For both World Wars, the element of alienation and drifting apart from the soldier husband, returning from the front as an unrecognizable emotional stranger, can be canvassed in many records, as is the even lower threshold level of these males for cruelty towards their kin. Next to this failed identification with the previously loved one, the loss of citizenship or mourning over lost identity with regards to belonging to a particular country was also repeatedly uttered by patients. Immediately after the First World War, women lamented the collapse of the Dual Monarchy, sometimes also hallucinating that it still existed or would be resurrected with them as empresses. This was the most common hallucination next to religious ones. After the Second World War, there existed a similar situation with women denying the fall of the Third Reich and habitually imagining themselves as brides of Hitler.

Generally, every woman had to state her nationality upon arrival in the clinic, which was one of the various assessment criteria of whether she possessed a lucid mind, besides, for instance, solving mathematical equations. Indeed, this rigorous testing could have quite drastic consequences for the examinee. For example, a woman, who was not quite sure or slightly hesitant which new nation she belonged to in the general post-

1918 turmoil of rapidly shifting borders in certain regions after the dissolution of Austria-Hungary, was automatically declared insane.<sup>30</sup> Likewise, an unskilled manual laborer with little or no formal schooling, who could not tackle a complex math question within a given time, shared the same fate.

A decided paradigm shift can be registered with new arrivals towards the end of the First World War: Until 1918, the average resident in the clinic had been either diagnosed as insane from birth or early adolescence, therefore spending their entire adulthood in care there as a long-term case, or as an elderly, senile woman, who had been basically retired there until she deceased. From 1918 onwards, however, there can be tracked an immediate influx of young women — usually in their late teens or early twenties — being hospitalized for short periods of time, normally a few days or at most a couple of weeks. This phenomenon started in the summer of 1918, when the war was still on, and lasted until approximately 1922/23, when these sudden waves seemed to ebb away. The diagnoses for these new subjects were drastically altered as well. While previously admitted women had been overwhelmingly described as suffering from either dementia praecox when senior or schizophrenia when showing defects from birth, terms like hysteria, melancholia, inferiority complex, paralysis progressiva (Marasmus), mania, or paranoia entered the files from 1918 onwards. In order to comprehend these new developments fully, a brief excursus about the political and military scenario in Carinthia at that time is pertinent for further transparency. Until 1919, this territory underwent a minor war after the actual one, with all the negative side-effects for civilians, such as lootings, denunciations, physical and sexual attacks. Towards the end of the First World War, forces of the Kingdom of Serbs, Croats, and Slovenes took control of the province capital Klagenfurt and laid claim to the geographic basin landscape, in which it is located.<sup>31</sup> Subsequently, the Carinthian population formed ad hoc militias, and the numerous stand-offs between the two adversaries produced atrocities against nearby non-combatants, committed by both sides.<sup>32</sup> When female victims as collateral damage of this guerilla warfare poured into the psychiatric clinic in Klagenfurt, the medical personnel was compelled to resort to more diverse vocabulary other than ‘senility’ or ‘schizophrenia.’ These terminological advancements, nevertheless, were still fundamentally disconnected from trauma typologies.

As mentioned earlier, rape and sexual abuse only started to be articulated in the patients’ files after another World War, so the doctors’ anamneses entirely obscured or

even omitted the belligerence and skirmishes these female civilians were exposed to in Carinthia at that time. In a quite peculiar fashion, the home front that had been relatively tranquil and stable for these women and girls during the four years of international battles turned into a guerrilla war zone with a gruesome tapestry of hostilities towards locals during the Greater War. One typical example, quite emblematic for all those young women and their desire for physical and emotional security, was the pupil O. Z. (\*1902 Homec), who became mentally ill during the war, especially when Gorizia, where she then lived, was attacked. She had to flee to the second-largest city in Carinthia, Villach, where she was diagnosed with dementia praecox and tuberculosis. An important factor in her anamnesis was that there were no reported cases of insanity in her family history, so it could be concluded with certainty that her state was not hereditary. O. Z. stayed in the Klagenfurt clinic from 1920 to 1927, where she passed away. Her recorded statements on the patient questionnaire, such as “I cannot be little O. any longer,” for instance, encapsulate her longing for and escapism to the protected, pre-war shelter of childhood and express the unbridgeable caesura war brought to her life by robbing her of youthful innocence in simple, yet effective words.<sup>33</sup>

Another noticeable discrepancy between war and post-war times from 1918 onwards is the actual physical description of the female bodies by the medics on duty. Until 1918 and regardless of age or social status, the women were all classified as “well-fed,” and this, it has to be emphasized, after four long years of war. In post-1918 evaluations, the technical term “schlechter Ernährungszustand,” which roughly translates as malnourishment, was almost unanimously applied to all new arrivals until about the mid-1920s.<sup>34</sup> Contrastingly, this survey of the physical condition of patients is evinced less after 1945, when malnutrition was hardly articulated at all. This, discernibly, can be interpreted as a political and financial tool to avoid budget constraints, since it suggested that especially underprivileged and refugee women were capable of physical work, once they got released, and thus would not turn into a welfare case — as depicted by the Kraepelin quote about simulating soldiers at the beginning of this article. Another macabre detail in that respect after 1945 is that the muscular and bone condition of the women was painstakingly scrutinized. The practical implications by staff thus were that the female in question was useful for both bearing offspring and accomplishing physical labor after her discharge. How much this vernacular was still influenced

by Nazi mindsets that until recently dominated that hospital can only be speculated about.

There further exists a stark contrast between post-1918 and post-1945 documents pertaining to the registration of patients' self-harm or violence against themselves. While practically no suicides or suicide attempts were listed on the medical charts after the First World War — which could be interpreted in many ways, for instance, as a religious or social taboo — they became a standard theme after the Second World War. The mentioning of in-clinic suicides stayed exceptionally rare, however, and this might have catered to the administrative purposes of the place, since spilled information about successful in-house suicides would have tainted its reputation as a safe haven for the mentally sick. The succeeding post-1945 examples of hospitalized women with suicidal tendencies are just the proverbial tip of the iceberg. In all cases, the patients' vanished will to live was always directly entangled with war or post-war anxiety and stress: I. T. (\*1899 Bolzano) attempted to end her life, so as not to fall prey to marauding soldiers right after the end of the war.<sup>35</sup> The innkeeper A. K. (\*1900 place unknown) wanted to hang herself, because her husband and son were missing in action.<sup>36</sup> The suicidal refugee M. P. (\*1898 simply classified as stateless) ended up in the Klagenfurt clinic several times from 1946 to 1947 with hysteria and a morphine addiction.<sup>37</sup> Her husband and son were missing, too. M. N. (\*1893 Vršac), a refugee in the DP camp Feffernitz, was brought to the hospital in the spring of 1950 after trying to kill herself. From 1944 to 1947, she had been interned in Yugoslav camps, her son was missing, and her 76-year-old mother had starved to death in a non-specified camp.<sup>38</sup>

Next to suicide, the neologism of depression or reactive depression also entered the files after 1945. The post-war displacement on a gargantuan scale, the loss of home or family, forced labor, (para)military brutality, rape, and the food and sleep deprivation of refugees, most of the times covering long distances on foot, directly and from a retrospect point of view quite understandably affected the women's and girls' psyche. Alas, their grief for lost dear ones was translated by doctors as being pathological: The teacher A. K. (\*1914 Budapest), for instance, worried about her child, because she did not know where it was (the child was not specified, it could have been a missing son after the war).<sup>39</sup> She was brought to the hospital twice in the summer and in the winter of 1945, diagnosed with depression and potential schizophrenia and given opium. H. B. (\*1922 Belgrade) came to the clinic in January of 1946, suffering from onsets of

depression and hysteria.<sup>40</sup> Her husband was killed in 1941, and she did not know where all her other relatives were. After spending two and a half years incarcerated in a Yugoslav camp, she ended up in the Carinthian town Spittal as a refugee. M. S. (\*1910 Firsach) also arrived in the winter of 1946 from Villach. During the war, she was sent to a death camp and after the war raped by two British soldiers. The medics diagnosed her with depression, too.<sup>41</sup> D. R.-K. (\*1902 Belgrade), a refugee in the DP camp Waidmannsdorf with no knowledge of the whereabouts of her family, was treated on and off for depression from 1945 to 1947, until she was transferred to Yugoslavia in November 1947.<sup>42</sup>

Paradoxically and parallel to these swift overdiagnoses, all women and girls were denied an adequate clinical recognition when it came to psychological trauma, then at least marginally acknowledged with their soldier fathers or spouses by the medical community, even in a provincial environment like Carinthia. As a matter of fact, the refugee H. R. (\*1929 Gudurica) in the camp Fürnitz, who was treated in November of 1947 for psychogenic attacks, subsumed this very poignantly: “The attacks started in 1945/46 and many women and girls in the camps had them, but nobody believed them or paid attention.”<sup>43</sup>

Post-1945 traumatization after being buried alive in the debris of bombed civilian homes became a particularly prevalent theme in the medical reports, harking back to Kraepelin’s original observation, alluded to at the beginning of this article. Two cases encountered in the archive are especially illustrative for post-traumatic paralyses of the body as well as the mind after the rescue from ruins: M. F. (\*1897 St. Ruprecht) lived in the hospital for over a year in 1948 with psychosis. In 1944 she was buried alive for a longer, yet unspecified period after bombardment and since then referred to herself as a “nervous wreck.”<sup>44</sup> A. P. (\*1907 Maribor), a refugee in the DP camp Kellerberg, was buried alive after bombings in March 1945. Albeit she sustained no visible injuries, she was sick from then onwards and blind for six months afterwards, and she could not talk until 1949. Her left leg and arm were paralyzed since the incident. In 1950 she was transferred as a chronically ill person from the regular hospital in Villach to the Klagenfurt clinic.<sup>45</sup>

That convoluted or terminal cases like this one were moved from one local establishment to the next was nothing uncommon. Equally, it was a frequent policy to return

refugee women like A. P., who ranked decidedly lower in the implicit hospital hierarchy, to their former native countries. Thus, these patients were transferred by authorities across transnational borders that, ironically, were otherwise almost completely sealed for ‘sane’ travelers. Sometimes, this permanent dislocation could easily resemble a substratum for a psychological state of disorientation, for instance, perfectly personified by Z. F. Rather than suffering from a severe mental insufficiency, her reaction to the doctors’ enquiries might be traced back to many episodes of being constantly uprooted with tragic trajectories of refugeeism. Having, quite symbolically, no known date or place of birth, she ended up in a refugee camp in Krumpendorf, after her entire family had fled from Croatia, where “everything is ruined and demolished.”<sup>46</sup> During the initial assessment talk with the clinic psychiatrist in May 1945, she got up and walked to the window, simply uttering that “she would like to see where she was.”<sup>47</sup>

Particularly the treatment of such ‘alien’ or ‘foreign’ women exemplified the overall political and economic agenda, based on either the disposing of inmates by relocating them to different institutions and nations or on muting and sedating them until an early and occasionally premature dismissal. Also, within the scheme of sedation, a social pattern was discernible, especially after the Second World War: Native citizens and women of means received opium, everyone else electroconvulsive therapy (hereafter ECT). After 1945, shock therapy, as it was euphemistically called, was almost unanimously employed for refugees and most poor locals, while women of higher standing were administered opium, which reveals a lot about the approach of the medical personnel towards the individual patients. This is even more deplorable, because most exiles from Eastern and South-Eastern Europe were described as not being able to speak German. So, on their forms, the *laissez-faire* comment “communication not possible” can be discovered. Consequently, simply by lacking the linguistic ability of making oneself understood, these patients ended up receiving shock treatment, since adequate verbal delivery was one vital assessment criterion. Therefore, where the demarcations of insanity were sometimes drawn very much depended on the mood of the doctor in charge, and this was especially fatal with the new and opportune technology of ECT.

Ever since its original conceptualization in Mussolini Italy of the 1930s, ECT has been disputed. Ugo Cerletti (1877–1963) and Lucio Bini (1908–1964) count as the godfathers of this treatment, and they conducted what they then decided to name electro-shock therapy in Rome in 1938 for the first time.<sup>48</sup> Cerletti, in fact, had been trained

in Munich under Kraepelin before 1914.<sup>49</sup> The immediate adoption of ECT as a rather novel form of cure was therefore diametrically opposed to the strict refusal of medics to employ the similarly new, yet still already decade-old diagnosis of post-conflict trauma. Whereas trauma diagnoses were bluntly absent as a psychiatric novelty in the feminized assessment of women patients, ECT, once commonly available, was, nonetheless, readily applied to these same patients. War and war-affiliated symptoms hence were perceived through gendered prisms by doctors and hospital staff in the wake of both World Wars for matters of public perception of and academic discussions about conflict and post-conflict traumas, as well as the entitlement to various types of traumas and the corresponding treatments. Trauma, accordingly, remained almost unanimously reserved for male patients, more specifically war veterans, whose accreditation as ‘hysterics’ in traditional Freudian lingo would have signified a social stigma and political conundrum.

#### **4 Conclusion and Outlook: Psychiatry, Patriarchy, and the Private Versus the Public**

Throughout the twentieth century, the adoption and application of trauma was extremely context dependent, and gender played a major role in this medical genesis and evolution. War and post-war periods with a distinct double helix of the private versus the public complicated the projection of trauma concepts onto certain patients even further.<sup>50</sup> As ‘feminized’ diagnoses, originating from Freud’s findings, would have shattered the image of masculine and military potency of individual nations, the public debate and latter recognition of soldiers’ traumas, circumscribed by various terms other than hysterical, became political vehicles. Traditional theories of hysteria, almost exclusively embedded into the private — for domestic — sphere, were retained for these soldiers’ mothers, sisters, wives, and daughters, who lived through the same wars and post-war eras. Still, their traumas, happening mainly on the home front and sometimes even accelerating *after* ceasefires due to paramilitary or post-conflict violence, had to stay depoliticized. Whether it was ex-combatant husbands and fathers, frequently returning more aggressive from the battle fields than they had left, rampaging troops on their way home after demobilization, or occupying armies, women’s encounters after wars did not feature as a political entity. Rather treated like side shows in the global theaters of World Wars, these experiences or the articulation of them within a trauma framework did not sit comfortably with national itineraries of post-war reconstruction



and rhetoric, either. As Miriam Gebhardt in *Crimes Unspoken*, for instance, amply discusses, the iconography of or myopia towards mass rapes in post-1945 Germany has been closely enmeshed and has substantially coalesced with Cold War mythopoesis and pact politics.<sup>51</sup> The same is relevant for Austria and perhaps even more so, since hailing the Allied armies as liberators from the fascist terror without differentiation allowed both society and succeeding governments to manufacture and idolize the country's victim status in the Third Reich at the expense of a germane dialogue about its Nazi past and collective or individual guilt.<sup>52</sup>

Furthermore, it took several decades and another war in Vietnam with all the negative psychological consequences for US armed forces plus local residents in Asia for PTSD to be finally diagnosed and clinically defined as such. Incidentally, it was the translation of a work by another doyen of psychiatry, namely Eugen Bleuler, into English about forty years after its original publication that facilitated the American interest in this matter during the emergence of mainstream psychiatry in the 1960s. This title by Bleuler was *Dementia Praecox or the Group of Schizophrenias*, translated into English in 1950 (39 years after it had appeared in German) and paving the way for the modern understanding of psychiatry.<sup>53</sup>

Palpably, the definition, acknowledgment, and application of today's PTSD with regards to patients or certain demographic groups of patients during the twentieth century derived from power hierarchies, as delineated by Foucault. Female patients thereby were frequently eclipsed from the trauma radar and rather charged with nineteenth-century and *fin-de-siècle* motifs of hysteria, for example. Within this biased setup, Allan Young's interpretation of PTSD as a conglomerate, "glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilize these efforts and resources"<sup>54</sup> is quite significant, although he does not explicitly factor in gender as a variable per se. In fact, the blind spot on clinical charts concerning women and post-conflict trauma lingered disproportionately long. Even the final recognition of PTSD in the western hemispheres of the 1970s and 1980s as a 'legitimate' symptom of female survivors after attacks remained primarily gridlocked in non-warfare and especially private realms, mainly lopsided towards domestic violence and incest.<sup>55</sup> For instance, Ann Wolbert Burgess and Lynda Lytle Holmstrom were amongst the first scholars to interconnect gender-specific transgressions like rape empirically

with the wider ramifications beyond clinics, involving executive forces or judicial powers, in *Rape: Victims of Crisis*.<sup>56</sup> As PTSD entered the catalogue of ‘respectable’ and recognizable illnesses for female patients in most industrialized nations, it, nevertheless, continued to be restricted to official peace times, more or less detached from war crimes against civilians. Political, humanitarian, and, last but not least, psychiatric recognition of personal traumas in correlation with wars and their aftermaths or military as well as paramilitary aggressions towards women only slowly evolved with evermore climbing numbers of civilian victims since the First World War. This devastating trend forcefully culminated during the Yugoslav wars in the 1990s with sexual violence as a graphically abject war strategy. Finally, only after the ethnic cleansing during these Yugoslav wars and the Rwandan genocide at the end of the twentieth century was the dichotomy of PTSD as a by-product of gendered violence during and after wars engineered ideologically and legally.

As the practical examples of the psychiatric institution in Klagenfurt validate, narrative acts by the female patients as methods of self-expression and thus healing were either obstructed or forged to accommodate political landscapes and interests in post-war transitions.<sup>57</sup> Since certain individuals were not necessarily welcome during the phases of nation building of the First and Second Republic in Austria, clinical diagnoses bore the potential to become powerful filters for questions of citizenship, nationhood, patriotism, and refugeedom. This non-narrativity or silencing of medical patients on the psychiatric women’s ward in Klagenfurt did not simply play along designs and fabrications of national identity or traditional gender norms, but also impeded more transparent and helpful formulations of post-war traumata for future generations of doctors and their medical practice. In light of what has been said, the lacuna of trauma diagnoses in female patients’ psychiatric files after both World Wars prevented more thorough studies and more profound expertise about this condition for the benefit of *all* patients, male or female, reverberating through to our millennium. With dozens of currently ongoing wars or military conflicts and millions of traumatized migrants, particularly civilians, on this planet, the stories of the psychiatric hospital in Klagenfurt perhaps attain an even more topical connotation.

## Endnotes

- 1 This article was developed within the EIRENE project (full title: “Post-War Transitions in Gendered Perspective: The Case of the North-Eastern Adriatic Region”) that is funded by the European Research Council under the Horizon 2020 financed Advanced Grant founding scheme [ERC Grant Agreement n. 742683]. For more details, please see: <<https://project-eirene.eu>>.
- 2 Samuel Butler, *The Iliad of Homer: Rendered into English Prose for the Use of Those Who Cannot Read the Original* (Cambridge: Cambridge University Press, 1898), Book II, accessed December 10, 2020, <[The Iliad, by Homer \(gutenberg.org\)](http://www.gutenberg.org)>.
- 3 William Shakespeare, *Romeo and Juliet* (New Haven: Yale University Press, 2004), Act I, Scene 4, lines 86–88.
- 4 The American Psychiatric Association recognized PTSD for the first time officially in 1980, when the term was adopted into the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. (Washington, DC: American Psychiatric Association, 1980), 236–239. See further, Marc-Antoine Crocq and Louis Crocq, “From Shell Shock and War Neurosis to Posttraumatic Stress Disorder: A History of Psychotraumatology,” in *Dialogues in Clinical Neuroscience* 2.1 (2000), 47–55. As the abbreviation PTSD cannot be unanimously employed retrospectively, it is reserved to refer to post-1960 cases and situations in this analysis.
- 5 John Eric Erichsen, *On Railway and Other Injuries of the Nervous System* (Philadelphia: Henry C. Lea, 1867) and *On Concussion of the Spine: Nervous Shock and Other Obscure Injuries of the Nervous System, in Their Clinical and Medico-Legal Aspects* (London: Longmans, Green, and Co., 1875). For railway accidents as neurological triggers, see specifically Ralph Harrington, “The Railway Accident: Trains, Trauma, and Technological Crises in Nineteenth-Century Britain,” in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870–1930*, eds. Mark S. Micale and Paul Lerner (Cambridge: Cambridge University Press, 2001), 31–56. This compilation contains many valuable approaches to trauma studies.
- 6 Sigmund Freud, *Jenseits des Lustprinzips*, 2nd ed. (Leipzig, Vienna, and Zurich: Internationaler Psychoanalytischer Verlag, 1921).
- 7 Emil Kraepelin, *Memoirs*, eds. Hanns Hippus, Gerd Peters, and Detlev Ploog (Berlin and Heidelberg: Springer, 1987), 189. Predating Kraepelin, the Napoleonic Wars forged the syndrome of *vent du boulet* [cannonball wind], while the expression ‘soldier’s heart’ became popular during the American Civil War.
- 8 This article is the result of a larger research project, namely an ERC Advanced Grant that is entitled “EIRENE — Post-War Transitions in Gendered Perspective: The Case of the North-Eastern Adriatic Region.” EIRENE deals with social dynamics after wars through the lenses of gender by combining a longitudinal approach which involves the two World Wars with a transnational objective, including the multi-ethnic areas of the four countries Austria, Croatia, Italy, and Slovenia. One integral part of this project is the investigation of women’s medical files at psychiatric institutions in Gorizia, Klagenfurt, Ljubljana, Trieste, Vienna, and Zagreb for the time frames 1918 to 1925 and 1945 to 1950.
- 9 For the German-speaking world, see Silke Fehleemann, “Die Nerven der ‘Daheimgebliebenen’ — Die Familienangehörigen der Soldaten in emotionshistorischer Perspektive,” in *Nerven und Krieg: Psychische Mobilisierungs- und Leidenserfahrungen in Deutschland (1900–1939)*, eds. Gundula Gahlen, Ralf Gnosa, and Oliver Janz (Frankfurt and New York: Campus), 227–252; Fehleemann and Nils Löffelbein, “Gender, Memory and the Great War: The Politics of War Victimhood in Interwar Germany,” in *Psychological Trauma and the Legacies of the First World War*, eds. Jason

- Crouthamel and Peter Leese (Cham: Palgrave Macmillan, 2017), 141–164. See further Erika Kuhlman, *Of Little Comfort: War Widows, Fallen Soldiers and the Remaking of the Nation after the Great War* (New York: New York University Press, 2012) for women’s downgraded status in the hierarchy of victim narratives and entitlements.
- <sup>10</sup> For the mechanization of battles in conjunction with trauma, see Eric Leed, “Fateful Memories: Industrialized War and Traumatic Neuroses,” in *Journal of Contemporary History* 35.1 (2000), 85–100.
- <sup>11</sup> See, for example, Frederick W. Mott, *War Neuroses and Shell Shock* (London: Henry Froude and Hodder & Stoughton, 1919); Sándor Ferenczi et al., *Psycho-Analysis and the War Neuroses* (London, Vienna, and New York: International Psycho-Analytical Press, 1921); Tracey Loughran, “Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and Its Histories,” in *Journal of the History of Medicine and Allied Sciences* 67.1 (2010), 94–119. For France, see Charles S. Myers, *Shell Shock in France, 1914–18: Based on a War Diary* (Cambridge: Cambridge University Press, 1940). The French equivalent to shell shock is *l’obusite*.
- <sup>12</sup> Lord Southborough addressing the House of Lords, April 28, 1920 (Hansard, *House of Lords*, 5th series, Vol. 39, 1095), as cited in Ted Bogacz, “War Neurosis and Cultural Change in England, 1914–22: The Work of the War Office Committee of Enquiry into ‘Shell-Shock,’” in *Journal of Contemporary History* 24.2 (1989), 227–256, here: 227. See further, Baron Francis J. S. H. Southborough and Sir Aubrey Lewis, *Report of the War Office Committee of Enquiry into “Shell-Shock”* (London: H.M.S.O., 1922). For Great Britain specifically, see Fiona Reid, *Broken Men: Shell Shock, Treatment and Recovery in Britain, 1914–1930* (London: Continuum, 2010); Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (Basingstoke: Palgrave Macmillan, 2014).
- <sup>13</sup> Scholarship on psychiatric testimonies of female civilians in Central Europe after the two World Wars is still somewhat deficient. Michael Robinson, for instance, looked into male patients’ records, whereas Bridget Keown deals with war traumas of female service personnel, both restricting their work to Britain and Ireland during and after the First World War. See Michael Robinson, *Shell-Shocked British Army Veterans in Ireland, 1918–39: A Difficult Homecoming* (Manchester: Manchester University Press, 2020); Bridget E. Keown, “‘I think I was more pleased to see her than any one ‘Cos she’s so fine’: Nurses’ Friendships, Trauma, and Resiliency during the First World War,” in *Family & Community History* 21.3 (2018), 151–165, and “‘She Is Lost to Time and Place’: Women, War Trauma, and the First World War” (PhD diss., Northeastern University, 2019).
- <sup>14</sup> Sandra M. Gilbert and Susan Gubar, *The Madwoman in the Attic: The Woman Writer and the Nineteenth-Century Literary Imagination*, 2nd ed. (New Haven: Yale University Press, 2000), xlii.
- <sup>15</sup> Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830–1980* (New York: Penguin Books, 1987).
- <sup>16</sup> See Judith Butler, *Bodies That Matter: On the Discursive Limits of “Sex”* (New York: Routledge, 1993), esp. 12–16.
- <sup>17</sup> Hélène Cixous, “Le sexe ou la tête?” in *Les cahiers du GRIF (Elles consonnent. Femmes et langages II)* 13 (1976), 5–15, here: 9.
- <sup>18</sup> See Michel Foucault, *Folie et déraison: Histoire de la folie à l’âge Classique* (Paris: Plon, 1961), *Surveiller et punir: Naissance de la prison* (Paris: Gallimard, 1975) and *Naissance de la Clinique* (Paris: Presses universitaires de France, 1988).
- <sup>19</sup> See Michel Foucault, *Les mots et les choses: Une archéologie des sciences humaines* (Paris: Gallimard, 1966).

- 20 Elizabeth A. Waites, *Trauma and Survival: Posttraumatic and Dissociative Disorders in Women* (New York: Norton, 1993).
- 21 Sigmund Freud and Josef Breuer, *Studien über Hysterie* (Leipzig and Vienna: Deuticke, 1895). It is important to mention that psychoanalysts of Freud's age occasionally attributed hysterical streaks to male patients, labelled 'effeminate' by their peers, as well. For withheld diagnoses of male or veteran trauma from *fin-de-siècle* to interwar Germany, see Paul Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890–1930* (Ithaca, NY: Cornell University Press, 2003). See also Mark S. Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge, MA: Harvard University Press, 2008); Hazel Croft, "Emotional Women and Frail Men: Gendered Diagnostics from Shellshock to PTSD, 1914–2010," in *Gender and Conflict since 1914: Historical and Interdisciplinary Perspectives*, ed. Ana Carden-Coyne (Basingstoke: Palgrave Macmillan, 2012), 110–123.
- 22 Although focusing on different geographic areas, *Social Class and Mental Illness in Northern Europe* is a useful title, conflating social backgrounds (and to a certain extent gender) with mental health care. See Petteri Pietikäinen and Jesper Vaczy Kragh, eds., *Social Class and Mental Illness in Northern Europe* (London: Routledge, 2019).
- 23 Herwig Oberlerchner and Helge Stromberger, "Die Klagenfurter Psychiatrie im Nationalsozialismus," in *Psychiatrie & Psychotherapie* 7.1 (2011), 7–10, here: 8. For a general history of the place, see also Paul Posch, *Landeskrankenhaus Klagenfurt: Geschichte der Landes- Kranken- und Pflegeanstalten des Landes Kärnten in Klagenfurt und der Klagenfurter Spitäler* (Klagenfurt: Kärntner Druck- und Verlagsgesellschaft, 1987).
- 24 Helge Stromberger, *Die Ärzte, die Schwestern, die SS und der Tod*, 2nd ed. (Klagenfurt: Drava Verlag, 1989) and "Ein Beispiel für 'Rationalisieren' und 'Sparen' im Nationalsozialismus — die Todestransporte von Klagenfurt nach Hartheim im Jahr 1940/41," in *Kärntner Jahrbuch für Politik 2003*, eds. Karl Anderwald, Peter Karpf, and Hellwig Valentin (Klagenfurt: Kärntner Druck- und Verlagsgesellschaft, 2003), 165–173.
- 25 Kärntner Landesarchiv, LB Landesbehörden, Klagenfurt, Landeskrankenanstalten, AT-KLA 655-2 Se Akten der Abteilung für Psychiatrie (Irrenanstalt), stationär behandelte Patienten (hereafter KLA), box 90. Due to ethical reasons, the mere initials of patients, not their full names, are provided.
- 26 KLA, box 78.
- 27 KLA, box 30. — The original description of the husband is "abgestumpfter Trinker" (all translations from German by the author).
- 28 KLA, box 82.
- 29 KLA, box 92.
- 30 The patients' forms contained a specific section on their *Nationale* [national belonging or citizenship], which had to be verified.
- 31 It is imperative to mention that Carinthia, to this day, has a mixed German- and Slovene-speaking population, with the Slovene minority amounting to circa 25% in 1920 and mostly residing in the borderlands to today's Slovenia.
- 32 See, for instance, Ute Weimann, "Die südslawische Frage und Jugoslawien: Grenzziehungen im Süden Österreichs unter besonderer Berücksichtigung der Kärntenproblematik," in *Das Werden der Ersten Republik ... der Rest ist Österreich*, eds. Helmut Konrad and Wolfgang Maderthaner. Vol. 1 (Vienna: Carl Gerold's Sohn Verlagsbuchhandlung, 2008), 119–138; Tamás Révész, "For the 'Freedom and Unity' of Carinthia? New Perspectives on the Military Remobilization in the Carinthian Borderland War (1918–1919)," in *First World War Studies* 7.1 (2017), 1–22.

- 33 KLA, box 28.
- 34 One has to keep in mind that many refugees, who had experienced starvation and hardship in occupied zones and on their escape routes, ended up in this clinic after 1918. It could also easily be the case that this was a tactic by doctors to elicit more money from the authorities in times of upheaval and need. As Volker Hess and Sophie Ledebur, for example, show, records became a means to a bureaucratic end, next to being an instrument for the staff to expedite medical knowledge and insights. Cf. Volker Hess and Sophie Ledebur, “Taking and Keeping: A Note on the Emergence and Function of Hospital Patient Records,” in *Journal of the Society of Archivists* 32.1 (2011), 21–33, here: 22.
- 35 KLA, box 75.
- 36 KLA, box 77.
- 37 KLA, box 81.
- 38 KLA, box 93.
- 39 KLA, box 76.
- 40 KLA, box 78.
- 41 KLA, box 82.
- 42 KLA, box 83.
- 43 KLA, box 86.
- 44 KLA, box 86.
- 45 KLA, box 95.
- 46 KLA, box 75.
- 47 KLA, box 75. This is an indirect quote, jotted down on the patient’s sheet by the clinical personnel.
- 48 See Norman S. Endler, “The Origins of Electroconvulsive Therapy (ECT),” in *Convulsive Therapy* 4 (1988), 5–23; Germán Elías Berríos, “The Scientific Origins of Electroconvulsive Therapy: A Conceptual History,” in *History of Psychiatry* 8 (1997), 105–119; Edward Shorter and David Healy, *Shock Therapy: The History of Electroconvulsive Treatment in Mental Illness* (New Brunswick: Rutgers University Press, 2007).
- 49 For a biography of Cerletti, see Roberta Passione, *Cerletti: The History of Electroshock* (Reggio Emilia: Aliberti, 2007).
- 50 Cf. Jürgen Habermas, *Strukturwandel der Öffentlichkeit: Untersuchungen zu einer Kategorie der bürgerlichen Gesellschaft* (Neuwied and Berlin: Luchterhand, 1962).
- 51 See Miriam Gebhardt, *Crimes Unspoken: The Rape of German Women at the End of the Second World War*, trans. Nick Somers (Cambridge: Polity Press, 2017).
- 52 Although female patients’ records in Vienna and Graz — the urban centers of areas (i.e. Lower Austria and Styria) that have been heavily affected by Red Army rapes — are inspected as well for this research project, an inclusion of the results from these clinics would have gone beyond the scope of this article.
- 53 Eugen Bleuler, *Dementia Praecox or the Group of Schizophrenias*, trans. Joseph Zinkin (New York: International Universities Press, 1950).
- 54 Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1997), 5.
- 55 For second-wave feminism and PTSD, see Allan V. Horwitz, *PTSD: A Short History* (Baltimore: Johns Hopkins University Press, 2018), ch. 5, esp. 107–109.

- <sup>56</sup> Ann Wolbert Burgess and Lynda Lytle Holmstrom, *Rape: Victims of Crisis* (Bowie, MD: R. J. Brady Co., 1974).
- <sup>57</sup> For medical purposes of individual narration, see especially Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford: Oxford University Press, 2006).