CULTURAL CODES OF FEAR: GENRE, GENDER, (MALE) MADNESS

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"Though this be madness, yet there is method in't".
William Shakespeare, *Hamlet*, Act II, Scene 2

This paper focuses on a specific type of archival material from the first psychiatric institution in Croatia, the Stenjevec Royal National Institute for the Insane in Zagreb, today the Vrapče University Psychiatric Hospital, dating from the period from its foundation in 1879 until 1900. More specifically, it focuses on patient narratives featuring fantastical beings, i.e., narrations about their life relying on the genre of belief legends. Based on this material, which is considered to be an important albeit atypical folkloristic corpus, the paper analyzes and interprets the status and functions of the genre of belief legends (more specifically, the memorate) in daily life narratives, personal stories and in coding affects (primarily fear). The role of belief legends is examined not only from the perspective of oral tradition and literature, but also in terms of their social and psychological position, and through the lens of psychiatric discourse of the time, which recognizes such narratives merely as symptoms of madness, translating and coding them as the language of abnormality and psychopathology.

Keywords: fear, affect, belief legends, memorates, madness, psychiatric discourse, Stenjevec asylum, hegemonic masculinity

Madness[1] is a site of exclusion from culture and society, that which is *outside*, abject, corrosive, even frightening, however, it is simultaneously their integral part, what is *within*, *topos*, the constitutive element of more or less all normative practices that exclude it. The contours of what, at some point in time, represented or was constructed as madness is contained in various documents, texts and in visual art, but perhaps predominantly in philosophy and literature. As Allen Thiher states, "[m]adness and theories about madness have nourished literature from antiquity, and conversely literature has provided the

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stuff upon which theory has worked" (Thiher 1999: 2). Of course, in doing so literature did not merely reflect the constructs of madness, but it also decomposed, unmasked and criticized them or offered catharsis. However, in the late 18th and during the 19th century, when clinics and psychiatric discourse were established (which monopolized the discourse of normality and rationality and, conversely, of non-normality and madness), written literature – according to Shoshana Felman in *Writing and Madness* (2003) – created a virtually distinct genre of *male* autobiography of madness. The male autobiography appeared as a space required to question, challenge or destabilize the power of psychiatric discourse, and became the site where all that is socially (and even medically) suppressed, silenced, forbidden or objectified may be expressed. Fostered by authors such as Flaubert in his *Memoirs of a Madman*, Gogol and his short story *Diary of a Madman*, Nerval and his autobiography *Aurelia or The Dream and the Life*, Balzac and his short story *Farewell*, and even Antonin Artaud and his *Theatre of Cruelty* (some of whom described their own experience of *entering* madness and being hospitalized[2]), the genre became a platform for self-expression and self-representation of madness, i.e., a space where the object or the objectified attempt to regain the position of the subject. These autobiographical writings highlight and emphasize the madness of the world, criticize normativity, or use madness almost as the moment of initiation for entry into the space of the sacred, all of which are strategies of resistance to preserve one's own subjectivity and to assume a critical stance towards social constructions of the pathological. However, unlike written literature, which questions, subverts or even invalidates the boundary between the normal and the abnormal established by a particular society or culture, oral literature of the period – especially the genre of the belief legend – had a completely different function and status, especially outside of its original, local context of the (micro)communities that shared it.

This paper focuses on the period of the establishment of Croatian psychiatry, which came into existence in 1879, with the opening of the first psychiatric institution, the Stenjevec Royal National Institute for the Insane, today the Vrapče University Psychiatric Hospital, until 1900, which might be regarded as its first period. The paper examines the genre of (proto)psychiatric discourse, primarily its relationship towards oral literature (and tradition), more specifically the genre of the belief legend, whose reflections may be found in patient narratives, and whose language is perceived as the language and discourse of madness. The paper also investigates patients' relationship towards the genre of the belief legend and its function in narrating their own lives. Although belief legends or their traces regularly appear in the narratives of both female and male patients, in this paper I will primarily focus on hospitalized men and their personal stories, but necessarily in relation to women's narratives, precisely because male patients (who outnumbered women by a third during the first several years of the Institute) are more often given voice and the right to speak within psychiatric discourse, especially in the first period of the Institute, and their

[2] Both Nerval and Artaud experienced being institutionalized, and their texts may also be regarded as the beginnings of anti-psychiatric discourse, which developed especially during the 1960s, albeit outside of literary field, as noted by Shoshana Felman (2003).

narratives are less fragmentary than those of women. The paper examines psychiatric discourse as part of the discourse of hegemonic masculinity,[3] which, although based in patriarchal culture, is not part of unambiguous masculinity which is identical in all segments of society. Rather, it is the privileged discourse that stems from institutional power, from social control and norm-setting institutions, of which psychiatry is a part. Therefore, the mechanism of hegemonic masculinity is not only directed at correcting women's excesses, transgressions and deviations, but it also partakes in or creates the processes of domination, control and censorship of other, less dominant and/or subversive masculinities, which is, in the case of psychiatric discourse, reflected as the right to set boundaries between the normal and the abnormal, the rational and the irrational, and consequently, as the right to sanction the transgression of those boundaries, with often gender-based distribution of diagnoses.

I will primarily deal with patient narratives recorded in their medical charts, only marginally touching upon the history of (Croatian) psychiatry, which is why I will not consider madness as a medical category, but rather as an evaluative, socially and culturally constructed phenomenon with fluid and unclear boundaries (cf. Busfield 1994: 261), often based merely on subjective evaluations and comparisons between the healthy/normal and the pathological, primarily in relation to behaviors and thoughts, as well as the language of the narrative. Patient narratives, or rather medical charts containing medical histories and sometimes including the "voice" of the patient, have in the last twenty or so years become recognized as a distinct textual/discursive genre,[4] but have not until now been studied

[3] I follow R. W. Connell's definition of *hegemonic masculinity* offered in *Gender and Power* (1987), and particularly in her 2005 study *Masculinities*: "At any given time, one form of masculinity rather than others is culturally exalted. Hegemonic masculinity can be defined as the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women. […] Hegemony is likely to be established only if there is some correspondence between cultural ideal and institutional power, collective if not individual. […] It is the successful claim to authority, more than direct violence, that is the mark of hegemony (though violence often underpins or supports authority)" (Connell 2005: 77). Even though this definition emphasizes the aspect of hegemonic masculinity as the domination over women, it is restrictive inasmuch as the mechanisms of hegemonic masculinity are not directed at a single social group or even a single gender, nor are they fixed; rather, they are interconnected with the dominant political, ideological and cultural context. I employ the term in this paper because it highlights *institutionalized* power relations in society, which become dominant or are being established during the period in question (such as psychiatry), and which are not aimed solely at correcting and subordinating the feminine, but also at other types of masculinity, typically on the basis of class and other divisions, thus becoming a repository of all that they are attempting to symbolically distance themselves from, marginalize or correct.

[4] More on medical histories as a genre which is, despite certain shortcomings, significant for the study of the (history) of psychiatric discourse and the conceptualization of madness may be found in Kay and Purves 1996; Berkenkotter 2008; Zabielska 2014; Bertoša 2018. For instance, Berkenkotter believes that, unlike contemporary "narrative" psychotherapists – who, in collaboration with the client, co-create or help create the client's own narrative thus facilitating the externalization of the source of fear, anxiety or inner conflict – in the early phase of psychiatric discourse, the aim of the discipline in recording patient narratives was to establish a diagnosis, justifying hospitalization and treatment. She believes that "as a genre the case history has acquired a conventional structure, style, and lexic that, over the last 250 years, has become the standard form of reporting in clinical medicine and psychiatry. Its organization, linguistic features, and rhetorical conventions function to guide the reader's acquisition of knowledge in a scientific discipline that

from the perspective of folklore studies, for several reasons. Firstly, archival materials of psychiatric hospitals are for the most part poorly preserved, unavailable, or not readily available, while the medical genre itself does not fall under the scope of interest of folklore studies. Secondly, fragments of belief legends – or rather the belief legend framework of patient narratives including its motifs and characters (fantastical/demonological beings) as well as contents and themes – were not collected in usual, "normal" storytelling or narrative situations, but were instead, in a sense, "coerced," only partially recorded, possibly even in an altered form, mostly in third person singular, leaving us with no information as to their truth status/the narrators' belief in their truthfulness, and furthermore, they lack the aesthetic dimension. However, I deem them to be a valuable contribution to the corpus of folklore studies because they enhance our understanding of the status and function of the genre, within oral culture, as well as outside it – primarily understanding its social and psychological aspects, and, above all, its role in structuring emotions, a fact previously pointed out by Lutz Röhrich in his text on belief legends in 1984. Furthermore, I consider patient narratives – as a "discourse within a discourse" – of import in advancing our understanding of the 19th century and the Age of Enlightenment in Croatia, when hegemonic masculinity begins to sanction, suppress and silence certain beliefs (in this case belief in fantastical beings) or to diagnose them as the language and a symptom of madness,[5] at the same time diagnosing men's and women's thinking, behaviors and narratives differently.

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often must act upon incomplete and subjectively reported information" (Berkenkotter 2008: 2). In other words, "reporting the history of the individual case as illustrative of a type of insanity had the rhetorical function of persuading others in the field that different mental illnesses could be identified through a detailed narrative of individual case histories" (Berkenkotter 2008: 52–53).

[5] The discourse on correcting and establishing rules, in the context of psychiatry as well as other social institutions such as prisons (which is pertinent for the understanding of the early period of psychiatry in Croatia), certainly relies on Foucault's study *Madness and Civilization: A History of Insanity in the Age of Reason*, which constitutes a shift with regard to the essentialist approaches of the time (and today) towards the history of madness and the history of psychiatry. The essentialist approach, primarily concerned with the history of medicine, perceives madness as a real illness, transhistorical in nature but named and cured differently through time, which is why its advocates believe it is possible to apply modern psychiatric categories to the interpretation of patients in the past, and they regard the history of psychiatry and the evolution of mental institutions as the history of scientific progress of treatment and care. However, it was Foucault who first put forward the thesis, later embraced by others (including the anti-psychiatric discourse of the 1960s), that the concept of non/normality is a social, discursive construct, and consequently, a basis for models of social exclusion, suppression and disqualification, and that both psychiatry and mental institutions form part of the system of disciplining, which consolidates the authority of administration, bureaucratic regulation and social control, whereby they form part of the nexus of power. In addition to *Madness and Civilization*, pertinent for the turn in the research of madness are Foucault's 1973 and 1974 lectures, on *Psychiatric Power* (*Le Pouvoir Psychiatrique*), followed by his lectures on non-normality (or abnormality) held in 1974 and 1975 at Collège de France, which were later published first in French as *Les Anormaux* in 1999, in Editions de Seuil/Gallimard, and in English in 2003 as *Abnormal. Lectures at the Collège de France 1974–1975*. In these lectures Foucault, among other things, examined the construction of "dangerous individuals" by means of legal and medical practices, which in the 19th century became the supreme authority and the center of power in charge of social "normalization." In both lecture series, Foucault diverges from the representations of madness which were at the center of *Madness and Civilization*, directing his interest towards an analysis of the apparatuses of power (*les dispositifs du pouvoir*), believing that their influence is reflected physically in the body, in an organized and technically precise manner, aided by different practices that need not neces-

However, to understand why some narratives become *symptoms* of madness, to understand how madness is culturally constructed and represented, the political, ideological and social context that produces the discourse about the (non)normal should be taken into consideration. As the editors of the collection of essays *The Anatomy of Madness* put it, "The recognition and interpretation of mental illness, indeed its whole meaning, are culture-bound, and change profoundly from epoch to epoch, in ways inexplicable unless viewed within wider contexts of shifting power relations, social pressures, and ideological interests" (Bynum, Porter and Shepherd 1985: 4).

Although I cannot venture into a comprehensive discussion of wider social practices or politically and ideologically produced affective atmospheres that co-create the discourse on non-normality, some introductory remarks about the first hospital for the mentally ill and the foundation of psychiatry in Croatia are significant for the understanding of the complex phenomenon of the construction of madness, which dictates correctioning and sanctioning of different forms of transgressive femininities and masculinities.[6]

GENDERING MADNESS: DISTRIBUTION, CONSTRUCTION, PRODUCTION

Initially, the Institute for the Insane was not conceived overly ambitiously: from the reports published in the medical journal *Liečnički viestnik* (Medical journal), it is possible to trace the evolution of the hospital from its initial capacity of only 250 beds, growing considerably over the next four years and admitting more patients that the physical capacities of the hospital allowed (cf. Glesinger 1959: 7). It continued to grow, becoming the largest

sarily be violent or their violence is more subtle and not always visible. In addition to Foucault, others, such as Michael MacDonald (1983), Roy Porter (2002), Erik Midelfort (1999; 2013) and Andrew Scull (2015) also situate procedural changes in the representation and construction of madness in the period from the 17th century onward, culminating in the 19th century. They believe that in the period before industrialization and the establishment of stronger state administration, or, before the "age of the masses," madness was not a phenomenon that required sanctioning.

[6] Even though I consider the gendering of madness to be much more of a psychiatric and cultural construct than their product, at least in the period under study, and although masculine and feminine madness cannot be analyzed separately, this paper focuses on men precisely because their narratives recorded in patients' charts are more complete. Male patient charts (in relation to women's narratives and diagnoses, which I have examined in a separate article) highlight the differences in diagnoses, as well as reasons for admission. Women's transgressions and deviations far outnumber those of men and include, among other things, too much reading or thinking, quarrelsomeness, aggressiveness or unruliness, being cheerful for no reason or sad for prolonged periods of time, being overly worried or overly carefree, neglecting household duties and passivity, or alternatively, excessive involvement, "inappropriate" sexuality or overzealous religiousness – all of which are reasons, scattered across different diagnoses, for which their families (most commonly husbands or fathers) or the broader community sanctioned women by committing them for treatment at the asylum, where they proceeded to spend months or even years. Given such an abundance of women's "transgressions," diagnoses and because they are repeatedly denied the right to speak, I deal with this in a separate paper entitled "Female madness and the feminine monstrous: genre as confinement and genre as affective repository", *Narrative Culture* 8/1, which will be published in 2021.

mental health clinic in the region, surpassing both Belgrade and Ljubljana (cf. Žirovčić et al. 1933: 46).

Regarding the initial gender distribution of the patients, men outnumbered women by approximately one third, however, this gap gradually decreased, so that some ten years after the hospital opened, the number of men and women was almost equal. Based on available data, it seems that most of both hospitalized men and women came from rural areas, that they were largely the poorest and least educated members of society or merchants and artisans. Only a negligible percentage of people belonging to higher, better educated or wealthier classes were hospitalized each year – only about 40 patients in the first ten years, signaling that mechanisms of the construction of madness, as well as its treatment, to a large degree depended on class status.[7]

The average age of patients hospitalized at the Stenjevec Institute was between 20 and 45, with around a quarter of the patients being over 45, who were most often diagnosed with dementia. This suggests that the first institution for the mentally ill performed a twofold role – as a "correctional" institution for younger people and as a home or poorhouse for the elderly and infirm. The argument that the Institute started out not only as an institution to treat or care for the ill and infirm, but also an institution correcting various deviations and transgressions sanctioning them both socially and medically, is supported by the fact that the Institute's first director, doctor Ivan Rohaček, took the position after working at the prison hospital at the Lepoglava Penitentiary, an institution which most directly dealt with punishing and disciplining. Even this brief overview suggests that the first hospital for the mentally ill reflected the asymmetrical power relations in society at large, not only in the relationship between the psychiatrist and the patient, but also the patient and his/her family or the wider community, pointing to the construction and representation of madness, as well as the role of class, ethnic and gender in this particular social context.

Although numbers indicate an "even distribution" of madness among men and women, thus at least seemingly undermining claims made by a number of feminist critics about the 19th century as the period of primarily female madness,[8] the numerical data does not reveal very much about the ways of gendering madness, i.e., it does not explain the different mechanisms of constructing *female* and *male* madness. More specifically, when the Institute in Zagreb opened, the number of hospitalized men was greater that the number

[7] Although there are no records of this, it seems possible that the higher social classes sent the ill members of their families to clinics in Vienna, Budapest and elsewhere, or cared for them at home, while it is also possible that, depending on different class status, certain deviations were not even socially treated in the same way.

[8] For example, in her influential study *The Female Malady*, Elaine Showalter wrote that women are situated "on the side of irrationality, silence, nature, and body, while men are situated on the side of reason, discourse, culture, and mind", or that, "[…] the appealing madwoman gradually displaced the repulsive madman, both as a stereotype of the confined lunatic and as a cultural icon" (Showalter 1985: 3–4; cf. Bernheimer and Kahane 1985: 1–32); while Phyllis Chesler in her pioneering study *Women and madness* stated that "Madness and asylums generally function as mirror images of the female experience, and as penalties for *being* 'female', as well as for desiring *not* to be" (Chesler 2005 [1972]: 16).

of women.[9] Nonetheless, over the next several years, this difference gradually diminished and their numbers became virtually equal.[10] However, these dry data give little insight into the reasons for hospitalization, its length, diagnoses, the right to tell one's story and have one's narrative recorded, or for that matter, the attitudes of the family or the community towards male patients in contrast to female ones. These attitudes differed significantly based on gender, and they suggest much stricter or more comprehensive disciplining and norming in the case of women, pointing to asymmetrical or nonlinear workings of psychiatric discourse and hegemonic masculinity. Cultural and social constructs and representations of female madness (which were later reflected in psychiatric nosology as the ultimate "corrective") show that women's transgressions were far more numerous and diverse than men's and that some diagnoses were virtually never recorded or given in the case of men; for instance satyriasis, masturbation-induced insanity (in contrast to nymphomania, recorded in female patients' medical charts, and criminalized earlier) and *mania religiosa*, also considered an almost exclusively *female* disorder in Croatia. This distribution of certain pathologies as exclusively female (which raises the question of whether madness is a social construct or a social product) reveals the workings of hegemonic masculinity and affective politics: correcting "exaggerated" religiousness is a way to establish power over spirituality, whereas controlling and penalizing sexuality establishes power over the bodies of disobedient women, of whose "excesses" the society is striving to rid itself.

MALE MADNESS AND HEGEMONIC MASCULINITY

But, what of "male madness," i.e., how does hegemonic masculinity or psychiatric discourse conceptualize and in turn correct and sanction male excesses: which masculine behaviors/thoughts/narratives are considered the symptoms of madness in this period?

[9] In his report about the Institute in Stenjevec published in *Liečnički viestnik*, its director, Ivan Rohaček, writes: "During the year 1880, 174 men and 110 women were admitted, in total 284 persons" (Rohaček 1881/3: 37), while the report published in 1883 in the same journal offers a list for the first four years, stating that 87 men and 55 women were treated during 1879, 174 men and 110 women during 1880, 173 men and 127 women during 1881, and 204 and 140 women during 1882 (Rohaček 1883/6: 84). Thus, men were more frequently hospitalized than women, however, later data indicate that men were hospitalized for shorter periods of time, either due to death or faster recovery, while women remained at the hospital for much longer periods, but their mortality rate was lower.

[10] With time, the gap between the number of men and women decreased, so the Annual Report of the Stenjevec Royal National Institute for the Insane, published in the *Liečnički viestnik* journal states that towards the end of 1885, there were a total of 269 patients hospitalized at the Institute, of which 137 were men and 132 women, while, for example, in September of 1886, when the hospital had the capacity of 250 beds, as many as 289 patients were in its care, of which 146 were men and 142 women (Rohaček 1887/5: 66). In 1885, there were 261 men and 199 women receiving treatment at the hospital, while, during 1884, there were 235 men and 174 women under its care (Rohaček 1886/11: 174).

Both male and female patients at the Institute had the status of the object/the objectified – whose bodies were subjected to medical gaze and examination,[11] and whose behavior was subject to micro-punishments and rewards used to regulate their time, activities, sexuality, etc. Nonetheless, they did not have an equal right to have their stories recorded, with male patients' narratives appearing more frequently in the medical charts, however scant and fragmentary they were. The reasons for their admittance and the length of hospitalization, as was already mentioned, were drastically different from those of women, and were mostly due to tertiary syphilis, alcoholism and alcohol-related violence, while older male patients were most commonly admitted for dementia. However, it seems that violence did not present a problem to hegemonic masculinity or to the communities from which the men came to the Institute if it was restricted to occurring *within* the family, though this too was sanctioned in some instances. Violence as part of primarily male culture and "family folklore" was, it seems, an integral part of everyday life, a fact not evident from men's but from women's patient charts: hospitalized women were traumatized and feared their abusers – fathers, husbands or other members of their family and sometimes, despite court rulings in their favor, remained at the Institute as the only safe place for years, while their abusers faced only temporary or brief incarceration or remained in the family. However, violence committed by men was not silently accepted, tolerated or approved of if it spilled over into the community, or as Robert Muchembled claims, the status of violence "gradually changed from that of a normal collective language, which had created social ties, and helped to validate the hierarchies of power and the relations between generations and sexes in the core communities, to that of a major taboo" (Muchembled 2008: 14). Although it is difficult to agree with Muchembled's thesis about the tabooization of violence, it is possible to talk about the tendency to *control* it, which means that individual violence is substituted or sanctioned by institutional violence – the penal/prison system and the medical/psychiatric system, with the confinement and

[11] From the very start, patients' medical charts at the Institute were printed forms with standard headings. The front page contained basic information about the patient: first and last name, date and place of birth, sex, marital status, occupation, religious affiliation, date of admittance and date of discharge or date of death, diagnosis, hereditary conditions and circumstances of admittance, whereas the inside contained empty sections for the doctor's remarks and notes, always beginning with *status praesens*, the patient's current state. Here, doctors first described the patient's physical appearance, and in the early years, special attention was devoted to the size and shape of the patient's skull, often accompanied by drawings, as well as to the appearance of their genitals, breasts, complexion of their face, etc., followed by "moral" traits, and, only very rarely, a very brief personal and family medical history. This was followed by dated entries noting therapies, reactions to therapies, patients' behavior, their state or character (often including moralizing evaluations), as well as conversations in the form of answers to the doctor's questions and patient narratives. At first, doctors' entries in the chart were frequent, but as a patient's stay extended, the entries became less frequent and ended either with a date of discharge, or, much more commonly, with the date and cause of death. In addition to the required data and initial notes, numerous medical charts of female patients contained countless pages filled with dates of menstruation, with no further explanation, or, in other instances, dates and hours of epileptic attacks. The form was printed in Croatian, whereas doctors' notes were sometimes written in German, but more commonly in Croatian. Patients' medical charts sometimes contained supplements such as letters from the family doctor who referred them for treatment, letters from their family, notes written by the patients themselves or their drawings, but this was the case only with the better educated, middle-class patients, who were only a negligible minority in the first period of the Institute.

isolation of individuals whose behavior was considered dangerous, disturbing or simply abnormal becoming strategies to preserve or establish (new) public order and morality (cf. Geller and Harris 1994).

During the first period of the Stenjevec Institute, most male patients – whose recorded segments of narratives contain traces of belief legends, with fantastical beings as protagonists – were hospitalized precisely because of the *spillover* of violence, first deemed unacceptable by their local micro-community, and then also by the psychiatric discourse, which does not diagnose violence itself, but rather uses patients' narratives (who use them to explain their own behavior) to establish the basis for diagnoses, most commonly including hallucinations or persecution mania for this type of behavior.

LANGUAGE, GENRE, MADNESS

Patients' (medical) charts, as mentioned above, constitute a distinct textual genre, a discourse within the psychiatric discourse, they are a patient's narrative within the narrative of psychiatric notes. They allow us not only to trace the construction of psychiatric diagnoses and nosology, but also to understand the function of the genre of belief legends and the differences between a memorate and a fabulate from a different perspective, which involves communicating difficult, inexplicable, incomprehensible conflict episodes in their lives that are not part of their "normal" everyday life, but do stem from it. These two discourses rely on entirely distinct bases, use a different language – vocabulary, syntax and semantics – and have entirely disparate functions, with the psychiatric discourse monopolizing the right to rationality by its institutional affiliation, and ascribing the other discourse, that of the patients, with the status of incomprehensible, typically on account of the language that the patients employed (or did not employ at all, because they were excluded from it). The language of the Stenjevec Institute patients is the language of belief legends, which they use in an attempt to explain and understand their self and their personal histories, and to provide a narrative framework for that which is outside, beyond language or beyond their previous life experiences; the language of belief legends and the language of the fantastical, frightening or impossible was the closest to an episode, event or emotion that they experienced but found difficult to comprehend or completely incomprehensible.

Ever since Foucault's *Madness and Civilization*, theoretical literature in various disciplines has been exploring the idea of madness as "the lack, the absence" of language, as the "absence from the production of meaning" and the inability of the subject to "enter" the space of language; madness is seen as the exclusion and breakdown of the system of meanings codified through language and culture. Or, in Foucault's own words, "In the serene world of mental illness, modern man no longer communicates with the madman. […] As for a common language, there is no such thing; or rather, there is no such thing

any longer; the constitution of madness as a mental illness [...] affords the evidence of a broken dialogue, posits the separation as already effected, and thrusts into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason *about* madness, has been established only on the basis of such a silence" (Foucault 2006 [1965]: xii-xiii).

However, patients at the Institute are not excluded from *all* language, but rather only from the language of psychiatric discourse, or language of hegemonic masculinity. Their sentences are not "fragmented" and unconnected, their syntax is not "twisted" and the content they narrate is not incoherent, but only when understood within the framework of oral tradition, which, especially in the case of belief legends, presupposes some degree of believing the truth or factuality of what is narrated on the part of the narrator and the recipient, and presupposes at least partial knowledge of the context by the recipient (cf. Dégh 2001). In the case examined here, the communication process fails, most probably for several reasons: the first is the recipient's/psychiatrist's lack of understanding and knowledge of the micro-context, which might be less problematic, while the second and more important reason is the disbelief in the truth or factuality of what is narrated (or even the possibility of it), whereby the belief legend does not cease to be a belief legend (a memorate), but does become a symptom of madness, because of the very fact that the narrator/patient relies on the supernatural as a key participant in the narrative or even its driving force. The *reasonableness* and rationality of psychiatric discourse means that the fantastic and supernatural are not accepted, or rather, they are excluded, in turn excluding the entire language that embodies them. Inscribing beliefs in the supernatural into psychopathologies is by no means a project exclusive to 19th-century psychiatry, but is part of a much wider and more comprehensive project of the Enlightenment, where different phenomena of vernacular culture, including beliefs (i.e., *superstitio*, among others) are positioned beyond reason and censored,[12] which is to some extent a continuation of the (Reformation and) Counter-Reformation project of correcting beliefs and their recodification as disorders.

Such a project also required the transformation of individuals – in this case from lower social classes, who are the bearers of and participants in oral tradition and culture – into patients, or, in the words of Ann Goldberg, "a cultural shift was required of whole

[12] Thus, Ann Goldberg, contextualizing the opening of a mental institution in Eberbach, Germany, in the early 19th century, wrote about the Enlightenment as playing a decisive role in how the construction of madness changed: "[...] the culture of educated elites had undergone over a century the profound changes associated with the scientific revolution and the Enlightenment. The 'desacralization' of the world that these movements brought about involved the substitution of science and rational inquiry for the supernatural. A world in which spirits, witchcraft, devil possession, and religious healing had been possible and meaningful had become anathema to the rationalist, scientific minds of a nineteenth-century educated middle class" (Goldberg 1999: 39), and, "In the name of 'humanity', 'progress', and economic productivity, the 'common man' was to be freed from his magical, superstitious thinking and practices, and shaped into a morally accountable, rational and industrious citizen" (ibid.: 63).

communities, that they cease their 'superstitious' use of magicians and quacks, turning instead to medicine and the asylum for help" (Goldberg 1999: 59). Yet this process of the pathologization of beliefs is not only the byproduct of the establishment of psychiatry, but it is also characteristic of the cultural turn with regard to oral culture, whose codes are lost or even expunged in the process of being translated into the language of science and reason: the language of orality with its specific formulas and beliefs is not only marked as primitive or primordial, but it also becomes the site of silencing, isolation and sanctioning.

The demands of psychiatric discourse for a linear, chronological and causal narration about one's life which are put before the patients, are at odds with the unstructured, chaotic, prelogical and even antilogical reality (as remarked by Hayden White in *Tropics of Discourse* (1985)) that takes shape only subsequently, with the help of language, that same language which is excluded from "reality" by psychiatric discourse because it often also encompasses what has not yet been "lexicalized" or what eludes lexicalization, in other words, events and experiences not belonging to the language system and commonly referring to emotions and affects.

Patients confronted with the request to narrate, rely on the narrative matrix with which they are familiar and which they intuitively recognize as suitable for structuring and transmitting affects, primarily fear and anxiety – the main impetus for belief legends – caused by the intrusion of the fantastical, supernatural and unfamiliar into the ordinary and everyday. Belief legends as a genre stem from everyday storytelling or conversations and are permanently open to other narrative genres such as personal stories, biographies and autobiographies, which leads to additional blurring of their boundaries and main characteristics, making them permeable to personal inscriptions, interpretations and meanings (cf. Marks 2018: 10), and even to instances of metaphor and metonymy, which, despite the plurality of approaches and debates over the characteristics of the genre, remain less examined in theoretical texts. Metaphoric and metonymic characteristics of belief legends and their significance to individual narrators are not easily or readily explored, partially because the concept, or the possibility of the metaphoric and metonymic characteristics of belief legends, at least at first glance, corrodes their foundational supposition about the belief (at least of the narrator and preferably of both the narrator and the recipient) in, primarily, the literal reality and truthfulness of what is narrated, that is, it presupposes that belief legends are used to communicate something *other* than what is said.

However, psychoanalytical approach to language (I am referring primarily to Lacan's psychoanalytical theory) underscores its Otherness, observing language as that which is to a degree always foreign to the subject, the meaning of which has already been established by an Other, that which the subject is forced to accept by entering into society and culture, but which never fully becomes the subject's own language,[13] so by implication, the subject speaks of something other than his/her own reality, and in so doing uses learnt,

[13] As Lacan states in his *Seminar II*, "language is as much there to found us in the Other, as to drastically prevent us from understanding him" (Lacan 1978 [1954/1955]: 244).

yet still foreign formulas and words, thus initiating the process that Lacan terms *alienation in language*. For Lacan, these formulaic accounts and words with which the subjects attempt to express their own story do not constitute signs, but rather nodes of signification (cf. Lacan 1966: 165) revealed in speech (for Lacan, this is *parole*), which is the "symbolic exchange" that connects subjects (Lacan 1975 [1953/1954]: 142). This exchange may be observed as a contract that assigns roles both to the one speaking and the one to which speech is directed, but it also divides them when the contract is not possible, which is the case with patients and psychiatrists at the Institute, because their nodes do not overlap and they do not share the same codes.

MALE MADNESS, FEMALE MONSTERS

Male patients at the Institute in Stenjevec rely on the structure and content of the memorate (in this case most likely arising from the fabulate, which, in turn, may be considered as shared codes within the community to which they belong, as well as the Lacanian *contract* regulating the symbolic exchange), because they recognize it as a form that initiates and enables narrating about one's own experience produced by something from the outside, something foreign and terrifying to the subject, which is then "translated" into the supernatural. Yet unlike women hospitalized at the same institution, who also rely on memorate-like belief legends in their narratives and who most commonly identify with the monstrous beings (i.e., they internalize them) the male patients mostly construct their subjectivity *in opposition* to the supernatural, i.e., they externalize all the blame for a certain, often violent event, projecting it onto only female frightening beings, most often fairies and witches.

Although Croatian belief legends present fairies as good, neutral or evil[14] – with evil ones semantically overlapping with witches – in the patients' stories or memorates, they are, without exception, evil, or an encounter with them causes unrelenting fear.

One such instance is the case of 41-year-old V. M., a barrel maker from Bjelovar, brought to the Institute for the Insane on 10 June, 1880, with an accompanying letter from a physician at the Bjelovar hospital where he was initially admitted. Apart from his personal data, his medical chart contains the narrative grounds on which the psychiatrist was able to establish the diagnosis of persecution mania: in other words, the patient is allowed space for narration, which is then written down in the third person, trying to retain his linguistic characteristics such as dialect, vocabulary and syntax, in order to transmit (or simulate) the patient's "authentic voice:"

[14] Ivan Kukuljević Sakcinski first classified fairies according to their habitat, into good, evil and volatile, with mountain fairies (which he terms "air" and "sky" fairies) being good, water fairies being evil, and those that live on earth both good and evil (Kukuljević Sakcinski 1851: 87).

> On April 29, he ran from... home and came back at 11 o'clock at night wet and hungry, saying that fairies had chased him around a campsite. Over the following days he always saw fairies dancing around the house, under the bed, the table, on the wall – he heard them tearing down his house and saw his neighbor, the local carpenter Kutin, among them, threatening him and shouting at him, etc. [V. M.] was afraid of Kutin all day because Kutin would kill him, and he was greatly terrified.
> During all this time, neighbors kept watch at his house, for fear he might run away.
> On May 3, he started abusing and hitting his wife and apprentice and being more and more angry all the time. In the afternoon, I found him locked inside the house, in a corner, curled up on the bed and he begged me and the town gendarmes to stay quiet and close the door immediately so that his enemy would not get in or shoot through the cloud.[15]

Shortly after the patient was admitted, the Bjelovar physician wrote: "he was calm, he said that the fairies were calling him, that they were singing and that he had to sing with them – and indeed began singing loudly himself. At another moment he said that hounds were after him – that there are always fairies around his bed."

From the notes, we do not learn much about the patient, apart from his age, occupation, marital status, religious affiliation (he is Roman Catholic as are nearly 90 percent of the patients), place of residence and his current state, yet, there is no information about his past – affective or factual, or his family circumstances, because such information is irrelevant or marginalized in psychiatric discourse in the initial period. However, what we do learn – the diagnosis of persecution mania, primarily based on the patient's narrative and partly relying on observing his behavior – raises the question whether doctors interpreted the belief legend format and the mention of fairies as key symptom of the illness, whereas his violent behavior towards his apprentice and the townspeople (and the less problematic violence towards his wife) was mostly unacceptable to his community. The very existence of a psychiatric hospital enables micro-communities to rid themselves of its more "difficult" or deviant members, who break social rules and norms in different ways, and it confers a dual role on the psychiatrist: of disciplining the "problematic individuals" and of transferring the language and genres of oral tradition to the realm of non-reason, into psychopathology.

Croatian belief legends about fairies, which also fall under the category of demonology, often begin with a person's reckless intrusion into a space that is not monstrous in itself, but may become threatening and sinister precisely because of the non-approved entry or the violation of an agreement, with this moment prompting the entire belief legend about the clash between the human and the supernatural, i.e., about the fairies' treatment

[15] The paper is based on manuscripts kept at the Vrapče University Psychiatric Hospital Archive in Zagreb, formerly the Stenjevec Institute for the Insane. Given the legal protection of patients' right to privacy and anonymity, and ethical standards of treating the mentally ill, the patients are not listed by full name, but by their initials and year of admission. The archival material is cited according to its existing organization at the hospital, i.e., based on year and alphabetical order; in this case: Vrapče University Psychiatric Hospital Archive rkp 1880 A – Ž.

of a human. Patient V. M.'s narrative begins at a "campsite," a location in nature outside of inhabited areas; we do not learn how he got there, but it seems to be a place where fairies reside, who then begin to "chase him around." He does not mention reasons for the fairies' vindictiveness and rage, leaving out the details of his own transgression (and fragmentary accounts and exclusion of details are one of the key syntactic and stylistic characteristics of belief legends), instead focusing on listing places inside the *house* where he can see them, and on their threats of destruction, incineration and murder. This subsequent and *reversed* intrusion of supernatural into the human space – which is a trait exhibited only by the invisible *mòra* (and only exceptionally by the witch) in belief legends – is what causes fear and panic, which V. M. cannot overcome or regulate, because he is powerless against the monstrous which defies "natural" laws; he cannot hide from a broken rule or contract. However, although the focus of his narrative is directed at fairies, although he recounts his own encounter and experience with fairy-like beings who are vindictive and violent, at one point he also mentions his neighbor, a real person, who participates in the attack and of whom he is terribly frightened: "[...], saw his neighbor, the local carpenter Kutin, among them, threatening him and shouting at him, etc. [V. M.] was afraid of Kutin all day because Kutin would kill him and he was greatly terrified." Formulas of authenticity, as Evelina Rudan (2006) terms them, constitute an integral part of belief legends, as segments belonging to the real world, which are named and verifiable, such as names of people, places or dates of events, which serve to anchor the belief legend in reality, adding to its truthfulness. However, in this case, the mention of his neighbor Kutin has a different function. He is not a witness or a participant in the encounter with the supernatural nor is he the guarantor of truthfulness, as is usually the case in belief legends, but rather, to employ Lacan's term, an *intrusion of the real* into the space of the imaginary; an irregularity and a departure from metaphor. The language of the Other that patient V. M. assumes is the language of his community and his culture, largely characterized by orality (that is, it is oral culture), and his narratives are also narratives of the Other, learned, adopted collective formulas which are simultaneously a way to communicate what is personal and private. In his 1984 text "Belief legend, fairytale, folk belief: collective fear and ways of overcoming it" Lutz Röhrich noted that, among oral narratives, belief legends in particular encourage, record and transmit, as well as structure fear; they are accounts of what is unsettling and frightening, or, in Röhrich's words, "belief legends describe social and religious consequences of breaking norms" (Röhrich 2018 [1984]: 353), which is severely and unquestionably punished. Moreover, he notes that demonic beings are a reflection of a restless consciousness and guilt. He continues, "Characters in belief legends are psychological complexes projected into the outside world, and are often projections of fear. By embodying supernatural characters in material form, the belief legend may, to a certain extent, banish unfounded fear. Belief legends are, thus, oral narratives in which people attempt to put their experiences of fear into words, explain them and, in so doing, remove their terror." (Röhrich 2018 [1984]: 354). Röhrich approaches belief legends from a psychoanalytical viewpoint, indirectly addressing the metaphoric and metonymic

characteristics of belief legends – if we understand their language and characters, we will also be able to discern which emotions and affects these concealed or suppressed transgressions communicate.

In V. M.'s case, it is possible to interpret the framework of the belief legend about fairies, which he recounts in the form of a memorate, as metaphorical sliding in the Lacanian sense: his fear of the fairies' retaliation, in the chain of signifiers, is the fear of punishment for breaking the promise or contract, in other words, we may interpret it as the projection of guilt, while the mention of his neighbor Kutin is the intrusion of reality, or the return of what is suppressed – it is much more likely that the transgression that provoked his fear is linked to his real neighbor than to female monstrous beings, however, the substitution of one signifier (the neighbor) with another (fairies) creates a metaphor, which in turn, produces a new sense and a new meaning. This new meaning is an attempt on the part of the subject to remove one's guilt, unease and anxiety from the self through externalization, by projecting it *outside* the self onto the *feminine monstrous*. Although the described situation probably refers to a conflict between two men, it is interesting that the guilt over the transgression, along with the fear and violence, is directed towards women with supernatural powers, from whom it is impossible to escape: the fairies may also be a metaphor for a conscience, which the subject is attempting to nullify or suppress by substitution. In this way, the male subjectivity attempts to "expel" its own inadequacy, failure or transgression from itself and inscribe it onto the female subjectivity, which is evil and powerful, thus trying to achieve its own unity: that which is unacceptable, incomprehensible and frightening must be expelled in the subject's constant play of mirrors, becoming directed at the (imaginary) feminine, which is, it seems, the symbol of the impermissible, deviant and wicked in the cultural imaginary. Thus, belief legends are not merely stories that serve to transmit and structure fear in an attempt to understand, dissolve or dissipate it, as claimed by Röhrich, but serve as bestiaries of socially unacceptable affects, such as anxiety, rage or aggression, whose narrative construction does not bring relief or catharsis. However, an aspect that I find particularly significant is that belief legends are also a mechanism that structures and stabilizes the disrupted, split subjectivity, in relation to – or in contrast to – the supernatural and the monstrous (as metaphors and, simultaneously, constitutive parts of humanity) that the subject is constantly struggling to "remove" or expel outside of itself. The supernatural, which is mostly demonic, may be interpreted as a threatening otherness, which – despite being internalized and belonging to the self – is so foreign to the subject that it keeps assuming new external forms and shapes, which are detached and must remain detached from the subject. Nonetheless, psychiatric discourse does not understand or take into consideration the metaphoricity of belief legends, the substitution of one signifier for another, nor does it recognize the genre of belief legend as structured fear; but rather, the very mention of fairies and their attacks becomes a symptom, not of intense affect, but of persecution mania. The patient was discharged from the hospital several months later, however the customary discharge note concerning his full or partial recovery is missing.

When women's narratives mention encounters with the demonic and with demonic beings, psychiatric discourse recognizes in them the affects of fear and anxiety. In contrast, such diagnoses are very rarely made for male patients, which might point to the mechanism of affective politics of hegemonic masculinity (partly echoed by the patients themselves, often projecting their own difficult and painful emotions onto women), which censors some of the "male" emotions and affective disorders – especially fear, anxiety, dread, unease or guilt – considering them as unrelated to the male gender, and instead attributing the range of "unacceptable" emotions and affects to femininity,[16] thus creating affective hierarchies which, among other things, deprive men of the right to certain emotions and, hence, the right to affective disorders.

A similar example of threatening and vindictive femininity – which Julia Kristeva terms the "non-assimilable alien" (Kristeva 1982) – that takes hold of a person and does evil is the case of J. N., a single 20-year-old from the vicinity of Zagreb, an uneducated farmer, hospitalized on 16 June, 1900 with the diagnosis of mania. His chart contains an interesting remark that mania has an affective cause, which is one of the rare instances where of acknowledging or recognizing "male" emotions. The doctor's note is brief and recounts the description of the patient's condition at the Sisters of Mercy Hospital in Zagreb where he had been originally admitted several days earlier:

> June 13. During the night, the patient wants to go home, sings, shouts, rips the clothes off his body, bangs on the windows, rips the mattress, smashes furniture.
> During his medical examination he is completely calm, responds in a composed manner, his demeanor is polite, smilingly denies that he was restless, and if he had been, he is not to blame but the girls who cursed him and bewitched him 'with a yellow frog and blessed earth' [quotation marks written by the doctor] out of envy, because he fell in love with a poor girl and vowed to marry her.[17]

The patient's narrative has not been recorded at all in this case, let alone a narrative relying on belief legends; however, a fragment of a belief system has been preserved, as reflected in the patient's denial of responsibility for his own behavior and his transference of blame onto girls who, he claimed, used a magical procedure to bewitch him out of vengeance, using "a yellow frog and blessed earth." Just as in the previous case, the patient justifies his aggression, for which he was hospitalized, by something external, by women's malicious activity: though he does not explicitly mention witches, he implies them, precisely by mentioning magical, supernatural powers and the knowledge that they direct *against* people, bringing them to the edge of reason. The intrapersonal aggression, which Lacan considers

[16] Even though this is a worn-out and eroded dichotomy, it should still be reiterated that the mechanism of hegemonic masculinity does not operate through institutional and institutionalized violence, but also by appropriating the "sphere" of reason and monopolizing it. Or as R. W. Connell states "Hegemonic masculinity establishes its hegemony partly by its claim to embody the power of reason, and thus represents the interests of the whole society [...]. Victor Seidler's account of patriarchal culture emphasizes the mind/body split, and the way masculine authority is connected with disembodied reason" (Connell 2005: 164).

[17] Vrapče University Psychiatric Hospital Archive rkp 1900: A-Ž.

an integral and continued segment of the self, is temporarily resolved by a projection onto an external Otherness, which is once again feminine. In addition to replicating the pattern of evil powerful women who deprive men of their sanity (which may also be a fear shared by the masculine society and culture), the case of this young man (who spent only a month at the Institute) is also an example of a psychiatrists' "creation" of patients and of social sanction of magical practices. Thus, before the establishment of psychiatry, as discussed by Ann Goldberg (1999), people did not normally seek the help of doctors to deal with magical practices and reverse their effects, but rather tackled the problem within their community by consulting "experts" and people in the know. However, the advent of the Enlightenment brought about more pronounced censoring of beliefs problematic from the social and scientific point of view, and they are increasingly perceived as impermissible superstitions or illnesses to be cured, in an intermixture with the theological doctrine.

The case of patient V. A., a married 56-year-old from the village of Lupoglav in Istria, admitted on 28 September, 1881, and discharged on 20 April, 1882 presents a similar affective disorder provoked by fear and diagnosed by the psychiatrist as persecutory delusion. V. A.'s narrative is similarly minimized, his voice marginalized and absorbed by the psychiatrist's note:

> The patients is fearful, he is frightened because witches scare him, which is why he prays a lot and cannot sleep, he says he sees different wild beasts and nasty vermin that keep him from sleeping and disturbs him all the time. He keeps telling his household that the house of this or that neighbor is on fire, then he yells and those around him are barely able to contain him. He mostly sits in one place for hours without saying anything.[18]

Even such brief notes – which signal the lack of interest in the patient's personal history and story because they are primarily treated as *bodies* or objects – reveal, among other things, that towards the end of the 19th century the belief in witches is still alive, functioning as a metaphor for fear and anxiety within the oral cultural code – fear for one's own life, home or family – given that the witch is a representation of that which cancels and eliminates the material and physical, while her own transgressions and deviations, which are numerous and unpredictable, threaten the well-ordered and otherwise safe world.

These and numerous other examples from medical charts where men are given at least some right to their own narration and where they turn to folk beliefs and demonological characters from belief legends, show that these narratives much more commonly revolve around the feminine monstrous (which is also more common in Croatian belief legends than the male monstrous), with an occasional case which meanders between male and female evil, indicating ambivalence and uncertainty about the source of one's own anxiety, most frequently alternating between the devil and the witch.

[18] Vrapče University Psychiatric Hospital Archive rkp 1881: A-Ž

MALE POWER AND THE HYBRID GENRE: AN AUTOBIOGRAPHICAL NOTE OF A *KRSNIK*

In addition to projections and accusations against the Other, there are cases – albeit only a handful of them – of identification (or introjection) with a powerful being from belief legends. One of the most interesting ones, from a folklorist, sociocultural and ideological point of view, is the case of patient M. A., a 46-year-old farmer from the vicinity of Rijeka, admitted to the hospital on 17 February, 1879, with the diagnosis of "mania destructionis, in vero sumilites epileptico," and discharged from the hospital on 9 December, 1880, with a note about "health improvement."

Although demonological belief legends, as has already been mentioned, primarily communicate and structure fear in an attempt to explain and dispel it, this patient's story does not recount fear or anxiety, but rather his own power and even his acceptance of being hospitalized, while the language he uses can hardly be regarded as a "breakdown of language".

The accompanying letter from the doctor at the hospital in Rijeka where he was first admitted (there is no information about who brought him in) says: "As he became older, his desire (to destroy) grew, while he spent most of his nights out of the house. He became increasingly chatty, laughing without reason, his mood quickly alternating between cheerful and sad. Lately he has spent his time out of the house, where he smashed windows and destroyed beehives and burned down shepherds' cabins in the woods."

His narrative obviously attracted the interest of psychiatric discourse, judging from the fact that it was afforded more space in his medical chart than was the case with other patients at the time, i.e., he was given the right to his (presumably) authentic, individual voice, inserted into the medical notes and marked as direct speech, retaining the patient's vocabulary and syntactic structure:

> The patient is rather calm, of cheerful demeanor, pleasant to other patients and doctors. Today when I entered his room, he asked me in private to let him go home, and that he would reward me with a heap of gold as tall as myself. When I asked him where he would get so much gold, he responded: "Well, sir, if I wanted, I could open any till in Zagreb, but I don't want to. I am a *kresnik*, I was born as such in the caul, so I have great powers. I can do whatever I want, I can cure even the gravest of afflictions, not with herbs as you doctor do, all I need is my steam, to puff on the sick person, but I won't spoil [in his words, reduce] your work.
> When I told him that he was here at the hospital, God willing, to be cured in time, he said: "What damn hospital cures people?"
> 11 October, 1880. To date his mental state has not improved. He denies everything he had done before, but he came to me with a demand, that all those who claim he has wronged them should be written to: "he says, it is the wrongdoing of evil people who have wrongfully accused me. Take off my head if it is proven that I have done anything wrong." He says he collected alms at the church, that we should ask the pastor there,

> that I haven't taken a single dime; the great pastor of Rijeka will also praise me, who once gave me 2 gold coins. I am ready to submit to anything, whatever you dictate, to go to Lepoglava[19] if need be, let them take out my eyes, for all I know, if I have wronged anyone.[20]

Croatian belief legends about the *krsnik* (*kresnik*) are localized mostly to the region of Istria, the Croatian Littoral and the Kvarner Gulf,[21] where M. A. is from; the *krsnik*, just like the *mòra* and the witch, are "ordinary" people with supernatural powers and abilities, with one notable difference: the witch and the *mòra* harm an individual or the entire community, while the *krsnik* protects and helps them. The *krsnik* may be recognized already at birth, being born wrapped in the placenta (or caul), which is subsequently sown into his armpit affording him power and protection (Šešo 2003; Bošković-Stulli 1975), while belief legends mostly recount his ability to transform into animals, undertake night flights, combat the *štriga* (witches) and his healing powers, which he uses to protect and help his micro-community, with his identity usually remaining hidden to those outside his community, which is a way of his community to protect him in return. In his narrative, M. A. lists some of the key motifs of belief legends: birth in the caul, healing powers and a confrontation with "evil people" who want to eliminate him, however, in doing so he does something that very rarely occurs in belief legends – he reveals his identity as a *krsnik*.

Although the psychiatric discourse recorded the patient's narrative (or its key elements), thus giving him the right to his own story and voice, it simultaneously rejected this voice, because the diagnosis of destructive mania, insofar as it is possible to discern from the notes, is given on the basis of *other people's* descriptions of the patient's behavior prior to admission. The medical chart does not provide any information on who referred him to the hospital or based on whose account the doctor in Rijeka made his diagnosis, but it may be assumed that it was not a member of his family, as was the case with other patients, because M.A, after spending several months at the Institute, suggested to the psychiatrist that he could remain hospitalized indefinitely if they would bring his wife and younger children to live with him in the asylum. In contrast to the other patients, whose narratives containing tropes and motifs from belief legends, as well as displaying affects, have been translated in psychiatric discourse as persecution mania, in this instance, the patient's story (as well as his behavior) is irrelevant in establishing the diagnosis and seems to have been recorded for other reasons. One of these could be the patient's emphasis on his own healing powers, which are real and effective compared to those of the doctors, and which, in the context of establishing the medical, psychiatric and rational worldview based on reason, should be recorded as atavistic and even disciplined. Or, as Goldberg

[19] Lepoglava Penitentiary is the oldest and most well-known prison in Croatia.

[20] Vrapče University Psychiatric Hospital Archive rkp 1879: A-Ž.

[21] In addition to appearing in the mentioned regions of Croatia, belief legends about the *krsnik/kresnik* can also be found in Slovenia, and other regions have belief legends about similar beings, such as the *mogut* in Turopolje, the *negromant* or *legromant* in Dubrovnik, or the *vjedogonja* in the Bay of Kotor, Montenegro. Similar belief legends about the *zduhač* are found in Bosnia and Herzegovina and Montenegro, while similarities also exist with the Italian *benandnati*, the Hungarian *táltos*, etc. (Šešo 2003; Bošković-Stulli 1975).

remarks, "No communication, no defense of belief was possible across this cultural divide" (Goldberg 1999: 62).

Like previously, more detailed biographical data is missing in the case of M. A., however, it may be assumed that at least some parts of his narrative (if not all of it) are *true* and that, whether because of being born in the placenta, or because he was indeed some sort of a folk healer, he adopts the socio-cultural image/code of the *krsnik* as his own reflection and introjects it, thus acquiring a sense of power characteristic of a person with supernatural abilities in a situation that seems hopeless, such as being hospitalized in a mental institution. The introjection is part of the process of symbolic identification and it is always associated with the speech and language of the Other, which, in this case, once again refers to the language of oral tradition and belief legends: by speaking about himself, M. A. is in fact speaking about the *krsnik* from tradition, in an attempt to comprehend the circumstances in which he found himself: because he is on the side of good, the *krsnik* is always confronted with the hostile otherness which is trying to dispose of him.

Röhrich's insight about fear as the foundational emotion and the catalyst of belief legends is useful, because belief legends do structure and transmit affects and function as their metaphors; nonetheless, it could be extended, in that the affects prompted or structured by belief legend are fluid and linked to the type of supernatural being they include or revolve around, thus, beings that help, such as the *krsnik* in this case, do not provoke fear but instead dissolve or dissipate it, or provide a sense of power and control. Belief legends, both memorates and fabulates, relate a person's encounter with the supernatural and the unusual, and relate the influence of the supernatural on the subjectivity, but do not commonly recount a person's experience *as* a supernatural being, as a person with exceptional abilities and powers that exceed human ones. Thus, in terms of genre, M. A.'s narrative may be characterized as a belief legend, more specifically, a memorate, a story about a personal experience of *being supernatural*, which – by the very act of being told, by the very fact of his personal admission – breaks or disturbs some of the foundational elements of belief legends about the *krsnik*, such as secrecy, concealing his identity and tabooization or refusal to divulge certain healing practices (healing all illnesses with "steam," or breath, in this case). Attempting to categorize oral narrative forms that arise from (extra)ordinary everyday life, and particularly trying to establish a more precise definition distinguishing between a story about a personal experience and a memorate, proves especially problematic in this instance for at least two reasons: firstly, a *personal* experience, or the narration about it, is never fully *personal*, since it is immersed and told in the language of the Other, the language of the society and culture within which the subject lives, and secondly, because narrative forms which are not part of the traditional folklore oral community corpus sometimes do not fall neatly into conventional (but nevertheless arbitrary) genre categories (cf. Stahl 1977: 22). The uncertain and reversible categorization of belief-legend subgenres of memorate and fabulate was already discussed by Dégh and Vászonyi, who cautioned that fabulates may arise from proto-memorates, i.e. from personal narratives about a supernatural experience, just as much as fabulates may serve

as a subtext for a personal narrative (cf. Dégh and Vászonyi 1974: 225). However, it would be incorrect to read this patient's story as a memorate, since his narrative is principally an autobiographical note, a fragment, albeit anchored in the belief system of oral tradition – the memorate background helps him to frame his life's story in line with the demands of psychiatric discourse, to frame his misunderstandings and conflicts with his community making false accusations against him, which ultimately managed to hospitalize him in a mental institution: apart from destructive tendencies, which he does not exhibit at the hospital, his "medical history" states that he laughs a lot and is chatty, which is obviously impossible or impermissible in the social context of being a farmer at the time, living a life which was probably not easy or simple. Therefore, his reliance on the supernatural and fantastic is one of the possible strategies of "escaping" his bleak daily life, a substitute that prevents the collapse and the decomposition of the subject, with the belief legend about the *krsnik* becoming a personal story of integrity, of acting properly and of the authenticity of his sense of power.

TOWARDS A CONCLUSION

Psychiatric notes in the medical charts of the patients treated at the Stenjevec Royal National Institute for the Insane covered in this study belong to the period from 1879 to 1900, the first period of the hospital and the earliest phase of psychiatry in Croatia. They are not equivalent to oral narrations, because they are written, fragmentary and mainly depend on psychiatrists as "unreliable narrators," who selectively recorded only those segments of narrations that they deemed "symptomatic," probably disregarding the rest. Therefore, they are difficult to analyze as "real" oral or written texts, nevertheless, they still reveal that certain patient narratives – those that rely on the genres of oral tradition (primarily the memorate), being deeply immersed in them in terms of their locality, class and status – obtain completely different meanings as well as interpretations in different contexts or discourses. Psychiatric discourse as the discourse of, among other things, hegemonic masculinity – in its early phase when the discipline was establishing control over normal and abnormal thinking, behavior and affective experiences and reactions, required "educating" citizens to become patients, thus starting the process of transforming, "translating" folk beliefs into the psychiatric nosology and diagnoses, at the same time offering smaller communities or families the possibility to rid themselves of their dysfunctional, maladjusted or deviant members. In Ann Goldberg's words, "the superstitions of patients posed serious obstacles to mental medicine, for the asylum was here faced not simply with the task of treating and "curing" such people, but with the cultural and social problem of transforming beliefs to the extent that these people could be made receptive to and understand the terms of patienthood and illness itself. Indeed, the two tasks – medical and cultural – were inextricably linked. As such, the process of transforming such people into patients – of substituting the language of the medico-psychological for that of the

divine – required a fundamental reshaping of the experience of selfhood and subjectivity" (Goldberg 1999: 69).

However, of course, this process is not only related to the advent of psychiatry, but was also part of the wider ideological context of the Enlightenment, which gave priority to reason, thus sanctioning various folk beliefs, but also created new and different affective atmospheres and regimes where the gendered distribution of affects and emotions took firm root – a fact ultimately reflected in the diagnoses which suggest that men, for all intents and purposes, do not have or cannot exhibit *affective* disorders, i.e., they are primarily denied the affect of fear, which they narratively structure by means of the oral genre of, conditionally speaking, belief legends. Basing my analysis of the medical charts on their recurrent themes, motifs and tropes, I categorize them as belief legends, more specifically memorates – personal experiences of an encounter with what is frightening and supernatural. Nevertheless, it is precisely this type of material that attests, for different reasons, on the one hand to the arbitrariness and restrictiveness of (sub)genre classifications in folklore studies, and on the other – somewhat paradoxically as well as more importantly for the purpose of this paper – to the multiple layers and functions of the genre of belief legends in everyday life, but primarily in narrating important personal (affective) experiences.

Although the material does not belong to the traditional corpus of folk studies, it still points to the circularity and inseparability of the fabulate and memorate – an issue discussed at length by Linda Dégh (2001) alongside numerous other folklorists – based on the fact that both forms are a "summary" of beliefs of sorts, which, without a shared consensus or social "contract" about the truthfulness of what is narrated, would serve no narrative purpose. It is precisely this "socio-contractual" element of belief narratives – which implies their truthfulness and is their precondition – that is betrayed and invalidated in contact with psychiatric discourse: what plays the role of a shared code of understanding in oral communities becomes the site of psychopathology and of exclusion from society in psychiatric discourse. While it appears that psychiatric discourse censored the very beliefs in the supernatural labeling them as symptoms of psychological disorders, which were most commonly diagnosed as persecution manias in the case of men, I believe that the actual status of a patient's belief in their accounts and fragments of their stories is not as significant as the almost intuitive recognition of the genre as a repository of affects. As a genre, belief legends are a storage of both individual and collective fears, which, in this case, makes the patients' memorates (as stories about personal encounters with the supernatural) nearly identical to personal life stories. The patients are faced with the psychiatric demand for a narrative. The narrative, to be in line with the demand of the psychiatric discourse to distinguish between what is normal and abnormal, must be logical, causal and coherent (while simultaneously excluding motifs and tropes of the so-called folk language), at the same time denying the continuity of narration, denying narrations as open, fluctuating processes, as visible from the almost invariably single entries of fragments of patient narratives in the patients' charts, most often only upon

admission to the hospital. To comply with this demand for coherent storytelling, patients rely on what is familiar to them, on their narrative *terra firma*: the *affective* genre of a belief legend. Belief legends narrated as memorates, thus, constitute part of an autobiography where the encounter with the supernatural is actually a metaphor, the sliding of meaning used to narrate difficult and incomprehensible episodes in one's life, employed in an attempt to give them meaning and explain them, to sort out the chaos of life, and narrate what is seldom or never discussed: one's own difficult and unacceptable emotions. Actual beliefs, as mentioned above, are the foundation of these autobiographical stories, but are at the same time almost irrelevant – anything that eludes clear or conventional causality, or that frightens the narrator/patient and is incomprehensible to them may be regarded as supernatural. Subsequently, the narrator/patient labels it only *approximately*, relying on collective imagery, on language as the space of the Other, where, for the subjects, words, concepts, and even affects are primarily always *foreign* and therefore *coded*, with the subject then attempting to decode and decipher them, assigning to them, to some extent, one's own meanings which rationalize that which constantly eludes rationalization – primarily affects and emotions.

However, what is narrated as monstrous and dangerous, what is referred to as the agent of trouble and fear, may also be interpreted as part of one's own subjectivity that the subject is attempting to exclude and displaced from the self: the examples of male patients from the Institute in Stenjevec point to a shared mechanism of projecting introagression onto female fantastical or imaginary subjects, most commonly fairies and witches. This mechanism is evident in fragments of patient narratives or, more precisely, in psychiatric notes. Although this mechanism is part of what Lacan terms the mirror stage, and is the foundational part of constructing the self, it also points to a phenomenon rarely examined in folklore studies, that is the canonization of the primarily *feminine* monstrous in belief legends (and, by extension, in society at large). This feminine monstrous functions both in fictional and nonfictional worlds: it is responsible for all individual and collective misfortunes, but it is also the unavoidable Other, in opposition to which – or rather, in relation to which – the masculine subjectivity is created; the feminine monstrous is the excess in a system which cannot exist without it, because the feminine monstrous enables shifting and sliding of meaning. As Bruce Fink, echoing Lacan, says, "something has to be pushed out in order for the inside to exist" (Fink 2009: 33). Oral tradition obviously includes male monstrous beings as well, yet, in patients' narratives, they are either not mentioned or are completely marginal (recounting what frightened him, only one patient mentions that he is not sure whether it was the devil or witches), whereas the instance of the patient who identifies with the *krsnik* points to the introjection of the monstrous as a way of creating a space of internal power, which nonetheless belongs to a different being and not the "ordinary" human. Whereas the 19th century sees the development of the genre of autobiography of madness in written literature, oral literature, more specifically its genre of the belief legend/memorate, in this case becomes the male autobiography of fear and a way to defend of one's *normalcy* by narrating about the monstrousness

of the *other* and a threat coming from the outside. In this way, belief legends, on the one hand, make it possible to narrate about difficult emotions by means of a collectively shared story (because they arise from a fabulate, which is part of the tradition of the entire micro-community), while, on the other, they enable the narrative organization of chaos and confusion; in other words, they mark, organize and explain a temporal experience, at times providing the possibility of catharsis, or of defending one's right to normalcy, as well as the normalcy of all affective states, especially fear. In this way they become the basis for therapy through conversation, long before Freud articulated the basic principles of psychoanalysis; however, in psychiatric discourse which is primarily the discourse of (hegemonic) masculinity, these "male" affects are sanctioned or unrecognized, and the narratives, with their motifs and tropes, are banished from the space of normalcy.

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KULTURALNI KODOVI STRAHA: ŽANR, ROD, (MUŠKO) LUDILO

U tekstu je fokus na specifičnoj arhivskoj građi prve psihijatrijske institucije, Kraljevskog zemaljskog zavoda za umobolne Stenjevec u Zagrebu, današnje Klinike za psihijatriju Vrapče, iz njezina prvoga razdoblja od otvaranja 1879. do 1900. godine, točnije na naracijama pacijenata u kojima se pojavljuju fantastična bića, odnosno koji se u pripovijedanju o vlastitu životu oslanjaju na žanr predaje. Na temelju te građe, koju autorica prepoznaje kao važan, iako netipičan folkloristički korpus, analizira se i interpretira status i funkcije žanra predaja, to jest memorata, u pripovijedanjima o svakodnevnome životu, osobnim pripovijestima te kodiranju afekata, ponajprije straha, ne samo u usmenoj tradiciji i književnosti nego i u njihovoj društvenoj te psihološkoj dimenziji, ali i u psihijatrijskome diskursu koji takve naracije prepoznaje tek kao simptome ludila, odnosno prevodi ih i kodira kao jezik nenormalnosti i psihopatologije.

Ključne riječi: strah, afekti, predaje, memorati, ludilo, psihijatrijski diskurs, Stenjevec, hegemonijski maskulinitet