



PRODUCING DESIRE

Changing Sexual Discourse in the Ottoman Middle East, 1500–1900

DROR ZE'EVİ

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The Body Sexual

Medicine and Physiognomy

Medicine, its conceptions of the human body, and the sexual script it produced provided the scientific basis for most sex-oriented discourses in Muslim Middle Eastern societies. Its injunctions and prohibitions, believed to originate in scientific knowledge, were subsumed by other discursive arenas, from literature to sacred law, almost intuitively, as part of their basic assumptions about the world.¹ This was true as long as these discourses could maintain a common coherent basis, but the changes brought about by new medical knowledge at the end of the eighteenth and throughout the nineteenth centuries created a rift between this and other arenas in which sexual matters were discussed.

This chapter traces the basic theories and concepts of traditional Ottoman Middle Eastern medicine as they relate to male and female sexuality, to the sexual and asexual body, and to the mechanics of sex. Medical developments throughout the period, culminating in major changes in the nineteenth century, brought about a crisis of discourse. As I hope to demonstrate, the discrepancy between changes in medical knowledge and in other discourses created an unresolved tension in the array of sexual scripts, which resulted in confusion and a sense of foreboding.

MEDICINE'S AUTHORITATIVE VOICE

Medicine's image as a set of cosmologically anchored, almost divine scientific facts gave its texts, specifically those based on the Galenic tradi-

tion, a unique standing in society before the modern period. While other disciplines, such as dream interpretation lore, were believed to be inferior manifestations of the word of God as interpreted by the *ulema*, medicine had become a powerful discourse with an autonomous status. The period's authors recognized this status in their classifications of the sciences.² In some respects, we can even say that medicine's standing rivaled that of religion. God's message was given in many different and contradictory voices. Orthodox *sunna* may have been the officially sanctioned norm in many cases, but Sufi sects of all hues, and other Islamic groups, proposed different, sometimes conflicting interpretations of religion, thus posing a constant challenge to orthodoxy's claim of axiomatic truth. Medicine, in contrast, seemed to the lay public almost unequivocal, despite outside challenges and arguments among physicians about medical methods. Tensions between common medicine and prophetic traditions, which never assumed center stage, were already resolved to a large extent by the fifteenth century.³ Thanks to the efforts of Ibn Qayyim al-Jawziyya, Jalāl al-Dīn al-Suyūṭī, and their contemporaries in the fourteenth and fifteenth centuries, few voices of dissent or doubt disrupted medicine's authoritative voice.⁴ Its message, seemingly unconcerned with relative morality, commanded special authority, almost reverence. When looked at as a sexual script, pre-nineteenth-century medicine became a major voice in the discursive world of educated social groups.

Furthermore, since the dominant medical system throughout most of the period espoused a holistic view that created interdependence among the cosmos, the elements, the soul, the body, and its constituent parts, it was fully compatible with a religious view of the universe and man's place within it. While elements and humors were the prevalent theoretical currency, medical discourse also allocated limited space to divine intervention, through the several souls that animated the body and made it function. Thus it did not appear to counter religious knowledge or to threaten its standing, and over the years a clear *modus vivendi* was established to safeguard the boundaries between manmade science and God's absolute truth.

OTTOMAN MEDICINE AND ITS TRANSFORMATIONS

Throughout the centuries, incremental changes in the Islamicate world, notably by famous physicians such as al-Rāzī, Ibn Sina, and Ibn al-Nafīs, along with many others, largely transformed the basic corpus of ancient

Greek and Roman medical knowledge, changing practical aspects of diagnosis and treatment and making invaluable contributions to the development of medical sciences.⁵ With time, Galen's revised concepts became much more than a medical theory. In the manner of a paradigm in the Kuhnian sense, Galenic medicine had become a set of basic assumptions, ideologies and cosmologies, tools and methods, as well as a set of queries and a specific terminology, all of which created an enclosed medical world.

This is not to say that the theory was unchallenged. In the Ottoman world, curative knowledge was multifaceted and eclectic. Practitioners of medical systems prevalent in the Byzantine world and in Safavid Iran shared the stage with those specializing in Indian and Far Eastern methods. A place of honor was reserved for a set of vague medical ideas based on the Koran and the *ḥadīth* (known in Arabic as *al-ṭibb al-nabawī*, prophetic medicine) alongside popular medical practices performed by Sufis and other mystics believed to be endowed with healing powers. Yet only humoral medicine enjoyed official support and privilege, as well as the endorsement of the intellectual elite. Such popular medical concepts may have held sway in the minds of many people or may have been preferred as methods for treating disease, but intellectually (and therefore textually) they remained on the cultural fringes, vying for right of entry but never quite achieving it. Only physicians proficient in Galenic medicine attended to the sultans' health, practiced their craft in major city hospitals, formed important guilds, and compiled most of the medical treatises.

We know little about the origins of the Ottoman medical tradition. The first Ottoman authors of medical texts were residents of Anatolia who found their way to other cultural centers in the Middle East, such as Cairo and Tabriz, and returned home as physicians. One of the earliest medical texts in Turkish was a pharmaceutical treatise, *Khawāṣṣ al-adwiya*, composed by a little-known author, Murād Ibn Ishāq. A later author, Celaledin Hızır, known as Hacı Paşa (d. 1412), began his religious studies in Egypt, switched to medicine after an illness, and was later appointed head physician in Cairo's hospital (*maristān*). He wrote several books, including an original one on disease and cure (*Shifa al-asqām wa-dawā' al-ālām*) around 1380. In addition to the basic tenets of Galenic medicine, this book contains many observations from the author's own experience, including a detailed study of pneumonia and its symptoms. Later, Hacı Paşa wrote a few books in Turkish, including *Teshilü's-şifa*, an abridged and simplified adaptation of Ibn Sina's *Qānūn*, which be-

came quite popular in the Ottoman Empire and was later translated into German.⁶ Ibn al-Nafis's great work, *Al-mūjiz* (on which more later), was translated into Turkish around the same time as *Ḥall al-shifa*, by Cemalüddin Aksarayî (d. 1388).⁷ These works placed Ottoman medicine squarely in the great ancient Roman-Islamicate tradition and set the stage for this scientific paradigm in following centuries. Even later works, such as Şerefeddin Sabuncuoğlu's famous treatise on surgery, *Cerrāhiyyetü'l-haniyye*, are in fact translations or adaptations of earlier famous works in that tradition.⁸

In Western Europe the paradigm had been gradually eroded in the sixteenth and seventeenth centuries, giving rise to the basic precepts of modern medicine in the eighteenth. But while such transformations occurred in Europe, the Ottoman world felt secure in its knowledge, and the paradigm was not deeply shaken. Humoral medicine remained paramount well into the nineteenth century.

Yet physicians and theorists in the Ottoman world never ceased to discuss, develop, and advance medical theories and empiric studies. True, their forays outside classical humoral medicine were few, short, and far between, but the period's physicians wrote sophisticated experimental tractates based on accumulated experience and knowledge gathered from other medical cultures both within and outside the borders of the Islamic world. Quite a few books of medicine were written in the Middle East from the fifteenth to the nineteenth centuries. They ranged from medical encyclopedias based on Ibn Sina's famous *Qānūn* to special treatises on topics such as eye treatment, surgical operations, contraception, and sexology.

In the sixteenth century new medical knowledge was introduced, mainly in relation to the treatment of New World diseases such as syphilis, but these treatments were integrated with relative ease into the old system. A few decades later, several local physicians were influenced by the Swiss physician Paracelsus's ideas about experimentation in medicine, as well as by his critique of humoral concepts. Paracelsus (1493–1541) opposed humoral medicine and noted hereditary patterns. He also believed that the body was reducible to minerals (sulfur, salt, and mercury) and therefore curable by using chemical-based drugs. Another emphasis of Paracelsian medicine, perhaps more crucial to our investigation, was the study of bodily tissues that connect and separate body parts. At the time this did not amount to much as far as medical praxis was concerned, but it certainly gave physicians a new and challenging theory to debate. One such physician is Sâlih Ibn Naşrallah Ibn Sallūm (d. 1670), a native

of Aleppo who was the head physician (*hekimbaşı*) of the empire at the time of Sultan Mehmet IV (r. 1648–1687).⁹ His treatise *Ghāyat al-Itqān fī Tadbīr Badan al-Insān*, in which he devotes a chapter to the medical ideas of Paracelsus, gained some fame in the empire during the second half of the seventeenth century. A few years later, Ömer Şifai of Bursa (d. 1742), a devout Sufi and one of the greatest physicians of his time, wrote several innovative books. Most notably, he translated some of the writings of Paracelsus and wrote an eight-volume book titled *Jawāhir al-farīd fī al-ṭibb al-jadīd* (Unique Gems of the New Medicine) describing some of the new discoveries of European medicine.¹⁰

The outcome of these scholarly forays appears to have been a rejection of Paracelsian medicine, as is evident from the fact that Ibn Sallum's chapter on Paracelsus was not translated into Turkish and that few others developed the new concepts and practices described in Şifai's books. Further attempts to investigate the Paracelsian approach and other budding European medical ideas, such as translations into Turkish of treatises written by the Dutchman Herman Boerhaave (d. 1738), met with a similar fate. In his book on Ottoman science, Adnan Adıvar suggests that while Galenic medicine was still officially supported and sanctioned, presumably by court officials, there was an awareness of new medical approaches in external medical circles. Later, in the eighteenth century, advances were made in the study of disease, mainly in Vesim Abbas's *Düstūr-ı Vesim fī tibbī'l cedīd ve'l-kadīm*, in which he reached the conclusion that certain diseases were infectious through contact.¹¹ In another field, that of anatomy, Al-'Itāqī's *Tashrīḥ al-abdān*, written around 1632, seems to have been modeled on the work of Andrea Vesalius (1514–1562) and his famous book, *Fabrica*. Indeed, several figures in copies of al-'Itāqī's *Tashrīḥ* seem to have been adapted from Vesalius, and some of the material on human anatomy is clearly the result of new Renaissance knowledge.¹²

But by and large Ottoman medicine remained unconvinced of such new ideas and attached to its Galenic roots. Until well into the nineteenth century, most physicians theorized on this basis.¹³ Perhaps the clearest demonstration of this adherence is the fact that Ibn Sina's *Qānūn* was fully translated into Ottoman Turkish only in the late eighteenth century, albeit with comments and several additions. If early modern European ideas influenced local medical knowledge, it had to do with breaking the holistic view of the body and its parts as a reflection of the cosmos and its elements. One of the possible outcomes of such a change may have been a stronger emphasis on the body, as opposed to the earlier empha-

sis on its constituent parts. Discoveries in anatomy and Paracelsian discussions about the attributes of common tissue and membrane, rather than singular organs such as the lungs, the heart, and the liver, may have assisted in transforming the view of the body from an assembly of organs into an integrated whole.

Real paradigmatic change began to appear only with the upheavals of nineteenth-century reforms, when translations and adaptations of new European knowledge made their way to the core of the medical profession. One of the first books to spark this revolution was Ataullah Şanizade's compendium *Hamse-i şanizade*, a series of five books published in Ottoman Turkish from 1820 onward, incorporating new medical knowledge from Europe. Şanizade (d. 1826) was a brilliant and innovative physician and theorist (as well as musician, astronomer, and historian) who did much to integrate new medical knowledge with the old. His views on medicine encountered much opposition, mainly because of his support for surgery-based study of anatomy. As a result his request to dedicate his chef d'oeuvre to Sultan Mahmud II was denied. In time, however, the compendium came to replace the earlier canonic texts, and was fondly named *kanun-i şanizade* (Şanizade's canon), referring, of course, to the old master's *Qānūn*.¹⁴

Although the compendium formally adhered to the humoral system and other concepts of ancient medicine, it was here that blood circulation was mentioned for the first time as a scientific concept and as part of a different medical theory. Some of the terminology included in this book formed the basis for a new medical profession that was beginning to take shape.¹⁵ At the same time (1827), the first school of medicine was established by Mahmud II in Istanbul, and it was reorganized several years later by a group of Viennese physicians invited to the Ottoman court. In Egypt, Clot Bey, Mehmet Ali's French chief physician, published books similar to those of Şanizade and brought modern medicine to readers of Arabic. Here too, a medical school was founded in 1828 under the tutelage of European physicians, to be followed a few years later by a similar school in Tehran.

In the 1840s, Charles White reported: "The Ottomans have now overcome their prejudices in other matters connected with the therapeutic and pathological sciences. Subjects are now freely furnished to the school of anatomy. . . . Abdullah Efendi proposed, and Tahir Pacha readily directed, that the bodies of all convicts, dying in the bagnio, should be sent to Galata Serai for the purposes of dissection, and this without distinction of creed."¹⁶ By the late nineteenth century, with most medical studies being

undertaken in European languages (mainly French), the transformation, at least in the main centers, seemed to be well advanced.¹⁷

UNDERSTANDING THE BODY

In certain cultures the body is understood to be simply the sum total of all its parts: eyes, hair, heart, limbs, and so on. In others, it is seen as a more complex entity, of which the soul or mind is an essential element. Assuming the existence of a sensual or “desiring soul” (Arabic *al-nafs al-shahwaniyya*, Turkish *nefs-i şehvi*), Islamicate medical tracts written in the Roman-Islamicate tradition assigned sexual attributes and libidinal urges not to a soul divorced from body, but to one that springs from the body’s elemental composition (fire, air, water, and earth) and reflects its humoral balance.¹⁸ Thus the body, by virtue of its composing substances rather than any divinely appointed soul, would have a strong or weak sexual urge, a feminine or masculine, active or passive, penetrating or penetrated type of sexuality.

Such a mode of thinking shuns the role of the body as an autonomous unit that stands apart from the world around it and that is also distinguished from its constituent elements. The body is a relatively minor link in the great chain of being, an integral part of a larger system encompassing the cosmos, its elements, the humors that represent them, human limbs and organs orchestrated by these humors, the blood and semen formed by them, and so on. Originating in this all-inclusive cosmological theory, classical Ottoman medical tracts were concerned with relations among cosmic elements, body parts, and sexual drive. Physical motivating forces of sexual desire, the interrelated operation of sexual organs, and the organic differences between male and female sexualities were manifestations of an all-encompassing nature.

This view also envisioned man and woman as part of a continuum of perfection, leading from the basest creatures to the celestial. Man in this scheme of things was the crowning achievement of terrestrial creatures, whereas woman was regarded as a less-developed version of man, physically and mentally. This perception of the man-woman nexus was manifest, first and foremost, in sexual comparisons. Female sex organs and the mechanical functioning of female sex were believed to be flawed versions of the male.

Describing a similar conception in premodern Europe, Thomas Laqueur defines it as a “one-sex” model and proceeds to prove that men and women were believed to have different versions of the same sexual

organs until well into the eighteenth century. Laqueur was criticized for his claim that this was the only mode of understanding the relationship between men's and women's genitalia in European medical discourse. Cadden and others have shown that alongside this conception there were other, more nuanced ones. It appears that a similar idea of sexual resemblance was also prevalent in Ottoman period medicine. Yet the term *one-sex* is a misnomer that, at least in the Middle Eastern context, obfuscates the main point: women, though of the same sex, were seen as biologically inferior. As will be demonstrated later, in medical treatises women's sexual organs were indeed understood to resemble those of men, but they were also believed to be an inherently flawed version, manifesting, as it were, woman's lower place in the chain of being. Rather than "one-sex," this set of ideas should be defined as the "woman as imperfect man" model, or, for short, the "imperfect-man" model.¹⁹

This model presents itself in descriptions of the operation of sex, in graphic illustrations of the sexual organs, and even in terminology. Terms such as semen (Arabic *mani*, Turkish *meni*), testicles (*khisi*, *khāya*), and semen ducts (*sharāyīn mani*) were used to describe male and female organs and secretions alike. The boundaries between them, as far as biology was concerned, were blurred and could sometimes be traversed, as when, for example, a woman would grow a penislike clitoris and turn into a quasi-man.

Imperfect-man conceptions also meant that if women were almost men, and if sexual organs were liable to change under certain circumstances, then the difference between men and women was one of quantity rather than total opposition. It follows (though it was never actually stated) that sex between men and women may have been conceived of, mentally, in a very different manner than our modern discourse conceives it. In other words, the absence of a distinct two-sex model implied that there was no deep, inherent difference between homo- and heterosexuality. It also followed that having what we would now view as same-sex relations need not be a travesty, at least as far as "nature" was concerned.

Yet there was one difference, it seems, between Western European attitudes and Ottoman Middle Eastern ones. For most Islamicate societies, such sexual transformations from feminine to masculine were to be avoided at all costs. Precisely because corporeal boundaries are so unstable, because the world can so easily slide into anarchy, women (by gender) were to be kept women (by sex) even when such transformations took place. Men were to remain men even if surgery was called for to remove their femaleness. Much of the legal discourse was therefore

devoted to the erection of boundaries and to defining maleness and femaleness in indistinct cases.²⁰

In Western Europe, mainly during the eighteenth century, these perceptions changed radically, and the two-sex model that we are familiar with today became the paramount paradigm. But even when these modern medical practices and theories were introduced to the Middle East a century later and incorporated into medical treatises in Arabic and Ottoman, the texts remained ambiguous, clinging to earlier imperfect-man interpretations. This, as we shall see, created a discrepancy between the medical theory of sex, on the one hand, and the growing discomfort with same-sex relations on the other.

ELEMENTS, HUMORS, AND SEX

Male and female sex, sexual behavior, and the spectrum of sexual attraction and rejection were based primarily on the humoral makeup of each human being. We must therefore begin with a short description of the humoral system as it was understood and practiced in the Ottoman era.

Until the nineteenth century, the basic tenets of traditional medicine as presented in Ibn Sina's compendium were the baseline of medical knowledge. For practical purposes, doctors mostly referred to the Qānūn's famous abridgement and complement, *Kitāb al-Mūjiz*, written by Ibn al-Nafis in the thirteenth century and translated into Ottoman Turkish by the physician Ahi Çelebi in the sixteenth.²¹ The theory still held sway as late as the early nineteenth century in the main medical centers of the Ottoman and Iranian Qajar empires.²² According to the tenets of humoral medicine, human bodies were composed of four elements (*arkān* in Arabic)—earth, water, air, and fire—represented by four humors flowing in the body (*akhlāt, amziya*)—black bile, phlegm, blood, and yellow bile, respectively, to which several human attributes corresponded (see table 1).²³ Over the years physicians improved on the theory and the praxis, often incorporating findings from medical literature in Europe and India, and certainly expanding the rudimentary elemental system to account for the many variations of the human condition. Table 1 demonstrates how wide-reaching and omnipresent assumptions about the humoral balance of the body had become.

Early Hippocratic and Galenic theory assumed the need for a precise balance among the humors (*i'tidāl* in Arabic) to enable the human body to function properly. Whenever this single balance was upset (*khurūj 'an al-i'tidāl*), the person would develop symptoms of illness, and only restor-

TABLE 1. ELEMENTS, HUMORS, AND THEIR ATTRIBUTES

Element	Humor	Attributes	Gender	Age (Masculine)	Social Group	Sexuality (in Males)
Fire	Yellow bile	Hot and dry	Male	Adolescence	Rulers/ soldiers	Sexual
Air	Blood	Hot and humid	N/A	Adulthood	Clerics	Sexual
Earth	Black bile	Cold and dry	N/A	Old age	Peasants	Nonsexual
Water	Phlegm	Cold and humid	Female			Nonsexual

NOTE: In all tables, empty cells indicate that the *şeriat* and *kanun* law did not address the relevant categories.

ing the balance of the elements and the humors could restore complete health. Leeches were used to draw a dangerous excess of blood, and suction cups applied to rid the body of harmful excess air. Innumerable simple and complex drugs were devised to increase the level of a certain element or to decrease that of another.²⁴

Later developments of this paradigm, mainly those elaborated in the Islamicate world, introduced the concept of numerous personality types based on different “normal” equilibriums among humors to account for the many types of personality traits within the normal range. Such was the choleric type, who, with an increased quantity of air-as-blood in the body, would have an easily enraged personality and a volatile sexuality, and the phlegmatic type, who, with a surplus of water-as-phlegm in his veins, would be cool-headed and slightly lethargic even under pressure. Although not equitably balanced, and tilted toward one of the elements, these types were not seen as unfit. One of the physician’s main tasks, according to the tenets of late humoral medicine, was to define the right equilibrium for the specific patient and to restore that particular personal stability, rather than a perfect balance of the humors.

Humoral balance was assumed not only to differ from one individual to another, but also to vary in keeping with a person’s sex, age, class, and ethnicity. A male’s basic disposition—hot and dry—was expected to be different from a female’s; that of Turks to be different from that of Jews or Arabs; and a young woman’s humoral balance to be unlike that of an old one. All these categories are, naturally, very relevant to the understanding of sexuality. It seems that sexual difference was at the base of many such distinctions and characterizations and became one of the mainstays of the division into categories. The difference in humoral balance between

men and women, for example, was developed mainly to account for their different sociosexual outlooks and gender definitions. Differences between old and young were in large part meant to account for variations in sexual prowess. So, apparently, were discussions of ethnic and racial differences.²⁵

Gender, race, age, class, and disposition can all be seen as placed on a single elemental continuum in which the male is always hotter and dryer (or, in other words, contains more fire and air) than the female.²⁶ Heat, being the main motivating force of creation, gave men the advantage. Woman's imperfection was in essence caused by an inferior blend of humors, and that imperfection could be greater or lesser depending on how far removed it was from the perfect male composition.²⁷ Prepubescent boys, like women, were imperfect men, the only difference being that a boy had the potential for change whereas a woman was trapped in her imperfection. Likewise, someone could be nominally an adult male but possess many female attributes, which would place him in a different point on the scale, closer to women. A person's place on the scale also served as indication of his or her sexual prowess, appetite, and fertility. Various ethnic origins were positioned on a similar scale, to be judged and condemned according to their preordained humoral balance. Books were written to explain ethnic character through assumptions about ethnic and racial makeup. These naturally had to do with climatic considerations, so that people originating in Northern Europe, for instance, were believed to have a colder and wetter (therefore feminine) phlegmatic disposition, while desert dwellers in warmer climes were expected to have a choleric or bilious one.

READING THE BODY'S SURFACE

The elements composing the body and its character also had a hand in shaping its external form. Heat, to take just one example, would cause hairiness, as could be observed in the tendency of birds (whose disposition was known to be hot and dry) to grow feathers. Such obvious connections between the constitution of the body and its shape led scholars to two conclusions. The first was that there are ways to learn about one's humoral makeup, and therefore character, from one's outward appearance. The second is actually the opposite: since people belonging to the same ethnic group often have similar features, one must conclude that different races or ethnicities share common humoral balances and therefore common sexual character traits.

These assumptions stood at the base of the science of physiognomy (Arabic *qiyāfa*, Turkish *kiyafet*), or, more popular in the later centuries,

frāsa/fīraṣet, which was regarded as a subdiscipline of medicine. Following Ibn Sina's classification, two Ottoman bibliographic compendia, by Ha-jji Khalifa and Taşköprüzade, describe it as one of medicine's ancillary sciences, alongside disciplines such as chiromancy. It was held in high esteem until the nineteenth century.²⁸ In the classical period, books of physiognomy were used by janissary recruitment crews touring the villages of Anatolia and the Balkans in search of candidates for military service, and by palace officials buying slave girls for the harem. Such books were particularly handy when trying to assess the promise of sexual gratification.

One of physiognomy's basic assumptions was that sexual tendencies, potency, and libidinal appetites were reflected in the features of one's face and body. In the words of the *Kiyafet Name*, a famous Ottoman manual of physiognomy: "Know that it is a way to learn inner states from outer appearances."²⁹ Thus, social operations of differentiation, classification, stigmatization, and even, to some extent, political and social privilege were based on quasi-medical assumptions about people's appearance. *Fīraṣet* manuals provided the buyer of a slave and the man in search of a bride with a detailed guide to sexual potential. Each and every characteristic of a body part formed part of the puzzle. Some indicated sexual prowess, while their opposites demonstrated frigidity or weakness. All these can be located on a chart that describes the sexual and asexual personalities. Table 2 is based on an accumulation of Arabic and Turkish texts of the sixteenth and seventeenth centuries.

These attributes, common to many books in the pre-Ottoman and Ottoman periods, relate masculinity above all to a hot disposition, which means a preponderance of yellow bile and blood. As they age, men lose heat and therefore also sexual power. The highly sexed man is relatively short and heavyset. His head is large in relation to his body, his neck wide, his voice low and sonorous, his body hairy, his arms fleshy, his fingers short and chubby, and his testicles big. The size of the penis does not indicate either sexual prowess or fertility. A disposition tilted toward the cold elements and a physique that is delicate and hairless are signs of femininity in a man. Such a man's head is small in relation to his body, his limbs delicate and hairless, his hips narrow, and his testicles small. In general, feminine attributes such as wide hips or a high-pitched voice indicate a tendency to be effeminate and thus possessed of a woman's sexual tendencies.³⁰

Women tend to have a cold and humid disposition, although it is interesting to note the tension in several manuscripts between the common tendency to ascribe to all women a greater sexual appetite and the attempt to suggest that women with an excess of blood (which makes them,

TABLE 2. SEXUAL AND ASEXUAL CHARACTERISTICS
OF MEN AND WOMEN AS DESCRIBED IN FOUR TEXTS

<i>Organ or Property</i>	Sexual Characteristic		Asexual Characteristic	
	<i>Men</i>	<i>Women</i>	<i>Men</i>	<i>Women</i>
Height	(1) Short (2) Short	(1) Tall		(2) Taller or shorter than average
Weight	Heavyset	Thin		
Voice	(1) Low (+) (2) Low (+)		High-pitched	
Disposition (humoral balance)	(3) <i>Hot</i> Dry = prowess, but little seminal fluid Humid = great genital power	(2) <i>Saftavi</i> (bilious); a woman with a "fire" disposition is sexually active	(3) <i>Cold</i> Dry = little developed prowess Humid = weakness after intercourse	
Head			(2) Small	
Face	(4) Long = shamelessness			
Forehead and brows	(2) Blemishes near forehead			
Eyes and lids	(2) Languid, half closed Blemish (+) (3) Trembling = perverse and desirous (4) Light blue = shamelessness Bilious red = desire	(2) Languid, half closed (3) Twinkling = beauty	(3) Twinkling = effeminate	
Nose	(1) (4) Flat and broad (2) Flat and broad; blemish near nostrils sign of sexuality (+) (3) Curved = lascivious	(1) Flat and broad (2) Flat and broad		

Cheeks	(2) Puffy close to eyes	(2) Puffy = sexual frigidity
Mouth	(4) Wide	(4) Thin = weakness in intercourse
Chin	(2) Blemish = sexual nature	
Beard	Copious beard = sexuality	(2) Lack of beard = sexual incapacity
Neck	(2) Fat (+)	(2) Narrow
Shoulders		(2) Hairless
Arms and hands		
Fingers	(2) Short and fat (+) Big third section of thumb = homosexuals, whores, drunks	(3) Thin = weak character Headline ends at fourth finger (2) Fleshy Venus mound (2) Short and fat (+) Big third section of thumb = homosexuals, whores, drunks
Chest	(1) (4) Hairy (+)	(4) Hairless
Breasts		
Belly and navel	(3) Fat	
Waist	(1) Average sized	(3) Fat (1) Bigger or smaller than average indicates other things (small = knowledge; big = blameworthiness; long = stupidity)
Penis		(1) Small = cowardice (2) Narrow (3) Small and delicate
Testicles	(1) Big = courage and power	
Hips		
Legs and feet		

+ = Clear sign of sexual prowess/desire

NOTE: In all tables, empty cells indicate that the *şeriat* and *kanun* law did not address the relevant categories.

SOURCES: Information in this table was collected from the following books and manuscripts, as indicated by parenthetical numbers:

1 = *Kenzü'l-Havass*

2 = *Gizli İlimler Hazinesi*

3 = *La physiognomonie arabie* (late twelfth to early thirteenth centuries)

4 = *Kıyafet Name*

by default, hotter and therefore closer to men) are sexually more voracious. In the case of women, writers also devote more attention to external, mainly facial, clues to the shape and size of sexual organs. Thus the width of a woman's lips could be a sign of the width of her vagina, and their thickness a sign of the size of the labia. The color of her face and eyes, the shape of her nose, and the size of her thighs indicate a woman's sexual appetites and tendencies. Heavy thighs are an indication of an oversexed woman. A red face and blue eyes (commensurate with colder climes) suggest that the woman is sexually frigid.³¹

This shift of focus in describing the physiognomy of both genders, in which the man's bodily traits are used to indicate his general character while the woman's traits are used mainly to ascertain more about her sexual parts, can be explained by the fact that this literature was written by men for men, and much of it was indeed meant to help men find sexual partners. Authors devote more attention to similar male attributes only when they are intended to be sexual partners, as in the following set of instructions for choosing slaves at the slave market:

If you need a slave to be with you for friendship purposes, someone who will serve you for companionship and love games, he must be a man of medium height, and also medium build. He should not be too fat [*semiz*] or too thin [*zayıf*], nor should his waist be thick. Rather tall than short. His hair should be soft, not stiff, but its color may be black or yellow as you wish. His palms should be round and soft. His skin should be delicate, his bones straight and his lips the color of wine. His hair should be black [?] his eyes hazel colored and his brows and eyelids black, but not connected. He should have a double chin [*çift gerdanlı*]. His chin should be white spotted red like the fuzz on a quince. His teeth should be white and straight and his members of the right proportion. Any slave that matches these descriptions will be gentle, of good temperament, loyal, and docile.³²

Although we know that Mamluks and Ottomans made use of *fraset* wisdom in everyday life, to purchase military slaves and to recruit boys for the *devşirme* palace service as well as to buy slave girls in the market, it is hard to say to what extent such physiognomic descriptions were taken at face value. One can find quite a few descriptions of young, tall, and slender male beauties who do not fit the textbook description of the sexualized male but who are possessed of remarkable sexual skills and power. Yet such physiognomic descriptions persisted throughout the period and had an influence on popular imagination. Under such "scientific" pressure, it is no wonder that men held their beards in such high regard, and did their best to present themselves as heavysset and sturdy.

Being slim-waisted and close-shaven certainly was not *à la mode* for serious men in the Ottoman Middle East.

ERECTION, EJACULATION, EXCESS, AND MODERATION

Another theme recurring in premodern medicine was descriptions of the sexual mechanism and the way it operates. Several basic questions were posed. The first was the reason for intercourse: why do men and women desire to copulate, and what purpose does copulation serve? The answer given by most physicians in the pre-Ottoman and Ottoman periods was that while it was God's will to perpetuate the human race, His vehicle for creating the actual desire for sex was the desiring soul. This force pervades both men and women and drives them to seek sexual intercourse. It should be noted that from the medical point of view, and in line with the one-sex paradigm, there is no differentiation between the sexual drives of men and women, and there is certainly no assumption that women cannot or do not enjoy intercourse as much as men do.

One bodily reason for desiring intercourse was the need to discharge accumulated semen, conceived of as refined and "whitewashed" blood that the body manufactures constantly in order to reproduce. As Basim Musallam has shown, in antiquity there were two opposing theories. One (Aristotle) held that only males had semen, and the other (Hippocrates and Galen) that both sexes produced it. Ibn Sina, though siding with Aristotle on most matters, conceded that women also had semen, but that this semen was soulless and therefore inferior to male semen, serving mainly as "matter" to be shaped and formed by male semen. The final claims for the equal nature of male and female semen and the insistence that female semen was also soul-containing come from the writings of Ibn Qayyim al-Jawzīyya in the fifteenth century, taking his cue from Islamic prophetic traditions and jurisprudence.³³ In the Ottoman period this became a basic tenet of sexual discourse.

Since women were believed to produce an analogous kind of semen in their bodies, albeit of lesser quality, the need to dispel the substance affected men and women alike, strengthening the resemblance between the sexes. As we shall see, even when the guiding principles of medicine began to change in the nineteenth century, the idea of a desiring soul remained prevalent in Middle Eastern medical circles and lodged itself in medical texts adapted from Western Europe.

Early authors of medical texts were aware of the need to awaken the desiring soul and to produce desire as a precondition for successful in-

tercourse. Foreplay is discussed often and takes into consideration the needs of both partners to the sexual act. But authors often go beyond simple discussion of foreplay and suggest other measures. Reading stories that instill lust; watching others, including animals, perform intercourse; and bathing or even shaving one another are some of the measures proposed in several texts.

A second set of discussions questioned the relationship between abstinence and sexual urge. Young people were said to be like waterskins. Their seminal fluids were believed to accumulate in the testicles or ovaries with no outlet. When too much semen collected, body heat rose and intercourse was sought. "If one abandons intercourse [*cimat terk ise*]," says Eşref bin Muhammed, an early Ottoman physician, in his book *Hazā'inü's-sā'ādāt*, "little by little pains begin. In a kind of escalating motion, the body begins to fail. Eyesight might weaken; tumors might form in the testicles or in the ureter." Kemal Paşa Zade (also known as Ibn Kamāl Pasha), a famous physician who was also a statesman, *‘ālim*, and author, writing in Arabic, gives a rather more sophisticated and detailed description of the process. His explanation, perhaps translated from an earlier Arabic manuscript, is based on humoral imbalance caused by incomplete transfer of essence from other organs to the testicles and the penis. According to Kemal Paşa Zade, disease and health in connection with intercourse are always a function of particular humoral balance. Thus, people who are hot and wet (with an excess of blood and white bile) may indulge in intercourse as much as they please, while those with cold and dry dispositions are liable to be harmed by an excess of intercourse.³⁴

A person who wishes to avoid these illnesses must have regular intercourse in adulthood, and in certain cases, in the absence of intercourse, masturbation should be used.³⁵ The only exceptions to this medical recommendation are sworn celibates, such as nuns, monks, and certain Sufis, who never indulge in intercourse, thus conditioning their bodies to maintain a low level of semen production, and old people whose semen production declines and whose bodies find other outlets for it.

Yet abstinence is not the only dangerous habit that lurks in the world of sex. The result of overindulgence in intercourse may be similar or worse. Overworking the semen-producing mechanism endangers health in a different way, producing even more perilous results: "Strength decreases, the light of the eyes becomes weaker, the nerves/sinews become powerless, the heart weakens, and phenomena such as trembling, shivering, spasms, paralysis, forgetfulness, bad habits, heaviness of the mind, insolence, or cowardice occur, each one of them a serious problem. Those

who practice too much intercourse will encounter these problems one by one, so it is necessary to protect the body.”³⁶ Thus, one of the first sexual lessons a fifteenth- or sixteenth-century intellectual reading medical texts, or a patient listening to his doctor’s advice, may have learned is the ancient rule of moderation and temperance, harking back to Greek antiquity. One must not abstain from sexual activity because lack of intercourse may lead to disease. Indeed, one should seek and encourage it in order to stay healthy, but care should be taken to avoid excess and loss of vital heat lest the same consequences, or even worse, occur.

Since periodic discharge of all semen is crucial to keeping one’s health, partial evacuation can also cause trouble and bring about ailments. Incomplete discharge occurs when the male fails to rid himself of all the semen held in the testicles or, to be more precise, when his partner fails to extract it all. Only a young, healthy woman’s womb has the power to absorb every drop of semen, drawing it out, as it were, from the testicles. Al-‘Itāqī describes the way in which a woman’s uterus attracts semen: “During intercourse, the uterus comes nearer the mouth of the vulva and naturally, the passage of the uterus descends to the level of the mouth of the vulva to attract semen. It becomes as narrow as a canal through which not even a single hair can enter so that it can attract semen and protect the fetus.”³⁷

Any sexual partner who cannot perform this complex task is therefore inadequate. Thus, having intercourse with old, weak, or ugly women may be dangerous for men, presumably because their powers of suction are diminished. This is also true of sex with women who are menstruating, those who have just recovered from illness, and those deprived of sex for a long time. Sex with minors, young boys in particular, may have similar dire consequences.³⁸ Although it was assumed that women too need to evacuate accumulated semen, their predicament is seldom mentioned. Some believed that the menstrual cycle was the mechanism by which they accomplished this.³⁹

The dangers of excess intercourse, abstinence, and partial evacuation had a bearing not only on the choice of sexual partner but also on positions during intercourse. This aspect of medical discourse seems to have benefited from, or at least engaged with, Indian medical discourse, alongside the more conservative Galenic teachings. In order to attain complete discharge, the preference was for positions in which the woman serves as a vessel for the semen to be poured or drawn into. Doctors recommended the missionary position. Having intercourse lying on one’s side was not recommended because in this position it is harder for the man to unbur-

den himself. Nothing was worse, it seems, than for the woman to be on top. Here another danger compounded the one of nonevacuation. The woman's liquids, including her semen, were liable to penetrate the man's penis and cause disease: "It is also claimed that being underneath means that the man is weak [*erün aşığı yani zayıf olur*]. [The position in which] the man is on his back and the woman gets on top of him may cause many kinds of damage. It is claimed that the woman's water might enter the man's penis. If this happens the man's semen does not vacate completely, and many kinds of ailments await him. But this intercourse in which the woman is on top is considered safer for a pregnant woman."⁴⁰

Medical tracts reiterate and reproduce some common views about the nature of intercourse and mainly those that place the male partner "on top," in a position of power in relation to the sexual partner. Yet while these suggestions may have had their roots in common thought, it was more than just cultural preference couched in medical terminology. It is interesting to note that at this early stage, before syphilis was recognized and diagnosed, there is hardly any mention of the danger of contracting disease by infection during intercourse. These attempts to restrict positions and the warning against contamination by the woman's fluids are perhaps an early indication of awareness of such dangers.⁴¹

Being faced with so many dangers in intercourse, men may opt for masturbation as a safer sexual practice and as a solution to the problem of discharge, but medical treatises warn against too frequent relief through such practices. Masturbation (*zeker tutmak, ele oynamak*), they claimed, may cause anxiety, make one forgetful, weaken the penis, and blunt the mind. Furthermore, it destroys the natural propensity for intercourse:

It is like a person who, by being greedy, takes out his money and buys any food that appears before his eyes, even when it is not tasty, then leaves it and tries another. Having bought it, he leaves it with regret because his greed forces him to. Until one day, his purse is empty. When he is hungry he sees many good foods, but when he comes to take the first, there is nothing in his purse. This time he unfortunately stays hungry. He cannot fill up the greed in his eyes. Having spent his property, nothing is left in his purse of strength. Because when the load of weakness falls on a person, no one can save him at any time. The road is long. It is necessary not to waste the provisions of power, and God knows best.⁴²

This discourse, widespread in Arab and Turkish-speaking areas of the Ottoman world, offered a sexual script that went hand in hand with orthodox sexual taboos, such as having sex during menstruation or having sex with minors or boys, and gave them scientific sanction. In some

cases, the script limited the choice even further, to young healthy women, stigmatizing all other sexual choices as unhealthy and even dangerous from a medical point of view. In this respect, medicine is an orthodox discourse. Yet by accepting and promoting the imperfect-man model, it was also compatible to a large extent with other sexual scripts, in which homoeroticism and same-sex relations were more common.

The message driven home was not one of sin or shame, nor was it an attempt to instill a new puritan sexuality. It was a call for moderation and continence. As in Galen's Rome, sexual energy is described here as a resource that men have in limited quantity and, if squandered, may lead to impotence and disease.⁴³ Although not couched in the same terms, the Hippocratic idea of *calor genitalis*, or vital heat that preserves the virility of the male body, still dominated local medical thinking and the sexual script that it heralded. It was far more important to preserve the body's supplies of sexual energy and not squander them than to pick a sexual partner of the right sex.

The critical change introduced by early Christianity, the attempt to reshape the body, to teach it to behave differently, to "prize it from the physical world,"⁴⁴ and to deny the reverence owed to the vital sexual heat, did not take place in the medical script of the pre-Ottoman and Ottoman Islamic world. Here, sexuality still adhered to the same ancient values espoused by the Hippocratic writer.⁴⁵ In this respect, the changes wrought by the nineteenth century, as we shall see later, were much more revolutionary in Ottoman than in European culture. Whereas Europe's Victorian tendencies had some roots in the Christian early rejection of the physical body, in the Ottoman Middle East no such rejection of the body and its sexuality was manifest.

GENETICS, SEMEN, CONCEPTION, AND DEVIATION

Similarity between men and women was not limited to sexual urges and needs. Both sexes were believed to have analogous powers of procreation. This was made clear in discussions of semen production, fetus formation, and the resemblance of a child to its parents. While earlier Islamic medical discourse, based on Socratic ideas of (male) form and (female) matter assumed an imbalance between the types of semen produced by each of the sexes, now physicians seem to have agreed that both men and women produced semen with productive potential, and therefore both took part in conceiving the fetus, fighting to bequeath to the newborn their gender characteristics.

In describing the production of semen, the metaphor most often used in medical tracts was not a machine or the natural world, but rather the stove and the process of food preparation. As the desiring soul overtakes a person, in other words, when men and women feel lustful, the body becomes a kitchen in which the seminal essence is produced. The body works in perfect concert. The heart becomes a bellows, the testicles an oven, the ovaries cooking pots, and the kidneys grinding machines. A new human is being prepared. Eşref bin Muḥammed encapsulates the process:

When the heart's movements pick up [*katırak etmeğe başlar*] the nerves heat up, the kidneys are working as if grinding, and the brain extracts a substance. At a certain point in time, as a result of this motion, each member of the male and female body produces a drop of blood [*kan*]. All the blood that assembles from the top of the head to the toes of the foot collects in the groin [*bel*]. From the testicles two veins [*sınır*] emerge. It is there that the blood collects. In the course of this motion the tips of the nerves wash the blood white. Next the male member is pulled, drawn, thrown out by the heart's movement.⁴⁶

Kemal Paşa Zade offers a similar description. In his version, however, the collected semen is not just an essence of the body parts, but also of the qualities represented by them. The heart provides the animal spirit (*al-quwwa al-ḥayawānīya*), which enables sensation and movement, and the brain produces encapsulated forms of the senses themselves and the power of movement. All these collect at the back of the brain and flow down from it, through the hollow of the spine to the kidneys and the testicles. Kemal Paşa Zade also develops the idea of a wind, or *pneuma*, an ethereal and powerful airlike substance that originates in the heart and allows the penis to inflate. This, he says, is the reason for the immense pleasure of intercourse. Since it connects all the organs to the penis, the *pneuma* causes heating and inflammation, and the body is filled with it to bring animal-like satisfaction.⁴⁷

Myriad mini-drops representing limbs, organs, and attributes combine to create a DNA-like substance that reproduces the form and spirit of the creating body. This conflation of semen with blood, which may have found further proof in descriptions of embryology in the Koran, had a bearing on sexual morality that went beyond mere transubstantiation.⁴⁸ Blood, semen, and milk were seen as different representations of the same basic substance cooked and concentrated in different ways. Al-Itāqī, the seventeenth-century author of *Tashriḥ al-abdān*, a book on human anatomy, describes it as follows: "One section [of the menstrual blood] can be improved by nature. This section has three parts; one nour-

ishes the fetus; another becomes fleshy and fatty to fill the spaces in the fetus, and the third part goes to the breasts to produce milk.”⁴⁹

Blood, semen, and milk, therefore, had sexual and reproductive connotations. Breastfeeding was seen as an act akin to intercourse in that it endows the baby with the attributes of its mother or wet nurse. Hence the emphasis placed in *sharīʿa* law on the status of children who were breast-fed by the same woman as blood relatives (*maḥram*) of her biological children. Blood oaths and other acts involving touching or licking blood were also believed to be ways of partaking, albeit in diminished form, of the blood source’s attributes, in a quasi-sexual manner.

When intercourse takes place, medical texts went on to say, male combines with female semen to produce a fetus that resembles its parents. This resemblance, as well as the sex of the fetus, depends on the level of intrinsic vitality in each of the two portions of combined semen. The level is not simply a reflection of the person’s basic vital power. It also depends, to a large degree, on the pace of intercourse and on the physical and mental state of each of the partners while having sex. When, for instance, there is real passion between a man and a woman during intercourse (and, some say, when they climax together), vital heat increases and the result is bound to be a healthy boy.⁵⁰

Local medical tracts from the sixteenth to the nineteenth centuries insisted on the woman’s contribution to procreation even in the face of contending theories, such as monogenesis, favored in Western Europe for some time in the early modern period. When new medical knowledge in the seventeenth century “proved” that male testicles were the only organs capable of producing semen, al-ʿItāqī mentioned this theory but made it clear to his readers that he did not accept its premises, by prefacing the discussion with “physicians also claim” and ending it with “only God knows the truth.”⁵¹

Although men and women were believed to possess equal powers of procreation, a female child was still regarded as a deficient version of the male. The birth of a girl may result from incomplete or unsatisfying intercourse. In pre-Ottoman medical tracts, known and utilized in the empire, it was claimed that female sex, or even feminine characteristics in a man, are a sign of dominant female and weaker male semen. In the contest between male and female semen, the more powerful one transforms the weaker and dominates it, or, as al-Rāzī explains, “Femininity or masculinity occurs only in accordance with the prevalence of one of the two semens over the other in quantity and quality, until one of them becomes the one that transforms (*muḥīl*) and the other the one that is

transformed (*mustahīl*).”⁵² In some cases, when neither the male nor the female semen is clearly prevalent, all kinds of intermediate stages are likely to occur. These range from the masculine female to the effeminate male, with hermaphrodites being an extreme case, a pure equilibrium between the father and the mother.⁵³

As al-Rāzi develops this idea of a competition between male and female semen, he concludes that *ubnah* (passive male “homosexuality”) is a result of the same contest. At times the outcome is such that the man, though having clear visible male traits, is prone to be a *ma’būn*, a male who prefers to be penetrated by another male. In most such cases, he says, the male in question is not a “perfect” male in that his penis and testicles tend to be smaller and closer to the groin than average male organs. As a result, the erogenous zones of such a male would be much closer to the anus than for other males. It may be gathered from al-Rāzi’s writings on the subject that the other type of same-sex behavior, what is sometimes described as “active male homosexuality” (but actually refers to men who prefer to penetrate other males), was not considered a medical problem of any kind. Cast in al-Rāzi’s terminology, the problem was mainly one of erogenous zones and vital power, not an issue of same-sex intercourse, which he ignores altogether.

In al-Rāzi’s world, *ubnah* is clearly a biological defect, not a deviation or a sin. It is genetic rather than psychological or cultural, and people in such a predicament should be treated to heal the disease as far as possible. Yet as Rosenthal points out, al-Rāzi’s choice of title for the treatise, “the hidden illness,” indicates that this type of homosexual behavior was frowned on and considered shameful in the Abbasid period. The treatment he recommends for *ubnah*, in line with Galenic concepts of humoral effect, consists of heating the penis and cooling the anus, or, in more precise terms, warming up the area of the penis and testicles, rubbing ointments on them, and bathing the genitals, preferably by maids and slaves trained as surrogate sexual partners. At the same time the patient’s lower back and anus should be cooled down by placing wet rags on his backside, enemas of rose water and vinegar, and encouraging him to practice “active” intercourse.⁵⁴

Several authors, including Ibn Sina and Ibn Hubal, contested al-Rāzi’s views. They pointed out that some persons affected by *ubnah* may be physically better endowed than other males. Their disease cannot, therefore, be genetic and cannot be caused by weaker male semen. They concluded that *ubnah* is a cultural disease, or one spurred by the imagination. These are people who have accustomed themselves to nonvirtuous ways and to

feminine behavior.⁵⁵ Instead of receiving medical attention, they should be punished for their sinful behavior and made to see the error of their ways. Here, again, the emphasis is on the “passive” form of intercourse, not on homosexuality in general. What the two approaches had in common was the understanding that *ubnah* was bad and that whether caused genetically or psychologically, it should be made to go away.

A century or two later, medical texts did little to determine which of the two outlooks was correct. In fact, most texts of the pre-Ottoman and Ottoman periods do not deal with this issue at all. Although sixteenth- and seventeenth-century medical tracts do not shy away from discussing same-sex intercourse, *ubnah* is not part of the discussion in any way. We may offer two contradictory explanations for this fact. One is that this subject was so shameful that physicians preferred not to deal with it at all. Another explanation, perhaps more plausible, is that contemporary physicians had a hard time putting their finger on the problem. “Passive” male intercourse was seen as weakness, perhaps, but not as a disease that needed treatment or punishment. It is difficult to argue from silence, but taking into consideration other discourses, such as dream interpretation and erotic literature, it seems that the early Ottoman attitude to male “passive” intercourse was one of indifference. This was some people’s preference, it was part of the spectrum of normal sexual behavior, and it was not to be considered deviant in any way.⁵⁶

PERSISTENCE OF THE IMPERFECT-MAN MODEL

Premodern medicine in the Middle East, like its European counterpart, adhered to the imperfect-man model. Rather than a dichotomy, in this discourse men and women inhabited a sexual continuum. If anything, Middle Eastern medical tradition was more adamant on this subject and more resistant to opposing ideas. This manifested itself in the assumption that both men and women create semen, in the idea that both sexes have similar sexual prowess and appetite, in the claim that procreation was in effect a collision between male and female semen that formed the fetus, and in the assumption that the female vagina and uterus were an undeveloped version of the male penis and scrotum (see figures 1 and 2). Al-‘Itāqī, in the seventeenth century, basing his discussion on Vesalius’s sixteenth-century book, describes this last assumption in no uncertain terms:

The Uterus is the organ which produces the baby. Its shape is like the penis and the testis of a man. But the penis has grown outwards and is complete.

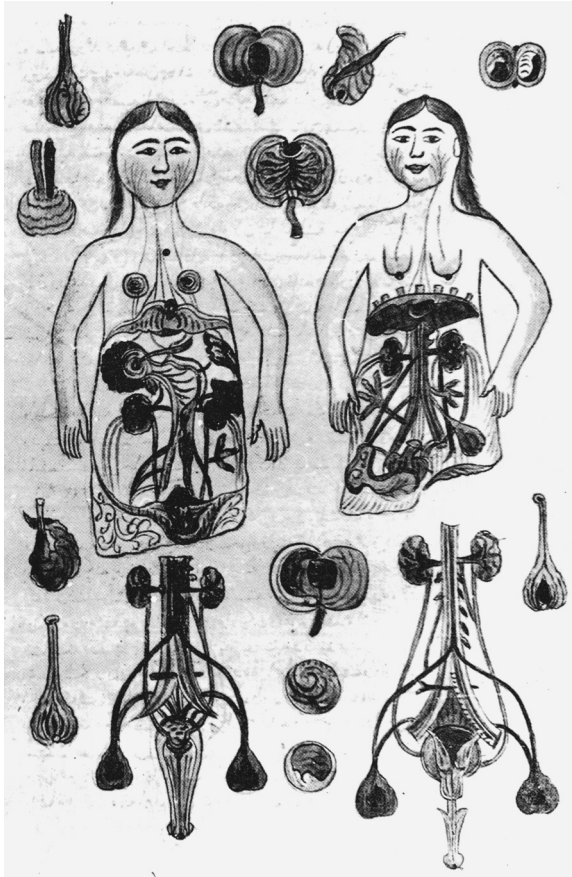


Figure 1. Urogenital system in the female, probably adapted by the author from Vesalius. This is perhaps meant as a male (*left*) and female (*right*) description. Note the penislike urethra and vulva and the androgynous form of the figures. Shams al-Dīn al-ʿItāqī, *The Treatise on Anatomy of Human Body and Interpretation of Philosophers (Tashrīḥ al-abdān)*, p. 166.

The uterus is incomplete. It is inside the woman. However its shape is nearly the same as that of the penis. Some physicians say that it resembles a frozen penis. Its neck is like a penis. For this reason, the penis is a mold of the uterus and the uterus is like a tunic of the penis. The female testis is like the male testis, but the male testis is larger and round; it is slightly ellipsoid, and is placed outside. The female testis is smaller and slightly oval; it is placed on both sides of the vulva.⁵⁷



Figure 3. Operation to remove penislike clitoris. Şerefeddin Sabuncuoğlu, *Cerrāhiyyetü'l-haniyye*, Bibliothèque Nationale de France.

There is a part of the female vulva that is called *tılak* (clitoris) in Turkish. In some women it is so big that it may be ugly to look at [*şöyle büyük kim nazarda kabih olur*] and in some women it is as big as the male member and they have intercourse like men. In Arab lands [*diyar-ı Arabda*] they cut it. The way to do it is to hold the redundant part that should be cut in your hand, or to hold it with an implement, and to pull it upwards, but do not cut off the skin so as not to create a blood flow [*ta'kim kan boşanmaya*]. Afterwards treat it for infection. As for the redundant flesh [*lahm-ı zayid ya'ni artuk et*] that grows inside the womb and is attached inside the womb, perhaps like the tail of a beast [*canavar kuyruğu gibi*] and protrudes out of the womb, and that is why the ancient doctors called it *maraz-i zenebi*; its treatment is also cutting.

Such examples of graphic description are relatively rare in late premodern Middle Eastern medical tracts. But the fear of indeterminate sexuality, the danger of moving from one sex to the other (particularly from female to male), persisted even as these ideas changed in European med-

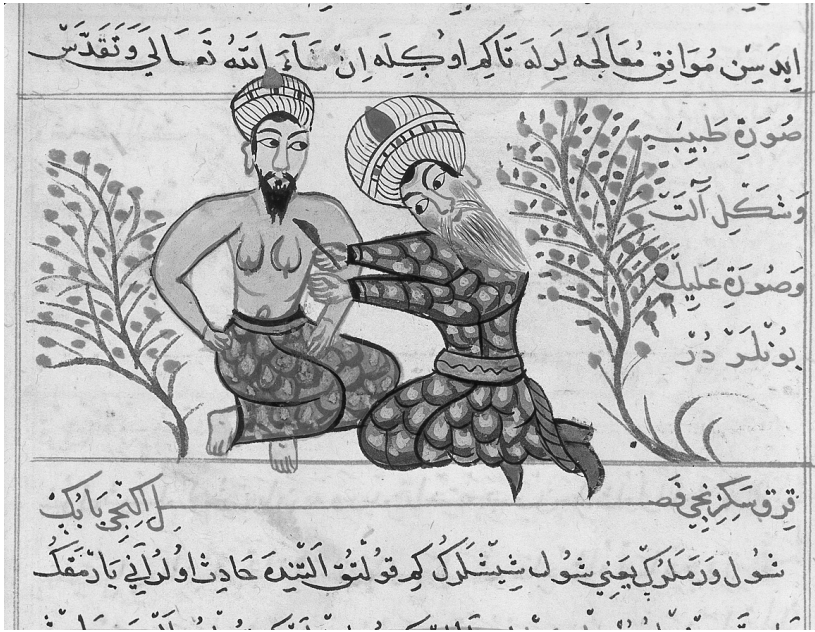


Figure 4. Operation to remove womanlike breasts. Sabuncuoğlu, *Cerrāhiyyetü'l-haniyye*, Bibliothèque Nationale de France.

icine. When the first European-style medical tracts were written in Istanbul and Cairo, authors were acquainted mainly with eighteenth-century medical work and even older tractates. Such old-style work is often quoted, translated, or mined for illustrations. Thus, in Şanizade's *Hamse*, first published in 1826, both drawings and their interpretations hang on to the imagery typical of the older paradigm, in which female sexual organs were drawn and described as similar to males'. Figures 5 and 6 are a set of drawings from the *Hamse*.

In his descriptions of female reproductive organs, the ambiguous transfer of new medical knowledge is even more pronounced. "The testicles of women are called *mahzanateyin* [ovaries, 'bird's nests']," explains Şanizade. And he goes on: "The tendons tying these ovaries to the uterus [he sometimes uses the term *mecari fālubiye*, fallopian tubes]⁶⁰ are said by surgeons to be the female version of males' semen conduits." Speaking of the recent discovery that eggs are produced in the ovaries, Şanizade's description becomes even vaguer. He loosely describes vessels

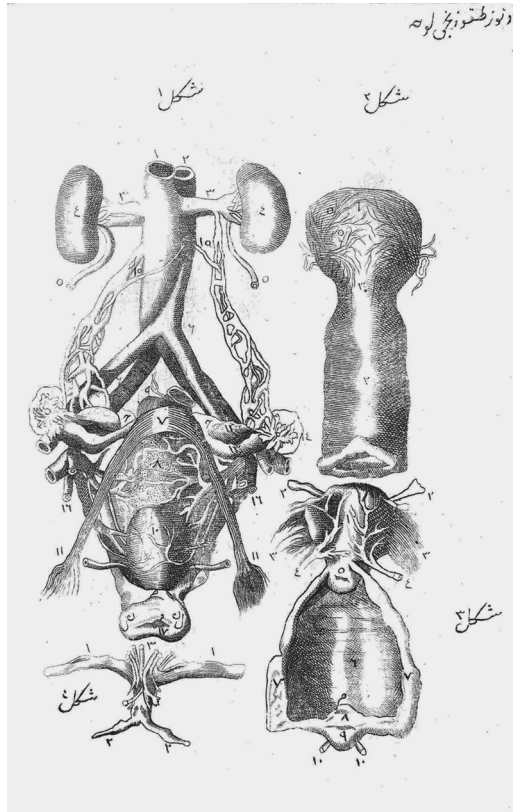


Figure 5. The vagina and uterus (upper right) depicted as malelike penis and scrotum. Mehmet Ataullah Şanizade, *Hamse-i şanizade*, book 1, p. 39, drawing 39.

intended to collect and dispense the “cooked food essence”⁶¹ by means of certain eggs, thus incorporating the newly discovered female egg into the old medical discourse. “These eggs,” he continues, “are also said to be means of reproduction.”⁶²

This sense of ambiguity may also explain the almost total disappearance of older descriptions of the reproductive mechanism. All those descriptions, produced and reproduced endlessly by premodern physicians, about the production of semen, the role of the internal *pneuma*, the mixing of male and female semen, and the dangers and benefits of coitus, had to be discarded in the face of new empirical evidence. Yet, for a long time the new two-sex model failed to register. The belief that men and

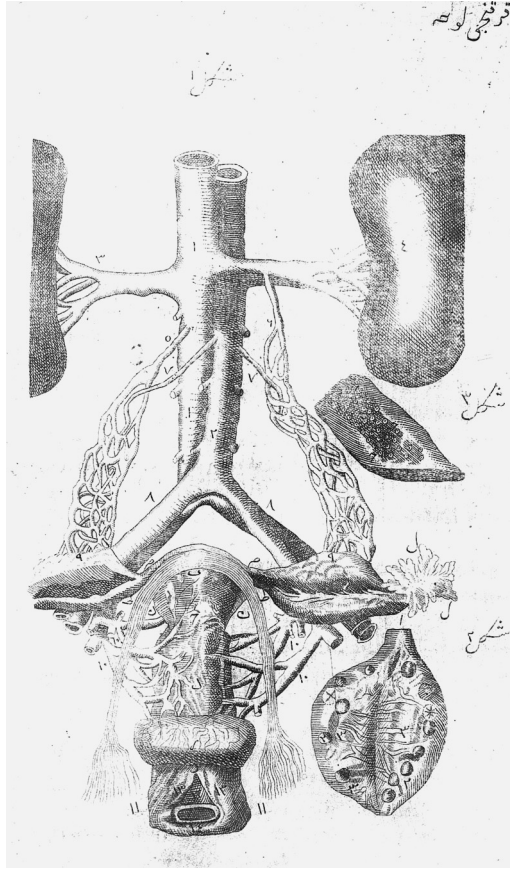


Figure 6. The vagina and ovaries. Şanzade, *Hamse-i şanzade*, book 1, p. 39, drawing 40.

women were of the same sex was retained, but the medical underpinnings and logic of the imperfect-man model slowly dissipated.

FEAR OF THE SEXUAL

As the nineteenth century unfolded, the focus changed. Humoral balance was no longer mentioned, and the terminology of the old paradigm—ancient terms such as *the desiring soul*, *elements*, *humors*, *pneuma*, *chyle*—gradually disappeared. These terms were replaced by a description of anatomy based mainly on French, German, and Italian pathological surveys, and by literature on diseases, symptoms, and cures.⁶³

These new texts seem much closer to what we recognize as modern medicine, although in many cases they contain remnants of the “old” medicine interspersed with the new. In this radical change of discourse, the work of Clot Bey, Muhammad Ali’s French chief physician in Egypt, was probably critical.⁶⁴

With a new emphasis on hygiene and disease symptoms, with chapters devoted to nascent psychological discourse and an emphasis on children’s health and disease, the new outlook should have been concerned with sexuality, but one looks in vain for a new perspective on sexual matters in nineteenth-century medical tracts. New books on medicine seem to deny the existence of a sexual drive and ignore the possible implications of sexual intercourse. This denial of sex is felt more acutely precisely because the older books discuss sex and sexuality so openly and unreservedly. It is as if sex vanished altogether from medical discourse.

There are several reasons for this denial. Around this time—the end of the eighteenth century—Western medicine developed a careful morality that required distance from (mainly female) patients and had pronounced reservations about bodily contact.⁶⁵ In European clinics and medical literature, sex was discussed gingerly, using codes and euphemisms. In translation this oblique terminology may have been completely lost, leaving Arabic and Turkish texts silent on the matter.

But this silence was also based on internal developments. As we have seen, in the course of the nineteenth century Ottoman medical discourse did not relinquish the imperfect-man model, and it continued to uphold its basic assumptions about sex and sexuality. Thus a discrepancy emerged between the contents of new medical texts and the underlying assumptions of older ones. The sexual act could no longer be explained in the ancient manner, by recourse to a desiring soul, to the accumulation of semen in the male and female body, to the need for humoral balance, and to all the scientific baggage that such explanations entailed. The kitchen metaphor was replaced by a mechanical one; the decrepit humoral theory was exchanged for a more sophisticated outlook involving newly discovered cells and tissues. But since the new ideas as yet carried no conviction, the mechanism they offered instead was rejected.

We may contemplate another possible reason. In Europe the two-sex model evolved gradually, and its basis was not necessarily, or even primarily, in medicine. Its roots, as Laqueur shows, were to be found in political and social changes that preceded medicine, were in constant dialogue with it, and gave the new paradigm its main impetus. They emerged from the struggle over public space and the place that women

should occupy in it. Those arguing for giving women a right to full participation in politics and public life were required to move away from the one-sex paradigm and to seek another way of arguing for the rights of women. Describing them as a totally different sex, rather than a flawed version of the same sex, was one way to build a case for complementarity. Such discussions, from Jean-Jacques Rousseau to Mary Wollstonecraft, set the background against which the new medical discourse emerged and anchored itself. In the Middle East no such change took place prior to the modern period, and thus one further anchor for the new two-sex model was absent.

Furthermore, throughout the centuries, the antiquated imperfect-man model gradually came to a symbiosis with Islamic orthodoxy and koranic teachings about the body, about the relationship between men and women, and about social space as these were interpreted by the *ulema* in the Ottoman era. We can even assume that Islamic orthodoxy's sexual script was shaped, to some extent at least, by Galenic concepts of the body. The new paradigm, however, was more difficult to align with what, by the nineteenth century, had become an ossified and entrenched religious view. It was much more difficult to argue for the inferior place of women in society when they were no longer regarded as incomplete variations of men. If men and women were to be understood as parallel but unconnected creatures, religion's entire cosmological scheme would collapse.

The result was in the first instance an inability to accept and internalize the new model. Within the pages of new books of medicine, the old paradigm still held sway. Later in the nineteenth century, when the overwhelming pressure of evidence forced physicians in the Middle East to succumb and truly incorporate the new message, a growing discrepancy emerged between the discourse of medicine and other cultural and political spheres. While society at large continued to adhere to the old values, continued to see men and women as part of one continuum, and resisted women's entry into the public sphere in the tacit understanding that they were biologically inferior to men, medicine taught a different lesson. A basic premise had been removed from the discursive world of sex. As we shall see in later chapters, the process of adaptation and alignment of other sexual scripts was also long and arduous.