

The agnotology of abortion: A history of ignorance about women's knowledge of fertility control

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Investigating the history of abortion is rife with shifting assumptions about what constitutes abortion, and even who determines pregnancy, as well as the contingencies of time and place and the ideological limits of recorded histories. Emerging from traditional herbal and dietary remedies to constituting illnesses like green sickness and hysteria, women's knowledge and agency in controlling their fertility through the use of abortifacients is notoriously underdeveloped. This article reports on some of the constraints of researching historical abortion practices, and also proposes that women's knowledge of fertility control may have contributed to these constraints through a manufactured culture of ignorance: an agnotology of abortion.

Researching abortion in an historical context

Researching the history of abortion means attending to different terms of reference than those meanings of abortion commonly understood today. For us, an abortion is any procedure which terminates a pregnancy from the first day a blastocyst implants itself in the uterus until late in the second trimester of pregnancy. Historically, however, abortion was understood in a much more limited sense: as a termination occurring only in the later stages of pregnancy when a fully developed foetus had quickened, what we would now consider a late-term abortion. It is highly likely that historically women preferred to terminate their pregnancies as early as possible, as women generally do today. Many historical and anthropological studies of the practice of 'abortion' have not been very useful because what they investigate is usually this (historically) atypical form of abortion.

One of the birth control methods women have traditionally relied upon most is menstrual regulation (Browner 1985; Jochle 1974; Low and Newman 1985; Riddle 1997; McLaren 1984; Newman 1985; Ngin 1985). This is the stimulation of one's period before confirmation of pregnancy to

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ensure a non-pregnant state. Stephania Siedlecky quoting Norman Himes writes:

The use of herbal remedies or physical interference to induce menstrual bleeding or control pregnancy is a practice that has been found in every quarter of the globe dating to prehistoric times. Indeed writers in antiquity recorded centuries of accumulated knowledge of the medicinal qualities of local plants, but this information was already ancient by the time it was written down. (2001, 93)

While menstrual regulation has been used for more than just fertility control, to the extent that it was used for this purpose, we would understand it today as early abortion. However, when we want to speak about the experience of early pregnancy termination in the past, it becomes quite tricky epistemologically. In the days before pregnancy testing, a woman who had missed a period may have suspected that she was pregnant, but there was no way for her to know for sure. Because diagnosis of early pregnancy was always a retrospective diagnosis, only possible after a pregnancy was over, women never experienced a definitively pregnant state that they could be said to be wilfully terminating. Perhaps menstrual regulation was experienced by women historically as a protection against the threat of possible pregnancy, akin to what we would today think of as post-coital contraception. But whereas today we only have a matter of days in which this situation applies, historically women had weeks in which to act. Historically, 'contraception' may have covered a rather broad range of methods which were used up to a month or two following a sexual encounter. As King writes, "since conception was a gradual process taking place over several months ... contraception extended several months into pregnancy" (King 1998, 134).

For any potentially pregnant woman who did not want to be pregnant, a missed period would have been a concern. If she induced her menses in order to avoid pregnancy, then at this point she may have ascertained that she was pregnant, if an embryo was developed enough to be identifiable among the products of conception. She may have understood this as having "induced a miscarriage" (McLaren 1990, 8). But if her pregnancy was so early that the embryo was indiscernible, which would have been more than likely within a month after a missed period, she probably would not have thought of this as any sort of termination at all. She may have thought of this as an "effluxion" (Cressy 1997, 48) or

“expulsion” (Schiebinger 2004, 114). If the embryo was visible but highly undeveloped, she may have thought of this as the expulsion of a “mole” or false pregnancy, a “fausse-conception or faux-germe and not really a human creation of any kind” (Schiebinger 2004, 114).

So how are we to conceptualize menstrual regulation today? What would be most helpful is to forget about modern classifications of birth control like contraception and early abortion and try to understand it as an alternative form of fertility control in itself. But approaching it as such remains deeply problematic as women tended to conceal their practice of any kind of fertility control in the past. Nancy Burley writes that “abortion/infanticide in traditional cultures must be practised by women secretly, husbands being overwhelmingly unsympathetic” (Burley quoted in Knight 1991, 208). The same would have applied to women’s practice of menstrual regulation as a form of fertility control. This paper investigates the historical implications of this assertion and the extent to which menstrual control as a fertility inhibitor was gendered knowledge.

Agnotology in the Age of Enlightenment

I propose that historically women achieved a heretofore unrecognized level of reproductive freedom through agnotological strategies, or strategies for “culturally-induced ignorance” (Schiebinger 2004, 3). In her analysis of the neglect of indigenous Caribbean abortifacients during the colonial period, science historian Londa Schiebinger describes the “nontransfer of important bodies of knowledge from the New World into Europe” (2004, 3). Schiebinger argues that while knowledge of abortifacients was devalued and ultimately lost during the eighteenth century, this was not the case with emmenagogues, or drugs used to induce menstruation:

Although abortifacients did not rank as a class of drugs in European *Materia Medica*, emmenagogues did. Beginning in the late seventeenth and throughout the eighteenth century, physicians experimented extensively with emmenagogues or menstrual regulators, medicines considered important for women and widely used across Europe and among European populations in its colonies. The use of emmenagogues during this period is astonishing; every woman, it seems, felt the need to regulate her menses. Studying the efficacy of these medicaments, a physician proclaimed, “their number is almost infinite, new ones are discovered everyday”. (181)

Schiebinger's agnotology of abortion is very important in that it shows how knowledge of emmenagogues in the eighteenth century was valued and preserved, while that of abortifacients languished. This demonstration of the circulation of knowledge related to menstrual regulation versus the non-circulation of knowledge related to fertility control has applications for other periods of history as well. It also hints at the incalculable benefit women accrued historically in keeping the fertility-limiting aspects of menstrual regulation hidden from men.

Schiebinger's focus is on the loss of knowledge through neglect and certainly abortifacient knowledge was diminished in the context of ancient history, as well, when a significant "nontransfer of knowledge" occurred between women engaged in fertility control practices and medical men whose textual versions of menstrual stimulation have become authoritative sources for us today. However, this paper will focus on what Schiebinger calls the "sequestering of knowledge" (152). I argue that, in order to provide some protection from the unsympathetic intrusion of men into their fertility control practices, women have historically employed ignorance as a "*strategic ploy* (or active construct)" (Proctor 2008, 3 emphasis in original). In his book, *Agnotology: The Making and the Unmaking of Ignorance* (2008), Robert Proctor, describes three kinds of ignorance: that which results from basic lack of knowledge; that which is selective, so choosing to remain ignorant; and that which is engineered, or strategic and designed to deceive. It is this last kind that resonates with my research, which Proctor describes thus:

The focus here is on ignorance as something that is made, maintained, and manipulated by means of certain arts and sciences. The idea is one that easily lends itself to paranoia: namely, that certain people don't want you to know certain things, or will actively work to organize doubt or uncertainty or misinformation to help maintain (your) ignorance. They know, and may or may not want you to know they know, but you are not privy to the secret. This is an idea insufficiently explored by philosophers, that ignorance should not be viewed as simple omission or gap, but rather as an active production. Ignorance can be an actively engineered part of a deliberate plan. (8-9)

Proctor goes on to describe the impact of scientific method on the so-called 'occult sciences' or dark arts, like alchemy and astrology which were 'practiced in the dark, hidden from view.' Proctor argues that "much of the rhetoric of the Scientific Revolution was directed toward eliminating

secrecy, to open up practices to inspection – whence the omnipresent rhetorics of ‘light,’ ‘clarification,’ and eventually ‘enlightenment.’ Alchemy done in the light became chemistry” (9-10).

Women’s traditional practice of fertility control was also caught up in the Scientific Revolution. Done in the light, menstrual regulation became abortion. That this “enlightened” version of birth control became illegal in the early to mid-nineteenth century demonstrates again that women had excellent reasons for managing their fertility surreptitiously. John Riddle describes one example of these agnotological practices. He writes:

When a woman declared her fetus dead, a medieval physician did not examine her, and even if he should do so, he lacked a stethoscope to hear a heartbeat. No medieval records that I have found alert a physician to be aware that a woman might lie about her condition. If we can generalize on this discrete evidence, it appears that when a woman said “dead,” dead the fetus was thought to be. Thus, a medicine that assisted its expulsion could appropriately be given. (1997 108)

The assumption that women have been the subjects of sexist mythologies circulated by men is ameliorated by strategic interventions like these, where it served women’s purposes in covering up their practice of fertility control. Because fertility control was always intimately involved with definitions of womanhood, women were protective not just of the technical knowledge involved, but of the meanings which could potentially attach themselves to these practices and the women who used them. For socio-political reasons, menstrual ideology often had to serve the dual imperative of supporting women’s management of their fertility while obscuring what was known about this management within a usually pro-natalist context. This was all part of “women’s business” or “women’s things,” as the Greek term for menstruation, *gyneikaia*, translates. Not only were women the creators of a system of knowledge geared to the regulation of fertility, but they were also participators in a system of ignorance which served to “sequester” this knowledge. Women may not just have colluded with men in perpetuating false notions about their menstruating bodies, but may have been the originators of some of these notions, this being what gave them their authority in the first place. Menstrual agnotologies were as constitutive of women’s health historically as was the knowledge and practice of menstrual regulation itself. They provided women with invaluable epistemological camouflage in their

practice of fertility control and this needs to be taken into much greater account when considering practices of abortion in the past.

An example of the ways in which women are assumed to be ignorant of methods of fertility control emerges in some historical research. For example, in their analysis of the historical and cross-cultural usages of menstrual regulation, van de Walle and Renne claim that women's use of emmenagogues for birth control before the nineteenth century "was exceptional rather than part of an everyday health regime" (van de Walle and Renne 2001, xiv). They link this to

the pro-natalist tenor of many of these societies, where regular menstruation is promoted by various means and is viewed as a sign of good health, it seems likely that traditional emmenagogues or menstrual stimulators have been used mainly to enhance rather than to limit fertility. (xiv)

This pro-natalism argument is earlier complicated by McLaren, who suggests that, "On the other hand other societies may be convinced that their high levels of natality could be even higher if constraints currently employed were not in place. In this case, we have an example of high but *limited* birth rates" (1984 3). The pro-natalist argument also takes little account of the secrecy and covertness with which women limit their fertility within a pro-natalist context. As Lucille Newman writes:

The need for secrecy is most evident in those societies where women are secluded and where a strongly patrilineal system demands high natality ... In both these patrilineal areas [Afghanistan and Egypt], women's autonomy is severely limited and the use of nonprescriptive methods necessarily must entail secrecy. (1985 17)

Robert Engelman (2008) has also found that women comply rhetorically while resisting or questioning reproductive regimes. He writes:

In a village in Mali, a predominantly Sunni nation, I met Djenaba. She was sixteen or seventeen – she wasn't sure which -- and the mother of two. The new baby, a girl, tugged at her breast as we spoke. Djenaba said she was happy to have just one year between births, if that was Allah's will. And when I asked her how many she wanted to have in all, she replied quietly, eyes down, "As many as I can." A more nuanced answer surfaced as I pressed on with the interview, asking her about the health of her children, the

circumstances of their births, and how she had met their father. Her parents had arranged the marriage, she said, but the wedding hadn't actually taken place until after the birth of her son, when she was fourteen or fifteen. Suddenly her composure and her voice both shifted, and she confessed that she could have waited to become a mother ... She wished she could wait now, at least three years, before becoming pregnant. She wondered where she could find some of these [contraceptive] pills, because she did not want many more children and none any time soon. "It's too hard," she said, "we don't have any wealth." (2008, 139)

Whether a woman lives in a high-fertility regime or not, if menstrual regulation is a known part of women's healthcare practices within a given cultural context, then it probably constitutes one of the primary means of birth control for women in this context. Riddle argues that throughout history women commonly used emmenagogic plants, "mostly herbs, in order to control their reproduction" (6). He writes:

there was considerable evidence in the records that women had both contraceptive and abortifacient pharmaceutical agents. Women thought that what they took worked successfully and I found that modern scientific reports tend to confirm their practices as probably being effective. (7)

My argument is that beginning sometime in the sixteenth century with the scientific revolution and increasing throughout the seventeenth century into the Age of Enlightenment, male physicians were becoming more and more suspicious of women's alternative use of emmenagogues. Throughout the eighteenth century this knowledge seemed to remain limited in application to prostitutes, slaves and women of dubious honour. However, throughout the nineteenth century as humoral theory began to lose influence, physicians were coming to the somewhat shocking realization that the use of emmenagogues as abortifacients was standard among all classes of women. While it appears that the rate of early abortion increased in the nineteenth century, the nature of the practice of menstrual regulation as a covert form of fertility control can be understood as a continuation of women's practices historically. It was just that it was not until the nineteenth century that the medical establishment developed a clear understanding of how women were using emmenagogic drugs consistently for the purpose of limiting fertility.

I suggest that humoral theory was potentially an agnotological opportunity which women exploited. Shorter implies as much when he writes:

I dwell upon this medical interest in emmenagogues because it helped reinforce the popular tradition of uterine folklore ... Women historically were not all that concerned about irregular menstruation unless caused by pregnancy. It was the doctors, operating under the influence of antique theories about "bad humors" that helped make available to them drugs for abortion. (1982 181)

Shorter makes it sound as if women were almost indifferent to the existence of these "antique theories," but I believe it was quite the contrary. Women were greatly invested in them because it was these very theories which allowed them to treat possible pregnancy. Belief in plethora, and other false ideas relating to women's menstruating bodies, allowed women to cover their practices of fertility control, until the nineteenth century when humoral theory became defunct and menstrual stimulation illegal.

Humoral theory, menstrual regulation and hysteria

According to the Hippocratic regime, which centred on the teachings of the physician Hippocrates in the Classical period of Ancient Greece from around 4-5 BC, women's health was dependent on the regular evacuation of menstrual blood. How did this idea develop? In his essay "Menstrual Catharsis and the Greek Physician," van de Walle argues that "menstrual stimulation owes much to the humoral theories of Hippocrates and Galen, and to the list of materia medica compiled by Dioscorides" (2001, 3). The belief that menstruation needed to be regular in order for women to enjoy good mental and physical health may have made sense to Greek physicians in the context of humoral theory. Humoral theory however may also have developed in part to explain menstrual practices already in existence among women.

Women's traditional rituals surrounding menstruation, such as menarcheal puberty rites, may provide evidence of an older menstrual ideology involving layers of restricted knowledge. Girls' rituals centred on menarche can be understood as promoting on a public level the identification of menstruation with fertility. However, these rites often had a concealed component where the girl received teachings from an older, female instructor. It's possible that part of this menstrual pedagogy was

related to alternative meanings for regularized menstruation involving fertility control. In *Hippocrates' Woman*, King explores the relationship between the 'illness of maidens,' female maturation and the rites associated with the Greek goddess Artemis. Artemis was understood by Greek women as guiding girls through the transition to womanhood. King's reading of Artemis' role in relation to the crisis surrounding delayed menarche is suggestive. If this Greek goddess was involved in rites related to menstrual induction at the time of the first menstruation, this can perhaps be understood as a kind of initiation into the practice of menstrual regulation.

The "hysteria tradition" (King 1998) is one potential agnotological strand in the history of emmenagogues being used to limit fertility. As part of Hippocratic doctrine, women's wombs were susceptible to wandering, which was the cause of many conditions. King seems to suggest that women and female healers or midwives developed the notion of "women suffering from the womb", referring to the eminent physician Galen (2AD) who wrote in his text, *On the Affected Parts*, that "I myself have seen many hysterikai women, as they call themselves, and as the iatrini call them" (quoted in King 1998, 232). Monica Green's discussion of medical practice in southern Italy in the Middle Ages suggests that women were still diagnosing themselves with a wandering womb, even when physicians were arguing against it. She writes:

as late as 1316 the Italian anatomist Mundino de' Luzzi...was still having to counter views that the womb actually wandered. Interestingly, he asserts that it is women who say that they "have their womb in their stomach" or in their throat or at their heart. (2002, 26)

These observations perhaps attest to the value of hysteria as a diagnosis to women if it meant treatment with emmenagogues. In the nineteenth century, the physician William Thomas Brand explicitly connects hysteria with pennyroyal, a well known emmenagogue, when he observed that "the old physicians had a high opinion of [its] virtues in hysteria and uterine obstructions... it is now, however, rarely prescribed" (quoted in Schiebinger 2004, 187). Susan Klepp, in her article "Colds, Worms and Hysteria: Menstrual Regulation in the Eighteenth-Century America" states that emmenagogues were not used to enhance fertility but "to restore general mental and physical health" (2001, 23). Absence of menstruation was "classified as either a disease symptom or as pregnancy." One of the

diseases understood as causing menstrual suppression was hysteria. Klepp writes:

In a married woman, hysteria was assumed to be caused by a sudden "suppression of the menses," and was accompanied by fatigue, low spirits, and feelings of "oppression and anxiety." The physical symptoms of hysteria included a sensation like that of "a ball at the lower part of the belly, which gradually rises toward the stomach, where it occasions inflation, sickness, and sometimes vomiting." (2001 25)

Klepp describes how in the eighteenth century, the diagnosis of hysteria was generally reserved for respectably married women. It was the perceived respectability of the woman herself which dictated whether her request for drugs to induce her menses would be interpreted by a physician as a request for emmenagogues or as a request for abortifacients. According to Katherine Williams, in the seventeenth century, "in women's cookery books, physicians' prescription or recipe books, and casebooks, hysteria is described as a disease predominantly affecting married, often pregnant women" (1990, 400).

While in the seventeenth century hysteria was theorized as "confined to the nobility," Williams demonstrates how physicians seemed to be just as willing to diagnose hysteria among "working and servant classes" (Williams 1990, 400). However, by the eighteenth century, physicians were coming to better understand the true nature of women's emmenagogue use. Humoral theory was still influential at this time, but this understanding of women's bodies clashed with physicians' developing knowledge about the regularity with which emmenagogues were being used by women as abortifacients. There was a cognitive dissonance which physicians seemed to resolve through moral judgments about the women applying for help with menstrual retention. While an asymptomatic respectably married woman could reliably receive treatment from a physician, in the case of single women or slaves, "where little or no respectability existed, then there was a tendency to see only abortive intentions" (Klepp 2001, 35).

In the eighteenth century, then, it was only in the case of women with little social power that physicians were able to enforce their new insight into women's motivations behind menstrual stimulation. These were the women who physicians were more likely to suspect of dishonesty and who were subsequently at risk of being denied treatment. However, in

Schiebinger's description of a woman who sought and received treatment elsewhere when her request for an abortion was refused by a physician (2004, 189), it is clear that women did have other options at this time. That women still had access to a more varied healthcare network in the eighteenth century meant that physicians were sometimes in a position that they could not be any more honest about their refusal to treat menstrual retention than women were in seeking treatment for it.

In her study of the colonial bio-prospecting, *Plants and Empire* (2004), Schiebinger describes the attitude of Sir Hans Sloane, an English physician and botanist who worked in the colony of Jamaica, as typical for the eighteenth century. She writes that "Sloane placed his discussion of abortive qualities of his flour fence in the context not of colonial sufferings but of the growing conflict between doctors and women seeking assistance in abortion" (2004, 109). This is Sloane writing to the governor of Jamaica:

In case women, whom I suspected to be with Child, presented themselves ill, coming in the name of others, sometimes bringing their own water, dissembling pains in their heads, sides, obstructions, etc. thereby cunningly, as they think, designing to make the physician cause abortion by the medicines he may order for their cure. In such a case I used either to put them off with no medicines at all, or tell them Nature in time might relieve them without remedies, or I put them off with medicines that will signify nothing either one way or other, till I be furthered satisfied about their malady. (in Schiebinger 2004, 109-10)

Schiebinger describes how "the German physician Johann Storch also reported 'tricking' a pregnant woman, whom he suspected to be seeking an abortion, by prescribing only a mild laxative" (110). She writes:

The conflict between women seeking help to end unwanted pregnancies and physicians who abhorred abortion continued to sharpen over the course of the eighteenth century. Physicians sometimes accidentally induced abortion by some medicines prescribed for another condition. "These women deny they are pregnant," one disgruntled physician wrote, "even after the doctor has received the aborted fetus into his hands." (189)

Although neither Sloane nor Storch specified the status of the women in question, it was generally "persons without integrity and the destitute" (Schiebinger 2004, 189) who were suspected of secretly using

emmenagogues as abortifacients in the eighteenth century. Similar to the case in the nineteenth and twentieth century when illegal abortion remained a safe option for those women who could afford to pay for it, respectably married women in the eighteenth century generally had access to medical assistance for menstrual stimulation, despite strengthening suspicions by physicians about emmenagogue usage. Women's ability to limit their fertility was not entirely dependent on medical assistance, however, and it was partly women's continuing reliance on alternative care for menstrual retention which motivated physicians to campaign for the criminalization of menstrual regulation in the nineteenth century.

While physicians' suspicions about "ill-intentioned women" did not gain momentum until the eighteenth century, Schiebinger claims that "warnings to midwives, physicians, and apothecaries about giving unmarried women medicines that might induce abortion date to at least the sixteenth century" (110). This suggests that part of the great variability in the symptoms of hysteria may be attributable to a history of suspicious physicians and "dissembling women" (Schiebinger 2004, 110). It may be that women fabricated whatever symptoms they thought necessary to get them the diagnosis and treatment they needed. This deceptive behaviour had a good chance of success as doctors did not often perform intimate examinations on women. As King writes, before the nineteenth century, "most diagnosis relied on the senses, but above all trust was placed in the testimony of the patient" (2004 118).

Klepp suggests that the symptoms of hysteria, at least in the eighteenth century, could be understood as symptoms related to unwanted pregnancy. Researching menstrual retention or "obstructed menses" and hysteria in the context of the American Revolution in her book, *Revolutionary Conceptions*, Klepp writes:

A woman was either gravid or obstructed, and the two conditions bore no necessary relationship to one another.... Some women who knew that they were pregnant might, of course, have lied about their condition.... The two symptoms that distinguished the pathological condition of obstructed menses from pregnancy were, according to one doctor, "mental despondency" and hysteria. The emotional state of the woman was the primary clue to her physical condition. "Grief and distress" were considered the predominant symptoms in cases of amenorrhea and could be accompanied by stomach pains, headaches, and melancholy. (2008 182-183)

When we look at the symptoms of women suffering “illnesses of the womb” throughout history, we may be witnessing not just the symptomologies of unwanted pregnancy, but also the expression of the toxic side effects of emmenagogue use.

Symptomology, toxicology, and dis-ease

The connection between toxicity and abortion, at least, is an old one. As McLaren writes:

Taussig noted in his classic *Abortion, Spontaneous and Induced* [1936] that much early medical knowledge about toxicology was drawn from women experimenting on themselves with various drugs and potions. The fact that between the seventeenth and nineteenth centuries the slang for pregnant was ‘poisoned’ reflected in part the association of toxic substances with attempts to end unwanted pregnancies. (1984, 102)

Research has demonstrated the toxic nature of some emmenagogues when used at an effective dosage (Farnsworth qtd in Siedlecky 2001, 108). Some of the symptoms of toxicity would have been extreme, quite frightening, and probably impossible to cover up. These are some of the side effects resulting from the toxic ingestion of just a small sample of abortifacients: abnormally low blood pressure, shock, abnormally low heartbeat or abnormally rapid heartbeat, abdominal cramps, fever, diarrhoea, hypersalivation, dizziness, nausea, vomiting, tremors, headache, muscle paralysis, confusion, delirium, seizures (Netland and Martinez 2000, 826). Throughout history, women may have been covertly dosing themselves for menstrual retention, but their bodies would have been reacting to these dosages and potential overdosages in quite overt ways, especially if the results were fatal.

Symptoms of the poisoning of the body may echo those symptoms designating poisoning of the soul. In medieval times symptoms were attributed to the devil which would later be interpreted as the symptoms of hysteria in the early modern period (Williams 1990, 384). Linnda Caporeal has argued that “convulsive ergotism, a disorder resulting from the ingestion of grain contaminated with ergot” (1976, 21), may have been responsible for some of the bodily phenomena attributed to witches in Salem in 1692. Ergot is also a drug which has been used throughout history as an abortifacient. It is quite possible that side effects resulting from the use of the rather broad pharmacopeia of drugs classified as

emmenagogues are partly responsible for some of the behaviours which became associated with witchcraft and subsequently with hysteria. "Supernatural possession" or bewitchment as the explanation for otherwise entirely suspect bodily phenomena was perhaps another agnotological story women used to keep their birth control practices covered. If this was the case, obviously this strategy was not a very successful one considering the number of women executed as witches during this time.

To the extent that it is possible that "convulsive ergotism may have been a physiological basis for the Salem witchcraft crisis" (Caporeal 1976), symptoms of toxicity resulting from emmenagogue use may have been a physiological basis for the diagnostic category of hysteria. Some of the symptoms which seventeenth century physicians attributed to hysteria were "inward and outward convulsions...violent movements of the extremities...mental status changes similar to delirium...violent localized headache ending in enormous vomiting...violent palpitations of the heart...abdominal pain...attacks of nausea, vomiting and diarrhoea without pain but preceded by an emotional upheaval" (Williams 1990, 386-87). These are remarkably similar to the 'toxidromes' described by Netland and Martinez as caused by "pharmacologically induced abortion" (2000, 824).

Up until the eighteenth century, when access to gardens was becomingly increasingly difficult and drugs were becoming commercialized, women generally self-treated and looked to lay practitioners for assistance with menstrual retention (McLaren 1984; Shorter 1982; Balaban et al 2003). If women also sought out medical care from doctors, it is more than likely that they were already dosing themselves with emmenagogic drugs which would perhaps explain why they appeared to be presenting with 'hysterical' symptoms. Not only were women probably reporting symptoms related to pregnancy and anxiety, as well as perhaps some fraudulent symptoms, they were also potentially exhibiting symptoms related to the toxic nature of some emmenagogues. The varying toxidromes of different emmenagogues would also have impacted on how individual women's symptoms expressed themselves and were perceived by others.

These mysterious, variable and consistently observed syndromes among women demanded medical explanations. Helen King, in her analysis of the historical origins of hysteria, makes it clear that the diagnosis of hysteria did not itself exist for the Hippocratics. She writes:

In the Hippocratic corpus, neither the diagnosis of *hysterike pnix* nor that of hysteria is made. The womb moves, causing a range of symptoms according to its eventual destination. (1998, 246)

The Hippocratics accounted for differing symptoms among women with the theory of womb movement. The diagnosis of "*hysterike pnix*" or womb suffocation came later when Galen tried to account for the variability in women's symptoms by proposing that some women suffered not from the retention of blood but from retention of seed. King distinguishes these "illness of the womb" in ancient times from those symptoms which later became associated with hysteria from the seventeenth century onwards. However, whether the diagnosis was womb movement, suffocation of the womb, or hysteria, physicians tried to frame women's illnesses in terms of the pathological condition resulting from retained menstrual blood.

Again, women's status seems to have impacted the interpretation of symptoms. While the Hippocratics believed that womb movement was more common among "older unmarried women and young widows, especially the childless and the barren (King 1998, 219)," later writers such as Aretaeus, a second-century AD medical writer, found that "movement of the womb mostly affects younger women, whose way of life and judgment are 'somewhat wandering' (King 1998, 222)." This opinion was repeated centuries later and made even more explicit by Aetius of Amida in the sixth century and Paul of Aegina in the seventh century. Aetius wrote that suffocation of the womb, or *hysterike pnix*, was "seasonal, happening mostly in winter and autumn, especially in young women who use drugs to prevent conception (King 1998, 235)." Paul wrote that the disorder "was most prevalent in the lascivious and those who use drugs to prevent conception" (King 1998, 236).

What is clear is that despite whether symptoms were recognised among younger or older women, widowed or unmarried, these were all women who would have been vulnerable to socially unsanctioned, extramarital pregnancies. According to Monica Green, during the Middle Ages, widows "living under traditional Lombard law would have been under special pressure" (2002, 41) to maintain chastity. She writes:

Although remarriage was not uncommon, husbands sometimes stipulated in their wills that their wives could retain usufruct of the husband's property...only on condition that they did not remarry. Given that remarriage would have threatened a woman with loss of

her property and perhaps guardianship of her children as well, maintenance of chastity may well have been a pressing concern. (41-42)

Despite their “intellectual accomplishment,” Hippocratic ignorance concerning women’s fertility control practice seems more likely than women’s ignorance which is what van de Walle seems to be arguing when he asserts that women primarily used emmenagogues for the purposes of “enhancing their fertility.” While there is little evidence that emmenagogues actually enhance fertility, there is some pharmacological evidence provided by Farnsworth that emmenagogues have fertility limiting potential. He notes that, “Of the 565 species of plants having a folkloric reputation for use as emmenagogues, ecboics, or abortifacients, 225 showed uterine-stimulating properties, but only about a dozen had been tested on humans” (Farnsworth quoted in Siedlecky 2001, 108). It seems quite possible that historically even learned men would have had a lesser understanding than learned women of how emmenagogues operated on women’s bodies. Even highly skilled medical men like the Hippocratics would never have had the opportunity to test and verify the actions of these drugs on their own bodies.

It could be true as van de Walle and Renne argue that women used menstrual regulation for fertility enhancement. Certainly there have been periods throughout history when, as a result of extreme conditions, undesired sterility became a bigger issue than usual for women. Also, there probably have been women who were truly amenorrheic for a long period of time and who, concerned about whether they were still fertile or not, may have used emmenagogues in the attempt to restart their menstrual cycle.

Feeling green

Further links between menses, dis-ease and dietary treatments are suggested in Helen King’s discussion of green sickness or chlorosis, the disease associated with young, unmarried women from the sixteenth until the beginning of the twentieth century. According to King, chlorosis was “a historical condition involving lack of menstruation, dietary disturbances, altered skin colour and general weakness once thought to affect, almost exclusively, young girls at puberty” (2004, 1). King writes:

Throughout most its history, for most medical writers, the prime symptom of the condition remained absence of menstruation: an

ambiguous symptom because it could mean that this ideally passive young woman had in fact evaded paternal control and become pregnant. Astruc warned that women lie: maidens and widows who fall pregnant try to explain their paleness away as 'menstrual suppression.' (2004 9)

Green sickness was a disease which "was embraced by patients as much as by physicians" (King 2004, 19). As opposed to the Hippocratic construction of this disease, however, the early modern incarnation was often linked to notions of deceptive women. According to King:

Rue and Trabac noted that the dietary symptoms of chlorosis resemble those of the first months of pregnancy; doctors must therefore be on their guard, Trabac warned, as there are some girls who try to conceal an unwanted pregnancy behind a diagnosis of chlorosis. ...Von Norden claimed that 'chlorosis resembles the early stages of pregnancy'...it was, he said, the 'family and friends of the patient' who were most likely to assume that an unmarried pregnant girl is in fact suffering from chlorosis. (2004 107)

The dietary disturbances which King describes as symptoms of chlorosis, such as anorexia and pica do seem to suggest that this early modern disease associated with the suppression of the menses may have been a cover for the secret treatment of unwanted pregnancy (9-10). And in a later discussion of pica King writes that "anorexia and pica were linked by Stengel who said that the patient 'often loses the desire for meat and substantial foods', but added that she may eat earth or chalk, plaster from the walls, slate pencils' (104). Perhaps girls were eating these "Things absur'd or unnatural (107)" in an attempt to treat a possible pregnancy. Lead in the form of diachylon paste, or an adhesive plaster, is a known abortifacient (Siedlecky 2001, 105). In the nineteenth century, it was noted that one of the diseases which overlapped with chlorosis was indeed lead poisoning (King 2004, 15). I would also argue that anorexia, or the refusal of hearty foods, could also be understood as the deliberate attempt by girls to avoid foods which might strengthen pregnancy and counteract the consumption of "hurtful things" (King 106) meant to disrupt pregnancy.

Conclusion

That our understanding of *gyneikaia* survives in such an impoverished sense, as the Hippocratic text entitled *The Diseases of Women*, partially

reflects the neglect of women's ritually based knowledge in the conversion from an oral to a literate society. Van de Walle and Renne's failure to recognise the extent of women's agency in the limitation of their fertility historically, however, may also demonstrate just how successful women's agnotological strategies have been at misrepresenting their reproductive agendas. In his article, "Flowers and Fruits: Two Thousand Years of Menstrual Regulation," van de Walle explores the consistency which defines the medical history of humoral theory beginning with Hippocrates (1997). This history of the medical practice of menstrual regulation could also potentially be read as an agnotology, a two thousand year history of doctors misdiagnosing women's practice of fertility control as organic disease in women bodies.

Reframing menstrual regulation as a practice which historically had a significant amount of ideological support as well as agnotological protection makes it clear that abortion was possibly a lot more common and, at the same time, a lot more secret than previously conceded (van de Walle 1997). While it cannot be stressed enough just how tactically useful the induction of ignorance has been for women in the maintenance of their health historically, in a contemporary Western context, agnotologies of abortion are outdated strategies. The contours of ignorance have changed shape since the criminalization and decriminalization of abortion, but we still find ourselves susceptible to a legacy of obscurity. This paper is an invitation to challenge the various ways we remain deeply ignorant about the significant role abortion has played throughout history and continues to play within women's lives today.

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