

Chapter Six

Challenging the Science of Woman: *Rethinking Nymphomania*

“(F)ancy the reflected picture promulgating the doctrine that most of the unmanageable maladies of men were to be traced to some morbid change in their genitals, founding societies for the discussion of them and hospitals for the cure of them... if too we saw in this magical mirror ignorant boys being castrated almost impromptu, hundreds of emasculated beings moping about and bemoaning their doltish credulity, showers of cases, ready for cutting... Should we not, to our shame, see ourselves as others see us?” Thomas Spencer Wells, ‘Castration in mental and nervous disease’, 1886.¹

For most of the nineteenth century, nymphomania was considered to be a gynaecological condition and treated accordingly. Any disorder of the reproductive system or sexual organs, however remote, could and did account for why a woman’s erotic desire was excessive and thus pathological. Erotic desire was organically conceived, which meant all the signs of nymphomania were believed to have an underlying physical cause. As the previous chapter outlined, such thinking provided the logic for certain radical and invasive surgical therapeutics. In the minds of some, isolating a woman’s erotic disorder to specific organs justified, a belief in their ability to effectively cure a woman of her unruly sexual desire by excising its source. This chapter argues the increasing rejection of much gynaecological surgery led to some important changes in the conception of, and approach to, a number of women’s afflictions including nymphomania.

From the late 1870s, calls for a more conservative approach to treating women’s afflictions dominated a great deal of medical discussion. Debate arose over the issue of

¹ Thomas Spencer Wells, ‘Castration in Mental and Nervous Diseases: A Symposium’; *American Journal of The Medical Sciences* 92 (1886): 455-471; p.470.

gynaecological surgery, especially in the treatment of those disorders increasingly described as mental or nervous. The reaction against the use of surgical therapeutics in such cases was multilayered. With gynaecology's increasing shift toward surgery, many of the issues expressed by the wider medical community were caught up in the ongoing resistance to such medical specialisation, as well as a concern with policing surgical boundaries. Yet, as this chapter shows, much of the criticism directed towards gynaecological surgery also reveals a real questioning of the gynaecological conception of certain disorders. Many believed the primary causality accorded women's sexual organs was woefully inadequate in a number of instances, and could not necessarily be supported by post-mortem evidence. Even when structural change or disease was found, physicians increasingly questioned to what extent this could be considered the primary cause of certain afflictions and justify surgical intervention. Such uncertainties, coupled with an increasing legitimacy accorded the idea of functional disorders, saw the return of the neuroses in British gynaecological thinking. One obstetric physician, William Smoult Playfair, played a particularly important role in these shifts, and this chapter traces the influence his ideas and criticisms had on the gynaecological approach to women's nervous disorders. By the close of the nineteenth century, the science of woman was undergoing many changes which were ultimately instrumental to the future conception of nymphomania, and its status as an independent disorder.

The surgical backlash

By the later nineteenth century, the issue of gynaecological surgery, including who should perform it and for what reasons, dominated discussion amongst various medical bodies and the medical press. Much of the objection to it from those in the general surgical domain stemmed from professional rivalry, especially the encroachment of obstetric practitioners into the hallowed and fiercely guarded territory of abdominal

surgery. Former president of the Royal College of Surgeons Thomas Spencer Wells, who had established his own credentials through his success with ovariectomy, was especially vocal in his criticism of any gynaecological surgery except that performed by a qualified surgeon. In a number of public lectures and journal contributions, Wells argued that gynaecology was a branch of general medicine, not surgery, and obstetric physicians were not capable of performing abdominal surgery.² He described the “wide difference” between “one man acting and ruling as a specialist, and a miscellaneous lot of men grouping themselves together and each pushing to the front as a society of specialists.” “But” he added, “herein is the danger with groups of gynaecologists.”³ He derided many gynaecological practitioners as inexperienced, and who, “exasperated by their fallibility”, yielded to the surgical temptation “in the hope that chance would favor them” which proved “how strong is the contagion of folly”.⁴ Wells was also critical of the high number of surgical procedures performed by gynaecological practitioners. He warned that unless the surgical tendency amongst such physicians was contained, the surgical profession at large would have to “bear up against the rebound of adverse public feeling”.⁵ Yet it was not just the frequency of procedures performed, or the encroachment of the gynaecological practitioner, that Wells’ objected to. He was also especially scathing of the fact many of these physicians were advocating the use of gynaecological surgery for the treatment of women’s nervous and mental disorders, which Wells argued, was completely ineffective.⁶

² See for instance, T. Spencer Wells, ‘Modern Abdominal Surgery: The Bradshaw Lecture delivered at The Royal College of Surgeons of England, December 1890’ *British Medical Journal*, December (1890): 1413-1416: 1465-1468. ‘Castration in Mental and Nervous Diseases: A Symposium’.

³ T.Spencer Wells, ‘Castration in Mental and Nervous Diseases’, p.458.

⁴ *Ibid.*, p.468.

⁵ T.Spencer Wells, ‘The Bradshaw Lecture’, *British Medical Journal*, p.1466.

⁶ T. Spencer Wells, ‘Castration in Mental and Nervous Diseases’, p.468.

Over the last quarter of the nineteenth century, the gynaecological treatment and approach to women's nervous and mental afflictions generated much discussion and division. Many physicians voiced their disapproval at the increasing use of invasive surgery with such cases. Wells was particularly critical of Lawson Tait and his followers who advocated the use of Tait's operation—salpingo-oophorectomy—to treat women's nervous disorders and 'menstrual epilepsy'. Wells declared that the removal of a woman's ostensibly healthy ovaries and appendages for afflictions displaying aberrant and disordered conduct was evidence of "loose professional morality" and particularly "open to abuse".⁷ He argued the network of physical, moral and mental reasons propounded by those seeking to justify such procedures meant few cases "that can anyhow be connected with the generative organs or functions, have a chance of escaping".⁸ Wells obviously did not regard his own use of the procedure in certain cases of puerperal mania in the same light. In an article in the *British Gynaecological Journal* in 1886, physician to the Chelsea Hospital for women James Hobson Aveling (1828-1892), makes mention of Wells use of oophorectomy in such cases. Aveling welcomed such a "happy application" of the procedure because it not only prevented the puerperal mania, but "guards against the propagation of children likely to suffer from hereditary insanity".⁹ Lawson Tait sent a letter to the journal expressing his surprise at Aveling's revelations about Wells's use of oophorectomy, given the latter's previous public condemnation of such surgery. In what was typical of the sarcasm these two rivals publicly employed against one another, Tait wrote that perhaps Wells was now "persuaded that there are many cases of mental disorder in which the removal of the uterine appendages could be justified."¹⁰ Tait expressed great hope the subject of surgery

⁷ T. Spencer Wells, 'Castration in Mental and Nervous Diseases', p.468.

⁸ Ibid., p.462.

⁹ J.H.Aveling, 'Notes - oophorectomy versus puerperal mania', *The British Gynaecological Journal* 1 (1886): 104.

¹⁰ 'Correspondence', *The British Gynaecological Journal* 1 (1886): 229-230.

in women's mental disorder could now be freely discussed, "and probably we shall add another to the already numerous victories of our art".¹¹

The dispute between Tait and Wells was particularly pronounced in 1886 due to their involvement in the much publicised investigation and then trial of Dr Francis Imlach in that year. Imlach, who was accused of performing an unnecessarily high number of salpingo-oophorectomies for cases displaying indefinite symptoms, had acknowledged the influence of Tait on his work and it was he who provided the obstetric physician with much public support during his civil trial. In the *British Medical Journal*, Tait described Imlach's case as not just "the battle of a man who has been grievously wronged", but "the battle of surgical progress" in the interests of "those suffering creatures (women) whom we have sworn to aid as best we can".¹² Wells, who was among a number of eminent surgeons and gynaecologists asked to comment on Imlach's statistics for abdominal procedures, appeared to use the trial to further his rejection of Tait's procedure, and any surgery being performed by obstetric practitioners. In a letter to the Hospital subsequently reproduced in the *Liverpool Courier* and *Lancet*, Wells declared the number of operations performed by Imlach as "so shocking as to be almost incredible".¹³ Both the newspaper and medical journal subsequently received a letter from Tait who noted his "amazement" at Wells' shock, given that 40% of Wells' own patients at the London Samaritan Hospital were themselves subjected to abdominal procedures.¹⁴

¹¹ 'Correspondence', *The British Gynaecological Journal* 1 (1886): 229-230; p.230.

¹² Lawson Tait, 'On some pending questions in Gynaecology', *British Medical Journal* (1887): 145-148; p.148.

¹³ 'Letters to the Editor' *Lancet*, 2 (1886): 749.

¹⁴ 'Letters to the Editor' *Lancet*, 2 (1886): 796.

The rivalry between Wells and Tait epitomised that between surgeons connected to the general hospitals who sought to retain control over all surgical matters, and gynaecological practitioners, especially members of the newly formed British Gynaecological Society (BGS), who regarded themselves as specialist surgeons. Formed in 1884, members of the BGS, such as Tait, were united in their desire to actively promote and seek to extend their surgical authority and fight the restrictions placed on their practice. In London's general hospitals abdominal and gynaecological surgical procedures were under the domain and authority of surgeons, not obstetric physicians. In the women's hospitals the situation was very different. In these institutions, obstetric physicians were responsible for performing all surgical procedures, thus enabling them to extend their surgical competence and experience, which, many argued, justified the extension of their authority outside the women's hospitals.¹⁵ Limited to a small range of surgical procedures in the women's hospitals, obstetric physicians felt their surgical abilities were being severely hampered. Members of the BGS sought to change this situation which the surgical fraternity desperately resisted.

Much of the criticism Wells directed at Tait and others focused on the efficacy of gynaecological surgery in the treatment of women's nervous or mental afflictions. Wells rejected the success many physicians attributed to extirpation of the reproductive and genital organs in cases of epilepsy, mania, and disorders of conduct, including those of an erotic nature. He questioned to what extent the recovery physicians' claimed they achieved with such an approach was due to the "amputation", or the shock arising from it. "It is a query", Wells wrote, "which takes the gloss off a mass of statistics."¹⁶ There is

¹⁵ On the development of gynaecological surgery see Ornella Moscucci, *The Science of Woman: Gynaecology and Gender in England 1800-1929* (Cambridge: Cambridge University Press, 1990) p.165-181.

¹⁶ T. Spencer Wells, 'Castration in Mental and Nervous Diseases', p.468.

no denying Wells was concerned with policing surgical boundaries and protecting the reputation of the surgeon. However, his concerns about the efficacy of gynaecological surgery also reveal an uncertainty about the extent to which certain disorders could be solely attributed to the workings of the reproductive organs. Such uncertainty was not isolated to Wells or those in the surgical domain. Increasing debate about the surgical approach to women's nervous and mental disorder exposes a real lack of consensus amongst physicians, not just in the treatment of such afflictions, but in the way they were conceived. In 1880, *The Obstetrical Journal of Great Britain and Ireland* examined Lawson Tait's ideas and work.¹⁷ Tait was cited as declaring his operation as offering to physicians "the means of alleviating an enormous amount of suffering of an otherwise incurable kind".¹⁸ Seeking to rebuke Tait's claims, the article suggested that in cases displaying grave nervous symptoms thought to be closely connected with disorder of the reproductive organs, perhaps the supposed cause was "no more than the exciting agent, the minor factor, of the disease". The authors proposed that the predisposing cause or major factor of such disorder lay "much deeper".¹⁹ Such a view certainly seemed to challenge the gynaecological conception of nervous disorders that directly linked them to the workings and dysfunctions of the generative system, thus justifying surgical intervention. In fact, the more physicians rejected the efficacy of removing women's reproductive organs for certain afflictions, the more doubt they raised regarding the extent of the causality accorded woman's sexual body.

While nineteenth century physicians continued to subscribe to the view of the female body as inherently prone to disorder and dysfunction, many were beginning to consider

¹⁷ 'Review of three pamphlets on spaying', *The Obstetrical Journal of Great Britain and Ireland* 8 (1880): 153-156.

¹⁸ *Ibid.*, p.154.

¹⁹ *Ibid.*, p.156.

the role other factors may play in certain afflictions. The exact cause and the effective means by which to treat a wealth of aberrant behaviour and disordered states increasingly preoccupied the later nineteenth century medical world. Medical periodicals such as the *Journal of Mental Science* (JMS), and the *British Gynaecological Journal* (BGJ)—the journal of the British Gynaecological Society—were beset with discussion about the causal significance of reproductive disease in mental disorder, the issue of sexual surgery in treating such afflictions, and the role of gynaecological physicians in the asylums. Much of the discussion and contributions within these publications inevitably advanced the vested and very different interests they represented. However, they also suggest the long held belief in the absolute responsibility of women's sexual body in her health and disorder was under review.

Reassessing

From its first volume in 1885 through to editions as late as 1905, numerous articles appearing in the *BGJ* continued to support the link between women's sexual body and a host of disorder, from aberrations of conduct through to severe derangement.²⁰ Over the course of the 1890s, contributions to the *BGJ* advanced the gynaecological origin of mental disorder, often in the context of arguing for the extension of the gynaecological practitioner into the asylums.²¹ Members of the BGS believed the gynaecological

²⁰ See for example, *British Gynaecological Journal* 11 (1895): 439-442; 14 (1898): 571-576; 15 (1899): 151, 318. Even by 1905, there were various contributions on the topic of the causality of women's uterine system in their mental disorder. See for instance, 'Gynaecology and Psychoses' *British Gynaecological Journal* 21 (1905): 1-3, which discusses the frequency of uterine disease amongst the insane which is posited as a cause or coincident symptom, or a factor modifying the delusions of the patient., which discusses the frequency of uterine disease amongst the insane which is posited as a cause or coincident symptom, or a factor modifying the delusions of the patient.

²¹ Contributions on this issue also came from physicians from Canada and America. See for instance Canadian physician Ernest Hall's article 'Gynaecology among the insane in private practice' *British Gynaecological Journal* 14 (1898): 571-576. Hall urged every physician to make a "thorough pelvic

practitioner was badly needed in the asylums to ensure correct diagnosis of women's disorder and alleviate much of the patient's suffering, linked as it was to their sexual organs. Consulting obstetrician in Dublin, and Vice-President of the BGS, Thomas More Madden (1838-1902) argued the lack of attention accorded the role of women's uterine disease in their nervous disturbance, especially by those in the asylums, meant many women were needlessly and improperly confined.²² He felt that often the symptoms pointing to the physical cause of a disease were obscured by the nervous symptoms. Nonetheless, he was adamant the highly complex organisation and relations of the reproductive system was such that "any serious disturbances in its structural or functional integrity" was "especially manifest in the protean forms of cerebro-nervous derangements to which women are thus particularly liable".²³ He called for the appointment to the asylums of medical visitors experienced in gynaecological practice so that patients could be properly diagnosed in the hope they "might be restored to mental, as well as bodily, health by appropriate treatment."²⁴

Calls from the ranks of those in the BGS to extend the role of the gynaecological practitioner were inevitable given the fact that the Society had been founded with the explicit intention of furthering the practice and authority of gynaecology. At its inaugural meeting in 1884 chaired by Dr Charles Routh, Robert Barnes declared that the formation of the society had become necessary for "the freer and more active study of gynaecology, and to challenge a better appreciation and position of those who pursued it."²⁵ Robert

examination" before signing papers of commitment. Hall believed this would send at least one patient to the hospital for every two that were sent to the asylum. *Ibid.*, p.575-576.

²² T. More Madden, *Clinical Gynaecology being a Handbook of diseases peculiar to women* (London: Bailliere, Tindall & Cox, 1893) p.474.

²³ *Ibid.*, p.475.

²⁴ *Ibid.*, p.482-483.

²⁵ 'The foundation meeting of the British Gynaecological Society' *The British Gynaecological Journal*, 1 (1886): 1-8; p.4.

Barnes, along with other members of the BGS including his son Fancourt Barnes (1849-1908), criticised the lack of attention paid to the study of gynaecology by those treating women's mental and nervous afflictions, especially in the asylums. In 1890 Barnes made a presentation to the London Obstetrical Society arguing the need for gynaecology to establish a closer relationship to those working in the women's asylums. His paper, entitled 'On the Correlations of the Sexual Functions and Mental Disorders of women', reiterated his belief in the association between women's mental afflictions and disorders of the sexual organs and thus the need for gynaecologists in these institutions. Barnes declared that even if reproductive disease was not directly causative "serious sexual disorder cannot fail to be an aggravated factor in the nervous disorder".²⁶ He argued the physician who rejected this association was "too often blind to objects outside the immediate range of his research".²⁷ The causal significance Barnes accorded dysfunction in the reproductive system also supported his belief in the use of gynaecological surgery to treat such disorder. In fact, Barnes' presentation to the Obstetrical society provided him with yet another opportunity to promote his greatest cause—extending the surgical domain of the gynaecological physician.

A staunch advocate of gynaecological surgery, Robert Barnes was especially critical of the limitations imposed on obstetric physicians performing abdominal procedures within the general hospitals. While Barnes himself was able to perform such procedures at St George's Hospital where he was obstetric physician, this was only due to a personal concession, and did not represent the norm with regard to the statutory rights of such practitioners.²⁸ Despite his own situation, Barnes argued the limited surgical rights of the

²⁶ Robert Barnes, 'On the Correlations of the Sexual Functions and Mental Disorders of women' *British Gynaecological Journal* 6 (1890-1891): 390-406; p.391.

²⁷ *Ibid.*, p.391.

²⁸ O. Moscucci, *The Science of Woman*, p.179.

obstetrician deliberately prevented the advancement of gynaecological science, and its access to what was a growing source of profit.²⁹ Such was his sentiment about the continuing resistance physicians faced he published a small pamphlet—*Relations between medicine, surgery, and obstetrics in London* (1884)—bemoaning the anomalous position of the institution. In the publication Barnes rejected the split some sought between the colleges of physicians and surgeons, and the increasing tendency towards dividing a case into its medical and surgical parts. Barnes argued such a situation meant each of the organs of the body were effectively assigned to the care of different specialists and lamented the fact “one cannot have so much as an organ to one’s self”.³⁰ His views were reflective of a desire amongst many gynaecological practitioners to consolidate their specialist expertise and extend the domain of their surgical practise. Faced with continuing resistance to their surgical practices and fearful that surgery even within the women’s hospitals may become further restricted, many of those in the BGS saw the asylum as offering great potential to extend their authority.

For Robert Barnes, the use of surgery in cases of mental disorder was not only an issue of treatment or extending the domain of gynaecology, but also one of furthering the knowledge of the gynaecologist. He described how “infinitely more precise our knowledge becomes when the opportunity is afforded of studying the condition of the economy when these organs are taken away”.³¹ “We are at once struck” he declared, “by the double light thrown upon the problem by the application of surgery”. Barnes felt that such were the insights gained from removing women’s appendages, it outweighed doubt as to the effectiveness of such surgery. While he acknowledged “the immediate design of

²⁹ In contrast to obstetrics, surgery was far more lucrative and far less time consuming. On this see O. Moscucci, *The Science of Woman*, p.169-170.

³⁰ R. Barnes, *Relations between Medicine, Surgery, and Obstetrics in London* (New York: W.Wood & co., 1884) p.20.

³¹ R. Barnes, ‘On the Correlations of the Sexual Functions and Mental Disorders of women’, p.399.

surgery is the relief of suffering”, he also admitted that whether a successful outcome was reached or not, “one good result is sure to be attained, that is, an increase in knowledge”.³² While not questioning Barnes’s conviction or motivation as to the benefits surgery could deliver gynaecology, his attitude does suggest he regarded women’s sexual bodies, particularly those locked away in asylums, as dispensable when promoting the cause of gynaecology. Despite the adverse effects of such invasive procedures, and the possible failure to alleviate women’s suffering, exploring women’s bodies was apparently justified in Barnes’ mind on the grounds it provided an opportunity for experimentation, and ultimately, the advancement of careers and medical science.

Amongst those physicians at Robert Barnes’ presentation to the Obstetrical society in 1890 were certain prominent alienists who openly supported his conception of women’s mental and nervous disorders. Many within the psychiatric domain, particularly those linked to the asylums, were devoting a lot of their academic and periodical discussion to the issue of the sexual origins of women’s mental afflictions. Contributions to the *Journal of Medical Science*, the journal of the Medico-psychological Association, reveal mixed opinions in regard to the link between the female sexual system and mental disorder.³³ In 1880, the results of Lawson Tait’s operation on a 17 year-old girl at the Birmingham Borough Asylum were noted in the journal, along with the ensuing discussion of members of the Association.³⁴ Tait received permission from the Lunacy Commissioners to perform oophorectomy in the hope it would provide some relief to the patient’s menstrual epilepsy. A marked improvement was recorded following the

³² R. Barnes, ‘On the Correlations of the Sexual Functions and Mental Disorders of women’, p.391.

³³ On the various name changes of both the journal and the association to which alienists belonged see Janet Oppenheim, *“Shattered Nerves”: Doctors, Patients, and Depression in Victorian England* (Oxford: Oxford University Press, 1991) p.27.

³⁴ ‘British Medical Association – Section of Psychology, Notes and News’, *Journal of Mental Science* 26 (1880-1881): 470-471.

operation. President of the British Medical Association's section of psychology and medical director at the West Riding Asylum, James Chrichton-Browne (1840-1938) suggested this was evidence of the important role of the sexual organs and functions in insane females. He argued for the examination of all female patients, although cautioned that operations should only be performed in extreme cases.³⁵ In contrast, Dr George Fielding Blandford (1829-1911) rejected the efficacy of Tait's surgery. He argued any improvement Tait may have achieved would have only been temporary.³⁶ Like Blandford, many asylum physicians were sceptical about the extent to which gynaecological therapeutics could alleviate female patients suffering. Yet it is interesting to note that despite this, many continued to support the correlation between women's sexual body and their mental disorder, even in the face of evidence to the contrary.³⁷

Much of the ongoing subscription to gynaecological conceptions of disorder amongst those in the asylum domain was influenced by the legitimacy accorded such explanatory schemes, particularly given the struggles psychiatry faced in terms of its credibility. Amongst the British medical fraternity, asylum medicine, like its practitioners, was not regarded as a truly authentic scientific undertaking. This was largely due to the general stigma attached to the treatment of the insane as much as it was to a belief that psychiatry was not constructed on somatic foundations. The authority accorded somatic models of disorder and medical practice associated with physical afflictions dominated the Victorian medical establishment. It was thus inevitable alienists would seek to align

³⁵ 'British Medical Association – Section of Psychology, Notes and News', *Journal of Mental Science* 26 (1880-1881): 470-471.

³⁶ *Ibid.*, p.471.

³⁷ An example of this was a case described in 1886 where an ovariectomy was performed on a patient at Bethlem because of the belief ovarian disease may be the cause of her insanity. While the procedure proved unsuccessful in alleviating her disorder the various comments on the case show a continued support in the link posited between mental alienation and disease in the reproductive organs. *Journal of Mental Science* 32 (1886): 224-227.

themselves with gynaecological conceptions of women's aberration in order to facilitate their own scientific status and legitimacy. As Janet Oppenheim states, like the rest of the medical profession, alienists "were keen to establish their place among the ranks of physiologists and pathologists who claimed to base the study of the human body, healthy or diseased, on a rigorous scientific foundation".³⁸

Distinguished alienist and joint editor of the *Journal of Mental Science*, Dr Daniel Hack Tuke (1827-1895), was one of the physicians present at Robert Barnes' presentation who supported the causal connection posited between women's mental alienation and their sexual function. Tuke also concurred with the call for greater support between the gynaecologist and alienist.³⁹ Also in attendance was the other editor of the JMS, prominent alienist Dr George Henry Savage (1842-1921), who had been Resident Physician-Superintendent of Bethlem Hospital from 1878-1888, and who also agreed with Barnes ideas. Savage proposed the onset of menstruation was good evidence of the nexus between women's sexual body and disorder because so many cases of excessive masturbation were observed at this time. For this reason, Savage offered tentative support to the idea of removing the ovaries in cases of excessive masturbation initiated by the onset of menstruation, yet admitted he had little experience with such a cure.⁴⁰ Tuke agreed with Savage that oophorectomy should perhaps be utilised in those cases of mania arising from excessive masturbation.⁴¹

In regard to Barnes' ideas about gynaecological surgery advancing physicians' knowledge, Dr William Hugh Fenton felt increased understanding of the physiology and

³⁸ J. Oppenheim, *Shattered Nerves*, p.35.

³⁹ 'Discussion on Robert Barnes, "On the Correlations"', *British Gynaecological Journal* 6 (1890-1891): 406-413; 416-430; p.411.

⁴⁰ *Ibid.*, p.408.

⁴¹ *Ibid.*

pathology of women would also greatly contribute to the work of the alienist. Fenton argued such knowledge was greatly needed because it was “impossible to disassociate mental disorders in the female from her sexual functions”.⁴² However, with a disorder such as masturbation, Fenton argued he could not decipher cause and effect, although he was sure the practice undoubtedly rendered any existing condition much worse. He related one case he had attended of a young woman married to an older man. The woman’s strong passions were unable to be satisfied by her husband, which resulted in “sexual paroxysms” accompanied by outbursts of violence. Her previous doctor had removed the woman’s labia minora which was said to be “enormously hypertrophied”, although this had no lasting effect on her condition. Fenton then had the ovaries removed in the hope of alleviating the woman’s mental imbalance, although he admitted such an exercise was purely empirical. Following the procedure, the woman’s paroxysms were severely reduced to one or two a year, which Fenton believed served as a useful precedent for the use of this procedure in such a case.⁴³ In his response Physician to the British Lying-in Hospital, Dr Heywood Smith (1848-1916) argued that although excessive masturbation was “far more common in females than was supposed”, he rejected removal of the ovaries as a cure because this did not lessen the sexual appetite. While Smith negated the logic of removing the ovaries in such cases, this is not to suggest it was because he did not support the organic conception of women’s excessive masturbation. Rather, he simply accorded ‘blame’ to the clitoris, and thus failed to see the point in removing the ovaries. He stated that the only operation that had a marked effect in cases of excessive masturbation was clitoridectomy, adding that if this failed “it was probably because it had not been done as freely as had been recommended.”⁴⁴

⁴² ‘Discussion on Robert Barnes, “On the Correlations”’, *British Gynaecological Journal* 6 (1890-1891): 406-413; 416- 430; p.422.

⁴³ *Ibid.*, p.423.

⁴⁴ ‘Discussion on Robert Barnes, “On the Correlations”’, *British Gynaecological Journal* 6 (1890-1891): 406-413; 416- 430; p.421.

Heywood Smith was not the only physician at the time to express doubts about treating women's excessive sexual disorder through operative measures on the ovaries. Even some members of the BGS expressed doubts about the organic conception of women's erotic desire on which such surgery was based.

In his staunch defence of surgical procedures on women's sexual organs, particularly his own work, Lawson Tait rejected the idea that removal of the ovaries or uterine appendages permanently affected women's sexual desire. In refuting the claims of his critics, Tait denied the link between women's ovaries, menstruation and their sexual desire, especially menstruation, as signalling the peak of women's desire. In a presentation to the Midland Medical Society in 1884, Tait declared that the idea of women's sexual desire being stronger at their menstrual period did not have "the slightest foundation."⁴⁵ He suggested rather than menstruation representing the height of a woman's sexual desire, it was actually the time when women are "repulsed" by the act.⁴⁶ While he acknowledged the difficulties in obtaining accurate or extensive evidence on the matter of women's sexual desire during menstruation, he felt that on the basis of his discussions with "some men", the general assumption could be emphatically contradicted. Indeed, from such discussion Tait came to the conclusion that "neither in man nor in woman is there any other than a distinct feeling of repulsion to the marital act" at this time.⁴⁷

Lawson Tait played a prominent role in contesting those who claimed removal of the ovaries 'unsexed' women. In 1886, the year of the furore over Francis Imlach, Tait wrote

⁴⁵ Lawson Tait, 'Note on the Relations of Ovulation and Menstruation' *Medical Times and Gazette*, May, (1884): 619-624; p.620.

⁴⁶ Ibid.

⁴⁷ Ibid.

a series of letters to the *Lancet* and *British Medical Journal* refuting the proposition that removal of the ovaries and appendages was akin to spaying.⁴⁸ Tait declared such surgery had no conceivable resemblance to spaying and did not affect women's sexual desire or feelings. Numerous letters responded to Tait challenging the nature of his claims or offering support. One letter published in the *Lancet* was from a veterinary surgeon who argued Tait was right to suggest spaying did not "destroy the sexual powers and desire". However, the man also warned that if the procedure was not performed properly, especially if any part of the ovary remained, "then there will be an over-excess of desire left" effectively reinforcing the idea such desire was located in the ovaries.⁴⁹ Despite much opposition, Tait continued to publicise his rejection of the organic conception of women's sexual desire and thus the detrimental effect of surgery. In a presentation to the British Gynaecological Society in 1888 directly addressing the effect of uterine procedures on the sexual feelings, he argued that just as men's sexual appetite was not seated in their testes, so a woman's was "neither in (her) uterus, tubes or ovaries".⁵⁰ The now Professor of gynaecology at Queens College admitted to his colleagues the subject was not a pleasant one to write about. However, he justified his comments because of "the ridiculous assertions made in open court by men who were in a state of acute prejudice and who had evidently nothing but tradition to go upon".⁵¹ Tait reported that of his patients who had undergone gynaecological surgery, all continued to show a "sexual competence which her husband regards as satisfactory". Tait's reliance on the views of a woman's husband raises some interesting questions regarding the value he accorded women's sexual desire. It is uncertain whether he sought the opinion of the husband

⁴⁸ See Lawson Tait, 'Casey v. Imlach', *Lancet*, 2 (1886): 375-376; 'Spaying', *Lancet*, 2 (1886): 470-471; 'Spaying or Removal of the Uterine Appendages?', *Lancet*, 2 (1886): 557.

⁴⁹ C.E. Onslow, 'To the Editor of the Lancet', *Lancet*, 2 (1886): 558.

⁵⁰ L. Tait, 'Notes on the influence of the removal of the uterus and its appendages on the sexual appetite', *British Gynaecological Journal* 4 (1888): 314-317; p.314.

⁵¹ Ibid.

because women simply did not speak about their sexual feelings to male physicians, or whether the 'health' of a woman's sexual desire was determined by the extent to which she continued to meet her husband's expectations and needs. Certainly Fancourt Barnes, who was present at Tait's presentation, rejected the opinion of the husband as a true reflection of what his wife was experiencing. Rather, Barnes argued, a husband could easily not know whether a woman's sexual appetite was present or absent because a woman may simply stimulate such desire to retain the affections of her husband.⁵²

By 1889, when his obstetrical text *Diseases of Women and Abdominal Surgery* was published, Lawson Tait declared that women were far less sexual beings than men. "As a rule" Tait wrote, women are "not sexual animals at all" but he then added that when they do become "aggressive", "no kind of surgical operation seems to alter them".⁵³ He cited one case where a woman had her ovaries, tubes and 5/6 of her uterus removed, yet who then proceeded to suffer an "advanced form of satyriasis".⁵⁴ Tait concluded this was evidence the sexual appetite was not in the ovaries or the clitoris, but "is chiefly mental and the sexual organs are only contributory to its indulgence".⁵⁵ On this reasoning Tait rejected the efficacy of surgery for cases of nymphomania. It could be argued Tait's rebuff of the organic conception of women's sexual instinct was in many respects expedient, given the fact that he was such an enthusiast of gynaecological surgery, and this was one of its main criticisms. Yet if his only motivation was to further his surgical cause then it is more likely he would have supported its extension to cases of erotic disorder. The fact he does not, and that he, and others with possible vested interests directly challenged the use of ovarian surgery in such cases, is extremely significant.

⁵² L. Tait, 'Notes on the influence of the removal of the uterus and its appendages on the sexual appetite', p.314.

⁵³ L.Tait, *Diseases of Women and Abdominal Surgery* vol., I (Leicester: Richardson &co., 1889) p.57

⁵⁴ Ibid.

⁵⁵ Ibid.

Another member of the BGS, Henry Macnaughton Jones (1844-1918) also rejected the efficacy of surgical intervention in cases of an erotic nature. He described one case in which he had removed “a most unhealthy” cervix from a lady who had been in an asylum for erotic mania. While the woman recovered immediately following the operation, eventually all the symptoms returned and she was sent back to the asylum.⁵⁶ For this reason Jones believed that with operations on the female generative organs there was “a greater predisposition to mental disturbance than after other operative procedures” which was further heightened if the woman had already suffered a previous attack.⁵⁷

The heated and very divisive issue of uterine surgery causing so much uproar both within and outside of the medical community undoubtedly contributed to many physicians’ rejection of such surgery for erotic mania.⁵⁸ Yet ultimately, in rejecting such operative treatment, physicians were also casting doubt on long held ideas about the reproductive or organic origins of nymphomania, and by inference, the source of women’s sexual desire. However, although many were adamant and active in their denial of such a conception of nymphomania, it seems they were far less able or ready to acknowledge the ramifications of their contentions. Many later nineteenth century physicians derided the somatic determinism underscoring the conception and treatment of nymphomania, yet their inability to conceive of afflictions outside this causal framework meant they failed to even contemplate the idea that this could be a non-somatic disorder. While the rejection of a surgical approach to nymphomania saw physicians questioning the organic conception of this disorder, this did not then see an immediate reassessment of exactly

⁵⁶ Henry Macnaughton Jones, *Practical Manual on the Diseases of women* 7th ed. (London: Baillere; Tindal & Cox, 1897) p.681.

⁵⁷ *Ibid.*, p.682.

⁵⁸ Claims such surgery offended a woman’s morality, violated life, and was an extension of vivisection further added to its detraction in the eyes of many. On this see O. Moscucci, *The Science of Woman*, p.158-160.

how physicians were conceiving female sexual desire and its potential for excess. Instead, the most pressing issue appeared to be their own reputation.

The idea that operative treatments actually worsened erotic disorders was also propounded by Thomas Spencer Wells who argued rather than emptying the asylums, such an approach actually “sent some women into them”.⁵⁹ He noted this was particularly with cases of nymphomania which, he argued, were for the consideration of the moralists not the surgeon.⁶⁰ Wells stated categorically that with nymphomania the removal of the sexual organs was “to say the least, unjustifiable”.⁶¹ “Would anyone “ he inquired “strip off the penis for a stricture or a gonorrhoea, or castrate a man because he had a hydrocele, or was a moral delinquent”?⁶² It is interesting to note the degree to which Wells’ comparison horrified him and was seemingly so absurd a suggestion. Up to this point physicians made few links between the types of surgery many so readily advocated for women’s erotic disorders and the lack of such ideas or treatments for men’s afflictions. Yet as Wells suggests, once physicians regarded the logic of treatments offered women for their sexual disorder as just as preposterous, they saw themselves in a very different and disconcerting light. It was perhaps this fear more than anything that ultimately drove many physicians’ rejection of the operative treatment of a disorder such as nymphomania in order to save the credibility of their science, and as such, their own position. That said, none were willing to question the very basis of the science of woman which was entirely formed around the notion that woman’s sexed body is utterly different and pathological, or the fact that no comparable science of man existed.

⁵⁹ T.Spencer Wells, ‘Castration’, p. 469.

⁶⁰ Ibid.

⁶¹ Ibid., p.470.

⁶² Ibid.

By the closing decade of the nineteenth century, many disorders previously accounted for by women's reproductive body were under intense scrutiny. While many practitioners continued to support a connection between women's disorder and her sexual body, and thus their authority over such afflictions, others were increasingly uncertain about the cause. Many physicians within and outside of gynaecology distanced themselves from the idea of isolating the 'source' of women's afflictions to the generative system at the exclusion of other factors. In turn, many questioned what purpose gynaecological treatments served if such disorder was not a product of the workings of women's reproductive organs. Prominent amongst these was gynaecological practitioner William Playfair who became particularly pronounced in his views about women's nervous and mental afflictions. Turning now to an examination of Playfair's ideas, we see a gradual reassessment in medical thinking initiated by his work which was decisive to the future conception of nymphomania.

William Playfair and the return of the neuroses

In 1884—the year the British Gynaecological Society was founded—Sir Thomas Clifford Allbutt (1836-1925) delivered the Gulstonian Lecture to the Royal College of Physicians on the topic of neuroses of the viscera.⁶³ In his presentation the eminent Leeds physician and one time Commissioner in Lunacy was extremely critical of gynaecology's treatment of women's neurotic complaints. He rejected the ability of the gynaecological physician to treat such disorders because of their “narrow uterine specialism” which, Allbutt claimed, meant a failure to consider any other causative factor except the reproductive organs.⁶⁴ Allbutt called upon his fellow physicians to rally against this “gynaecological tyranny” that left women “impaled upon a stem, or perched upon a prop,

⁶³ Thomas Clifford Allbutt, 'The Gulstonian Lectures on Neuroses of the Viscera' *British Medical Journal*, March (1884): 495-499; 543-547; 594-599.

⁶⁴ Thomas Clifford Allbutt, 'The Gulstonian Lectures on Neuroses of the Viscera', p.496.

or ...painted with carbolic acid every weeks of the year except during the long vacation, when the gynaecologist is grouse shooting, or salmon catching, or leading the fashion in the upper Engandine".⁶⁵ In order to respond to Allbutt's attacks, the British Medical Associations' Section of Obstetric Medicine arranged for a discussion on 'the local and constitutional treatment of uterine diseases'. The opening address of the meeting was to be given by specialist in midwifery, William Smoult Playfair (1836-1903).⁶⁶

William Playfair received his M.D from Edinburgh in 1856, and after a brief stint serving in Colonial India at the Calcutta Medical College, was appointed professor of obstetric medicine at King's College, London in 1872. He also served as obstetric physician to King's College Hospital from 1863 to 1898.⁶⁷ Playfair's excellent reputation and standing amongst the profession suggests his selection to defend the practices of gynaecology against Allbutt's attacks was appropriate. Yet in truth, Playfair was an unusual choice, given his own attitudes about much gynaecological practice. Indeed, it was not just the surgeons or those in general practice who rallied against the gynaecologist's narrow approach to women's disorders. In fact, the most vocal critics came from within the very ranks of the gynaecological profession, including Playfair himself.

In his official response to Allbutt, Playfair strongly defended the gynaecological profession whose "real and solid advances" within the last twenty-five years were

⁶⁵ Ibid.

⁶⁶ W.S.Playfair, 'On the proper Sphere of Constitutional and Topical Treatment in Certain Forms of Uterine Disease: Introduction to a discussion in the Section of Obstetric Medicine at the Annual Meeting of the British Medical Association in Cardiff', *British Medical Journal* (1885): 587-589.

⁶⁷ For further discussion of Playfair's career see Angus McLaren, *The Trials of Masculinity: Policing Sexual Boundaries, 1870-1930* (Chicago: The University of Chicago Press, 1997) p.91-110. Hilary Marland, 'Uterine Mischief: W. S. Playfair and his Neurasthenic Patients', in M.Gijswijt-Hofstra, R.Porter (eds.), 'Cultures of Neurasthenia: from Beard to the First World War', *Clio Medica*, 63, (2001):117-139.

‘unmatched by any department of medical science’.⁶⁸ However, there is no denying his opinion of the profession shared much with Allbutt, especially the treatment of those female afflictions “of a less determinate character”.⁶⁹ Playfair admitted with such ailments “there is much room for difference of opinion”, and “errors of practice are very apt to prevail”.⁷⁰ He acknowledged the difficulties gynaecology faced in treating women’s afflictions through means other than a localised approach, but also stressed the importance of general constitutional treatments.⁷¹ In a written response to Playfair read out at the same meeting, Allbutt also expressed his scepticism of the success gynaecology claimed its localised physical treatments offered women. Allbutt urged physicians to consider the complex relationship “of mind and pelvis and to weigh well how much of the sudden relief given by uterine medication is due to imposition upon the mind of the patient”.⁷² Allbutt also wrote that his criticisms were not directed to a well trained physician such as Playfair, and refused to accept that Playfair could represent the practice of other gynaecologists “as he may justly represent his own”.⁷³ Both men were very much in tune with each other regarding their concerns about gynaecology and their support for a more holistic or general approach to women’s afflictions. Indeed, Playfair had been rallying against gynaecology’s narrow localised approach long before Allbutt delivered his Gulstonian lecture.

Before he was asked to reply to Allbutt’s criticisms, Playfair had been publicising his rejection of the fixation on certain organs within the ‘science of woman’. He regarded

⁶⁸ W.S.Playfair, ‘On the proper Sphere of Constitutional and Topical Treatment in Certain Forms of Uterine Disease’, p.588.

⁶⁹ Ibid.

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² Ibid.

⁷³ T.Clifford Allbutt, ‘On the Local and Constitutional Treatment in Uterine Diseases’, *British Medical Journal*, September 26, (1885): 589-590; p.589.

such an approach as not only too narrow in regards to certain disorders, but also as having a detrimental effect on women's delicate nervous organisation. In *The Systematic Treatment of Nerve Prostration and Hysteria* (1883) published the year before Allbutt's lecture, Playfair stated "anyone who attempts to treat such diseases without careful study of the psychological characteristics of each individual patient, will inevitably fail".⁷⁴ This text established Playfair as a firm advocate against localised approaches to women's nervous or mental afflictions, inevitably contributing to the mutual admiration between himself and Allbutt. In fact, such was the alliance and agreement the two shared, they went on to jointly edit a gynaecological handbook, the well regarded *A System of Gynaecology*, first published in 1896. The views Playfair, Allbutt and others expressed in this edited collection reflected their desire to change the approach to women's afflictions for which they received much support, particularly from those in the wider medical profession. In one review their text was praised for its holistic approach which sought to focus on the whole woman rather than simply her pelvis. The reviewer noted this was a welcome change, and represented a better future for a profession that "has rarely in the past belonged to the harmless order".⁷⁵

In his contributing article to *A System of Gynaecology*, Playfair argued the factor overlooked and underestimated by so many gynaecological practitioners in their narrow approach to women's afflictions was the primary role of women's nervous system.⁷⁶ While he adhered to the view of the reproductive system as closely linked to the nervous system, and thus functional disturbance in those organs could cause a nervous disorder, he also rejected the suggestion that any time a local lesion was found in those parts it was

⁷⁴ W. S. Playfair, *The Systematic Treatment of Nerve Prostration and Hysteria* (London: Smith, Elder, 1883) p.72.

⁷⁵ *The Medical Magazine*, Vol.XI (1897): 188-189.

⁷⁶ W.S. Playfair, 'The Nervous System in Relation to Gynaecology', in T. Clifford Allbutt & W.S.Playfair (eds.), *A System of Gynaecology* (London: Macmillan, 1896): 220-231.

necessarily the cause. For Playfair, local pelvic disorders could not be the cause of mental and nervous disorder to the extent that gynaecology claimed they were. Even if a local lesion was found to exist in the reproductive organs Playfair still questioned to what extent this could be held as the primary cause, and was adamant treatment based on such evidence was not only erroneous but further damaging. He declared,

nothing can be more deplorably bad for a nervous, emotional woman, whose general health is at a low ebb, than to have her attention constantly directed to her reproductive organs by vaginal examinations repeated two or three times a week, pessaries constantly introduced... the cervix frequently cauterised, or the endometrium curetted, and the like; and yet these are things one incessantly sees in cases in which, on examination, no definite reason for such interference is found to exist.⁷⁷

Playfair's rejection of the gynaecological treatment of women's nervous disorders was influenced by his support for the therapeutic regime, originated by Philadelphia physician Silas Weir Mitchell (1829-1914), for those suffering the many and varied symptoms of nervous exhaustion. The 'rest cure' as it was known, was a treatment based on complete rest, a nourishing diet, vigorous massage, and total cessation of intellectual activity. It became immensely popular in America, especially for use amongst extremely nervous and undernourished or anorexic young women, and soon found its proponents in Britain, one of the more notable being Playfair himself.⁷⁸ Playfair corresponded with Weir Mitchell, noting his success with the treatment whilst also receiving correspondence from the American that detailed his own results.⁷⁹ The approach of the rest cure was directed

⁷⁷ Ibid., p.226.

⁷⁸ On Playfair's work with the rest cure see Hilary Marland, 'Uterine Mischief: W. S. Playfair and his Neurasthenic Patients'; Chandak Sengoopta, 'A Mob of Incoherent Symptoms? Neurasthenia in British Medical Discourse 1860-1920', in M.Gijswijt-Hofstra, R.Porter (eds.), 'Cultures of Neurasthenia: from Beard to the First World War', *Clio Medica*, 63, (2001): 97-115.

⁷⁹ On Mitchell and Weir's correspondence see Silas Weir Mitchell's archives, 'Correspondence', 'Letters to and from medical associates 1850-1928',

to restoring the patient's physical health, but was also particularly 'psychological' in its therapeutic approach. It was designed to break the will of those women who had deliberately resisted all other forms of treatment and medical authority. The intention with such women was to break down the strength of their will, which was itself perceived as disordered, and for the physician to gain complete moral influence over them.⁸⁰ The success Playfair claimed with such an approach inevitably contributed to his belief in the absolute inability of gynaecological surgery to effectively alleviate or treat women's nervous afflictions, even those of an erotic nature. Indeed, Playfair was particularly outspoken in his criticism of reproductive determinism in conceptions of women's erotic afflictions and the treatments sought to alleviate such disorders. He had been one of the more prominent critics of Issac Baker Brown in the events of 1866, blaming the surgeon's erroneous thinking for his misguided ideas about the efficacy of clitoridectomy.⁸¹ In his contribution to *The System of Gynaecology* in 1896 Playfair continued to promote his disapproval of surgical procedures for treating such afflictions declaring such an approach as "unscientific, unnecessary, and often hurtful."⁸² "Some" he argued,

have held that insanity may actually depend on morbid conditions of the reproductive organs; and it has even been suggested that for the cure of certain forms of insanity associated with pronounced sexual aberrations - such as excessive masturbation and erotic manifestations - the uterine appendages should be removed by operation. I have never been able to find any reliable evidence at all of this alleged connection.⁸³

accessed at, <http://www.collphylphil.org/FIND-AID/hist/histswml.htm>

⁸⁰ For a more detailed discussion on this aspect of the treatment see J. Oppenheim, *Shattered Nerves*, p.210-215.

⁸¹ For Playfair's criticism of Baker Brown see *Lancet*, 1 (1867): 29.

⁸² W. S. Playfair, 'The Nervous System in Relation to Gynaecology', p.220

⁸³ W. S. Playfair, 'The Nervous System in Relation to Gynaecology', p.229-230.

Playfair also rejected the correlation Robert Barnes and others posited between women's sexual organs and insanity, hysteria, and other forms of alienation. While Playfair acknowledged the presence of pelvic diseases amongst women in asylums, he rejected "the one has any direct connection with the other."⁸⁴ Rather, he stated, "insane women are [as] liable to uterine diseases as sane women are".⁸⁵ Similarly, he rejected any connection suggested between disease in the ovaries and the common incident of excessive masturbation observed in such patients.

The views Allbutt and Playfair shared regarding the diagnosis and treatment of women's nervous afflictions were influenced to a large degree by their support for, and commitment to, the neurasthenia diagnosis. Both played a leading role in championing the concept in Britain. The term neurasthenia had been in use since the beginning of the nineteenth century, however American physician George Beard (1839-1883) is generally regarded as being responsible for introducing the concept into western medical circles.⁸⁶ The term 'asthenia' emerged out of a reworking and division of the concept of spinal irritation into its asthenic and esthenic forms, corresponding to hypofunction and hyperfunction respectively. Asthenia was caused by excessive irritation that followed overstimulation, and produced a state of spinal exhaustion.⁸⁷ Through a set of papers in 1869, and then in his monograph on the topic published in 1880, Beard extended the explanatory mechanism of asthenia from the spinal cord to the cerebrum, describing neurasthenia as a process of cerebral exhaustion which constituted a functional disease of

⁸⁴ Ibid.

⁸⁵ Ibid.

⁸⁶ On Beard and neurasthenia see F. G. Gosling, *Before Freud: Neurasthenia and the American Medical Community, 1870-1910* (Urbana: University of Illinois Press, 1987); Charles Rosenberg, 'The Place of George. M. Beard in Nineteenth-Century Psychiatry', *Bulletin of the History of Medicine* 36 (1962): 245-259.

⁸⁷ On this see Jose Pinero, *Historical Origins of the Concept of the Neurosis* (Cambridge: Cambridge University Press, 1983).

the brain.⁸⁸ Beard believed neurasthenia was precipitated by activities that induced exhaustion. He specifically linked such brain exhaustion to the culture and lifestyle of late nineteenth century American society. In fact, civilisation itself was posited as “the one great predisposing cause” with “evil habits, excesses, tobacco, alcohol, worry and special excitements, even climate itself” secondary to it.⁸⁹ Beard described modern life as causing a “feebleness and instability of nerve action” leading to a heightened irritability and sensitivity.⁹⁰ While for Beard, neurasthenia was a concept describing the effects of modern American life, especially amongst the upper classes, the popularity of the idea saw medical writers and physicians in a number of countries readily adopt this disease entity.⁹¹ From the 1880s, along with hysteria, neurasthenia was the most talked about disease or neurosis in medical literature. It continued to attract enormous amounts of medical attention for the next three decades, bringing to prominence the views of certain individuals who would go on to play an influential role in early twentieth century medical thinking, including Viennese physician Sigmund Freud.⁹²

⁸⁸ As Oppenheim notes, “despite its impressive Greek etymology, however, the label meant nothing more arcane than nerve weakness, or debility of the nervous system.” *Shattered Nerves*, p.93.

⁸⁹ George M. Beard, *A Practical treatise on Nervous exhaustion (neurasthenia): Its symptoms, nature, sequences, treatment* (New York: William Wood, 1880) p.15.

⁹⁰ Ibid.

⁹¹ While the association of neurasthenia with a wealthier clientele contributed to the popularity of the diagnosis amongst this class and those physicians treating them, this is not to suggest British physicians necessarily subscribed to the idea that neurasthenia was a disorder confined to the affluent. Allbutt declared it was a disorder as common amongst the middle and upper classes of society as it was “in the wage earning and in the rural classes of England”. T.Clifford Allbutt, ‘Neurasthenia’ in T.C. Allbutt (ed.), *A System of Medicine by many writers* (London: Macmillan, 1896) p.738. Hilary Marland argues Playfair also came to share similar views about those susceptible to neurasthenia. ‘Uterine Mischief: W. S. Playfair and his Neurasthenic Patients’, p.133,

⁹² Kenneth Levin states the end of 1892 marked the beginning of Freud’s increased interest in neurasthenia and his theory of the sexual aetiology of the neuroses. Along with hysteria, obsessions, and anxiety, neurasthenia was one of the four major syndromes around which Freud sought to apply his theories about

Despite its enormous range of physical symptoms (actually a point of much criticism amongst sceptics in Britain), neurasthenia was essentially a disorder without any discernible anatomical pathology.⁹³ Neurological function was deemed disordered in the neurasthenic. While the condition—nervous exhaustion or weakness of the nervous system—was considered somatic in origin, no structural lesion of the nervous system existed to support such a conclusion. As a diagnostic category then, neurasthenia provided legitimacy to a variety of behaviour and symptoms by according them a causality of sorts. Even some of its harshest critics, such as British neurologist William Gowers (1845-1915) who lamented the overuse of the diagnosis, also admitted “there are many cases for which it is a convenient designation and to which it may be applied without other disadvantage”.⁹⁴ Despite some objections, neurasthenia was swiftly adopted as a standard medical diagnosis in Britain giving credence to the idea of certain disorders as functional and lacking an identifiable cause.

Playfair first became interested in the idea of functional nervous disorders through his obstetric practice which saw him consulted by many female patients suffering a variety of nervous or mental symptoms. The stigmas associated with both mental disease and the psychiatrist, along with the entrenched belief that any ill health in a woman was essentially reproductive, accounts for why many women turned to their gynaecological

the sexual origins of disorder. Kenneth Levin, *Freud's Early Psychology of the Neuroses - A Historical Perspective* (Pittsburgh: University of Pittsburgh Press, 1978), p.24-36.

⁹³ Unlike their French and German counterparts, British neurologists were critical of the neurasthenia concept. On this see Simon Wessely, ‘Neurasthenia and Fatigue Syndromes : Clinical Section’ in G. Berrios and R. Porter (eds.), *A History of Clinical Psychiatry: the Origin and History of Psychiatric Disorders* (London: Althone, 1995): 509-532. For contemporary criticism of the neurasthenia concept see, Sir A. Clark, ‘Some Observations concerning what is called Neurasthenia’, *Lancet*, 1 (1886): 1-2.

⁹⁴ William R. Gowers, *A Manual of the Diseases of the Nervous System*, 2 volumes (London: Churchill, 1892-1893), 2; p.1046.

practitioner.⁹⁵ Playfair admitted the subject of women's nervous afflictions was "almost accidentally forced upon my attention from the very frequent association of this type of disease within the gynaecological work which is my special province".⁹⁶ Yet he was increasingly unconvinced of a direct relationship between women's neurotic complaints and uterine disease so entrenched within the science of woman. He acknowledged that because neurology was a "comparatively modern study", many disorders had been wrongly diagnosed and attributed to obscure organic causes "instead of to a pure neurosis."⁹⁷

For much of the nineteenth century, the concept of neuroses was considered vague and unscientific by the medical world. Lacking an obvious or identifiable organic lesion or structural change, the neuroses did not meet the litmus test of scientific legitimacy.⁹⁸ In the early nineteenth century, French physician Etienne Jean Georget undertook a dramatic revisioning of the neuroses. Georget accepted most conditions deemed a neurosis were in fact the result of some anatomical lesion, yet he also sought to show there were a class of morbid states, including hysteria, epilepsy, madness, chorea, and hypochondria, which were not accompanied by any post-mortem evidence of organic disease. He believed such conditions were chronic, occasioned great suffering, and while suggestive of a serious problem, could not be linked in any definite way to somatic causes.⁹⁹ While his list of specific neuroses was eventually challenged, his contribution was, as Jose Pinero suggests, responsible for the persistence of the concept of neuroses in

⁹⁵ J. Oppenheim, *Shattered Nerves*, p.32.

⁹⁶ W. S. Playfair, 'Some Observations concerning what is called Neurasthenia', *British Medical Journal*, November 6, (1886): 853-855; p.853.

⁹⁷ *Ibid.*, p.854.

⁹⁸ For a detailed discussion of the origin and development of the concept of neurosis see Jose Pinero, *Historical Origins of the Concept of the Neurosis*.

⁹⁹ Georget's ideas were published posthumously in volume twenty-one of *Dictionnaire de Médecine* (1840). J. Pinero, *Historical Origins of the Concept of the Neurosis*, p.50

nineteenth century French medicine and those influenced by the Paris school.¹⁰⁰ In Great Britain, the neuroses experienced a very different fate, with the term vanishing for over half a century.¹⁰¹ This is not to suggest the phenomena of functional disorders did not exist. Such afflictions continued under different a name—‘reflex nervous diseases’. Numerous medical writers explained an array of conditions and aberrant behaviour, including an excess of erotic desire, through concepts of ‘nervous irritation’, ‘spinal irritation’ and the workings of the reflex nerves which maintained a tentative, yet crucial, ‘somatic’ element. As previous chapters have demonstrated, these reflex conceptions were used to explain the primary responsibility accorded the organs of women’s sexual body in her nymphomania and the treatment of such disorder. Yet the increasing rejection of a localised approach to many of women’s afflictions saw a reassessment of their ‘reflex’ aetiology. This then saw the gradual acceptance that much of women’s disorder, including that of an erotic nature, was less the result of their sexual organs and more the product of nervous function.

While not wishing to overstate the case, available evidence suggests there was growing acceptance amongst gynaecological practitioners of the primacy of the nervous system in women’s complaints. In turn, this contributed to the increasing emphasis gynaecology accorded women’s functional nervous disorders. Playfair has to be acknowledged as having an influential role in this shift. Indeed, his obituary in the *Journal of Obstetrics and Gynaecology* would later note that his work had shown many physician that a large number of diseases were due to “a general neurasthenia rather than a local lesion” which

¹⁰⁰ Following Georget, the work of Paul Briquet was also important to the concept of neuroses in nineteenth century France in particular, on the ideas of Charcot who eventually initiated a new period in the history of the neurosis. Ibid., p.51.

¹⁰¹ On the neuroses in British medical thinking see William F. Bynum, ‘The nervous patient in eighteenth- and nineteenth century Britain: the psychiatric origins of British neurology’ in W.F. Bynum, R.Porter,

had prevented “much suffering on the part of the female sex”.¹⁰² Playfair hoped that through a greater understanding of women’s nervous disorders gynaecology would be able to overcome its ‘narrow uterine specialism’ for which it was greatly criticised. In 1891, at the meeting of the Obstetrical Society of London where Spencer Wells delivered his tirade against surgical intervention in nervous disorders, Playfair delivered his contribution on the subject. In a paper entitled “On Removal of the Uterine Appendages in Cases of Functional Neurosis”, Playfair concluded the results of such surgical procedures were unsatisfactory and “not to be recommended”.¹⁰³ Like Wells, he felt such therapeutics actually made many conditions worse. Playfair argued for less interventionist treatments of certain morbid conditions whose origins lay mostly in the imaginative faculties. This meeting saw the Obstetrical Society formally agree that the reproductive organs “had no part” in certain cases of disorder, and operations on the generative parts were not to be used in an attempt to cure what were merely neurotic symptoms.¹⁰⁴ These important decisions represented a radical departure from what had dominated much medical thinking and practice up to this time, and were decisive to the way many disorders were conceived and treated by gynaecology in the future.

By the late nineteenth century, many physicians were following Playfair’s lead in calling for a more scientific and instructed gynaecology from “mere womb doctoring”.¹⁰⁵ In 1895, in his address at the opening of the Section of Obstetric Medicine and Gynaecology, William Priestly (1829-1900) argued the belief extirpation of the organs

M.Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. I* (London, Tavistock, 1985): 89-101. J.Oppenheim, *Shattered Nerves*.

¹⁰² Obituaries, *Journal of Obstetrics and Gynaecology of the British Empire* 4 (1903): 339.

¹⁰³ W.S. Playfair, ‘On Removal of the Uterine Appendages in Cases of Functional Neurosis’, *Transactions of the Obstetrical Society of London* 33 (1892): 116-121; p.119.

¹⁰⁴ *Ibid.*, p.120.

¹⁰⁵ C. Sengoopta, ‘A mob of incoherent symptoms’, p.17.

could relieve a woman's neurosis was an example of inappropriate zeal within the profession. Priestly declared he had lived long enough to have seen "the wax and wane of many enthusiasms which have had their day, and have had a share in bringing something like discredit on a department of practice which, rightly exercised, is productive of great good, but exercised unwisely, is capable of producing infinite harm".¹⁰⁶ Similarly, in his *Diseases of Women* (1898), John Clarence Webster (1863-1950) lamented the "narrow and debased specialism" amongst the gynaecological profession whose remedial measures were limited "to different forms of mechanical procedure - from passing a sound to extirpating the appendages".¹⁰⁷ While Webster accepted that many were inevitably tempted by surgery because "we all like short cuts to success", he saw this as avoiding more worthy and appropriate practices. "It is much less troublesome" he wrote, "to make a few cuts and to put in a few stitches, than to patiently analyse a subtle and puzzling case, and to exert our whole energy in overcoming an obstreperous or aberrant nervous system".¹⁰⁸ Webster, who acknowledged Playfair's influence on his ideas, regretted the scant attention gynaecology had paid to the neuroses when so many afflictions of women previously accorded an organic aetiology were obviously a disorder of the nervous system.¹⁰⁹

Despite the growing criticism of gynaecology's determinist approach and the increasing rejection of the reproductive causality of many of women's afflictions, this did not negate the view of women as inherently prone to disorder. Rather, a woman's weaker nervous system came to account for her inherent susceptibility to a wealth of neurotic disorders.

¹⁰⁶ William Priestly, 'On Over-Operating in Gynaecology', *British Medical Journal*, August 3, (1895): 284-287; p.284.

¹⁰⁷ John Clarence Webster, *Diseases of Women: A Textbook for Students and Practitioners* (Edinburgh: Young.J.Pentland, 1898) p.132.

¹⁰⁸ *Ibid.*, p.143.

¹⁰⁹ John Clarence Webster, *Diseases of Women*, p.143.

Playfair certainly never ceased to assert that women's difference accounted for her greater propensity for the neuroses. "The mobility of the nervous system, especially in the sphere of the emotions, which distinguishes the woman from the man," Playfair wrote, "influences the character and progress of all kinds of disease".¹¹⁰ Thus he concluded, "functional neuroses arise easily in women; they may assume tremendous proportions, and their growth may be readily fostered and encouraged until, like some noxious weed, they choke all health of body and mind."¹¹¹ Many in the gynaecological domain also resisted letting go of the idea that women's reproductive system meant her greater susceptibility to neurotic afflictions. Such physicians advanced a view of the integral relationship between the nervous system and women's sexual organs. "Sanity", Fancourt Barnes declared, "was not simply a matter of nerves". Rather, it was "a response on the part of the nervous system to the workings of the body."¹¹² Barnes suggested that unless physicians accepted this unity, more women would be unnecessarily condemned to asylums.¹¹³ Henry Macnaughton-Jones claimed the abnormal and morbid exaggerations of temperament defining the term neurotic was "not uncommonly found associated with pathological conditions of the woman's pelvic viscera."¹¹⁴ It was thus, he argued, an injustice to women if physicians deliberately ignored the role local disease in the pelvic region played in the morbid impulses of their central nervous system.¹¹⁵ He argued the influence of both mind and body in maintaining or disturbing an individual's harmony was "nowhere better exhibited in the organism than by the effects produced in the nervous system of a woman by the ordinary

¹¹⁰ W.S.Playfair, 'The Nervous System', p. 220.

¹¹¹ Ibid.

¹¹² Fancourt Barnes, 'On some Psychological Consequences of Suppressed menstruation' *The British Gynaecological Journal* 12 (1896): 113-115.

¹¹³ Ibid.

¹¹⁴ H.Macnaughton-Jones, *Practical Manual of Diseases of Women and Uterine Therapeutics for Students and Practitioners*, Vol.1 (London: Bailliere, Tindall & Cox, 1904) p.214.

¹¹⁵ Ibid.

physiological variations in the health of her sexual organs.”¹¹⁶ For this reason he suggested an approach to women’s afflictions that incorporated the role of the body as well as the mind.

Other physicians propounded the view that a woman’s weak nervous system made her more susceptible to the exertions of her reproductive system which then contributed to her neuroses. Consulting obstetric physician to London Hospital, George Ernest Herman (1849-1914) argued physicians had to appreciate that a weak nervous system made women especially prone to gynaecological complaints. Such women, wrote Herman, “feel more acutely; they increase their local troubles by fixing their attention on them; they imagine that they are going to have other disease”.¹¹⁷ Herman thus suggested the most obvious symptoms of the neurotic were often gynaecological in nature. Yet to assume this was the foundation of their disorder was, he argued, “a grave error.”¹¹⁸ Rather, the state of a woman’s nervous system was the determining factor in whether she could withstand the pathological potential of her sexual body, or succumb to it. The idea of women’s body making them particularly prone to certain neurotic afflictions inevitably appealed to gynaecology because it maintained its authority over such patients.¹¹⁹ It also meant that no matter how much physicians acknowledged a woman’s reproductive body did not entirely determine her health or account for all her disorder, they could continue to assert that the female constitution was weaker, always in a potential state of unrest, and thus in need of constant medical supervision.

¹¹⁶ Ibid., p.218.

¹¹⁷ George E.Herman, *Diseases of Women: A Clinical Guide to their Diagnosis and Treatment*. (London: Cassell, 1907) p.12.

¹¹⁸ Ibid.

¹¹⁹ Janet Oppenheim argues many female patients deemed neurotic were in fact treated by gynaecology because of the terrible stigma and fear associated with the asylum and psychiatric practice. *Shattered Nerves*, p.32.

Changes to the science of woman largely prompted by criticism of gynaecology's unscientific and erroneous approach to treating women's nervous afflictions, saw increasing acceptance of functional disorders. In turn, this shifted the certainty many physicians held about the generative cause of a number of largely behavioural disorders and resulted in the reassessment of many afflictions, including nymphomania. Sexual feelings themselves, rather than their origin or source, were increasingly accorded significance in discussion of women's nervous and mental afflictions, because of the impact such feelings could have on a woman's mental state, weak nervous system, or 'nerve force'. Conceptions of health based on nerve force went some way to stressing the role of the effect of the emotions on the body, as well as the need for moderation in all things.¹²⁰ This fixed energy conception of the body posited that every bodily and mental effort drained the limited fund of nerve force. Thus an intense activity of the body or mind effected an individual's entire equilibrium. Excessive emotional outlays, including those of an erotic nature, exacted an expenditure of this vital energy that was ultimately detrimental to one's physical and mental health. This was particularly the case for women because their endowment of nerve force was already below par, drained as it was by their periodic functions. Such an acknowledgment of the role strong emotions could have on a woman's health suggests the British medical world was undergoing great change in its conception and approach to women's afflictions. Yet in truth, physicians failed to explore the wider ramifications of their ideas. Despite the fact it was increasingly clear to many physicians that nymphomania was not strictly a disorder of the generative organs, there was far less certainty or discussion regarding what was regarded as the cause of a such excess or for that matter, erotic desire. In fact, designating

¹²⁰ On conceptions of nerve force see Cynthia Eagle Russett, *Sexual Science: The Victorian Construction of Womanhood* (London: Harvard University Press, 1991) p.108-119.

a wealth of aberrant behaviour as functional or nervous, such as excessive erotic impulse, served a useful purpose because it overcame the issue of exactly what caused such an affliction. Yet once physicians began to accept that nymphomania did not possess a definitive organic aetiology, they were faced with the question of whether it really constituted a distinct disorder at all. In fact as the next chapter shows, the discussion on nymphomania at the close of the nineteenth century, largely taking place in the psychiatric domain, reveals it increasingly occupied a far more ambivalent or variable position in medical thinking.

Chapter Seven

Sex in Mind, Sex in Body: *Nymphomania at the end of the Nineteenth-century*

“Desire is one of the strongest of animal passions. The wild animal, such as a stag, which is docile or timid to a degree will, when that *causa terrima belli*, love, enters in, become a furious and dangerous antagonist. Education and the restrictions of society have done much to suppress the appearances of emotion, and have controlled most markedly the exhibitions of sexual longing. But the roots of the evil lies deeper, and as soon as self-control is lost, one sees the passions manifested in all their naked truth. Love, under these circumstances, will have to be looked upon as one of the causes, and also of the symptoms, of mental disorder ... The consideration, however, of nervous inheritance would have something to do with the prospect, and any other cause of special bodily deterioration will have also to be noted.” George H. Savage, *Insanity and Allied Neuroses*, 1896. ¹

“Control is the basis of all law and the cement of every social system among men and women, without which it would go to pieces ... sufficient power of self-control should be the essence and test of sanity”. Thomas S. Clouston, *The Hygiene of Mind*, 1906. ²

In the 1900 edition of *A Cyclopaedia of Practical Medicine and Surgery*, there was no detailed entry for nymphomania. Instead, the reader was directed to see ‘mania’ under which were listed a variety of ‘types’, including hysteria, neurasthenia, epileptic mania, puerperal mania, menstrual mania, erotic mania, and nymphomania, which was defined as “a morbid irresistible impulse to satisfy the sexual impulse peculiar to the female sex”.³ The inclusion of nymphomania within a more general entry for mania illustrates the extent to which its status as a separate diagnostic entity had changed. Ongoing criticism of the gynaecological approach to women’s afflictions, and the increasing authority accorded functional nervous disorders, shifted the certainty many physicians previously demonstrated in their aetiological conception of nymphomania. A woman’s excessive and overpowering erotic desire and her concomitant behaviour continued to be considered an aberration. However, new explanations for such disorder altered the way nymphomania was conceived, and the place it occupied in physicians’ diagnoses. As a

¹ George H. Savage, *Insanity and Allied Neuroses* (London: Cassell & Co 1896) p.54.

² Thomas S. Clouston, *The Hygiene of Mind* (London: Methuen & Co., 1906) p.80.

³ G. M. Gould and W.L. Pyle, *A Cyclopaedia of Practical Medicine and Surgery* (London: Rebman, 1900)

specific disorder nymphomania was less and less satisfactory to many physicians. Although physicians continued to speak of nymphomania, it was more in adjectival form, stressing the aberrant behaviour observed amongst various mental or nervous afflictions.

Within *Cyclopaedia*, all varieties of mania were marked by a “great exaggeration of nervous action” linked to a “loss of the inhibitory action of the highest controlling centers of the brain.”⁴ Heredity was also noted as “a strong predisposing cause”, while such afflictions were said to be most common in “young adult life”.⁵ This chapter traces the increasing significance physicians accorded the workings of the brain, specifically theories of mental control and inhibition, as well as an individual’s heredity in their conceptions of disorder. The way these were outlined by prominent psychiatric physicians, in particular Thomas Smith Clouston, is of critical interest in this context. Through his writings and medical practice, Clouston played an influential role in the importance many late nineteenth century medical authorities accorded inhibition and heredity in an individual’s mental health. Drawing on Clouston’s work means this chapter is concerned with conceptions of aberrant behaviour as they were outlined within the psychiatric domain. While still faced with an ongoing struggle to achieve its legitimacy, by the close of the nineteenth century the psychiatric discourse was particularly influential in the way a woman’s excessive sexual impulse was perceived. In the shift away from a focus on the female reproductive system to an increasing concern with the dysfunctions of the brain, nymphomania was caught up in discussion of women’s capacity for control which was considered the decisive and determining issue in any individual’s mental health. Of particular importance to this chapter is not only how the significance physicians accorded an individuals’ control shifted the meaning and status of nymphomania as a disorder, but the factors that accounted for its lack in certain individuals or ‘types’.

Diagnostic shifts

By the later nineteenth century, medical discussion about nymphomania increasingly took place in the context of a wider discourse on mental disorders and nervous afflictions. Amongst asylum physicians, nymphomania was regarded as a sign or symptom of derangement, mania, mental disease, and full-blown insanity. The idea of nymphomania as merely a symptom of another disorder was propounded by certain

⁴ *A Cyclopaedia of Practical Medicine and Surgery*.

⁵ *Ibid*.

sections of the psychiatric domain long before it took hold within gynaecology. As early as 1870, Battey Tuke (1835-1913) rejected listing nymphomania and satyriasis as “distinct natural orders”, that is, separate disease entities. Rather, Tuke regarded these as “certain symptoms” common to “many forms of insanity and dipsomania, which may occur in climacteric insanity, insanity of pregnancy, insanity of pubescence or traumatic insanity.”⁶ Similarly in 1875, medical director at the West Riding Asylum, James Chrichton-Browne objected to the view that uncontrollable passions were a distinct form of insanity. He argued this could not be the case because of uncertainty as to whether disordered sexual desire was a mental disease in itself, or simply the symptom of something else.⁷ Chrichton-Browne cited the case of a young girl who exhibited intense eroticism and sexual desire at her menstrual period. He believed there was no accurate way of deciding whether such disordered displays were evidence of nymphomania, adolescent insanity, or any other form of insanity. Browne argued with such sexual disorder, the consequences of mental aberration could be “wrongly taken for the cause”.⁸

The most representative example of the psychiatric conception of nymphomania at the close of the nineteenth century is that in Daniel Hack Tuke’s *A Dictionary of Psychological Medicine with the Symptoms, Treatment and Pathology of Insanity*, published in 1892. While no single work can be taken as a complete reflection of this complex discourse, William Bynum is right in suggesting the comprehensive nature of Tuke’s Dictionary “offers a unique window into the late Victorian profession.”⁹ In the detailed entry on nymphomania written for Tuke’s *Dictionary* by French alienist Louis Gustave Bouchereau (1835-1900), a woman’s excessive sexual impulse was described as a condition which “affects and dominates her, all the impressions appeal to her morbidly impressionable state, and she often becomes the slave of her instincts”.¹⁰ Such behaviour was said to frequently appear “in the course of various mental disorders” amongst which were included mania, idiocy, epilepsy, general paralysis, hysteria, and brain

⁶ B.Tuke, ‘A Pathological Classification of Mental Disease’, *Asylum Journal of Mental Science* 16 (1870): 199-210; p.204.

⁷ James Chrichton-Browne, ‘Skae’s Classification of Mental Diseases’, *Asylum Journal of Mental Science* 21 (1875): 339-365.

⁸ *Ibid.*, p.356.

⁹ William F.Bynum, ‘Tuke’s *Dictionary* and psychiatry at the turn of the century’ in G.E. Berrios and H.Freeman (eds.), *150 Years of British Psychiatry 1841-1991* (London: Gaskell, 1991): 163-179; p.163.

¹⁰ L.G. Bouchereau, ‘Nymphomania’, in D. Hack Tuke (ed.), *A Dictionary of Psychological Medicine* (London: J&A Churchill, 1892): 863-866; p.864.

degeneration.¹¹ Bouchereau wrote nymphomania “must not be considered as a morbid entity”, but “a form or variety of mental derangement connected with affections which may differ as regards their seat, nature and development”.¹² Bouchereau, who had a close friendship with Tuke, studied under Falret, Baillarger and Charcot, and was made superintendent of the female wards at St. Anne asylum in 1879. In 1891 he was elected president of the *Société Médico psychologique* of Paris.¹³ While Bouchereau’s description of nymphomania suggests the idea of excessive erotic desire as a distinct entity was under review, the idea of such excess constituting disorder certainly was not. Indeed, the French physician admitted that while it was unjust to attribute all the actions of libertinism in women to “morbid proclivities”, nonetheless, he believed insanity must be suspected “and looked for” if “a woman after a long life of propriety and modesty gives herself suddenly to debauchery”.¹⁴ Bouchereau wrote the presence of a “violent irresistible sexual appetite which must be satisfied” should alert the physician to a disorder or even an insanity which “will soon become obvious”.¹⁵ In such states however, he believed nymphomania was generally a temporary phenomenon.

Bouchereau also contributed the entries on erotomania and satyriasis to Tuke’s *Dictionary*. The former was described as “intense morbid desire towards the other sex”, yet lacking sensual passion.¹⁶ With regard to satyriasis, Bouchereau rejected the idea that it constituted “a special and distinct affection.” Rather, like nymphomania, it was a “symptom” appearing in the course of various maladies, but “in a transitory form” and with a short duration.¹⁷ Extreme abstinence as well as excess, along with immoral books, a lesion of the brain, or traumatism at an early age were all offered as potential causes of the behaviour characteristic of satyriasis. Bouchereau noted satyriasis showed itself in obscene language, libidinous ideas, and a morbid proclivity to sexual acts. However the physician was unsure whether such cases were evidence of lunacy or simply “a perverted individual”.¹⁸ While the substantial entries on both satyriasis and nymphomania in Tuke’s *Dictionary* suggest excessive eroticism continued to attract much interest, it does

¹¹ L.G. Bouchereau, ‘Nymphomania’.

¹² Ibid.

¹³ ‘Obituary’ *Journal of Mental Science* 46 April (1900): 407-408.

¹⁴ L.G. Bouchereau, ‘Nymphomania’, p.865.

¹⁵ Ibid., p.864.

¹⁶ L.G. Bouchereau, ‘Erotomania’, p.460.

¹⁷ L.G. Bouchereau, ‘Satyriasis’, p.1108-1109.

¹⁸ Ibid., p.1109.

not mean they were considered major diagnostic categories. These entries reinforce the sense in which, by the 1890s, disordered erotic behaviour was expected amongst a range of mental and nervous afflictions and patients. Lacking definite organic aetiology, excessive erotic desire was deemed more a sign of some type of mental or nervous affliction than a disorder in its own right.

In *Insanity and the Allied Neuroses* (1896), leading London alienist George Henry Savage described “unrestrained or ill-regulated sexual passion” as a marked symptom of both mania and hysteria. By the time Savage was writing many physicians regarded both these disorders as highly protean, consisting more of an array of symptoms than any definable state. Savage claimed the symptoms of “what may be properly called hysteria” were so expansive as to incorporate “every shade of nervous disorder, from the simplest emotional storm of laughter with tears, up to violent mania”.¹⁹ He admitted he had great difficulty distinguishing between a nervous young woman with “mischievous tendencies” and cases classed as hysterical mania or nymphomania. Similarly in his lectures on Hysteria, Thomas Dixon Savill (1856-1910) noted it “consists only of symptoms; it has no recognisable anatomical features, nor any agreed pathological characteristics”.²⁰ A lack of self-control was decisive to the aberrant erotic behaviour noted in both hysteria and various forms of mania. For Savage, this lack destroyed the patient’s emotional and social character and thus their “ideas of propriety as regards the sexes”.²¹ In his detailed discussion on the various types of mania, Savage noted how “almost invariably” all involved “increase or perversion of sexual desire, leading to immoral or indecent acts”.²² In his description of ‘simple mania without delusions’, Savage outlined how such cases saw a woman’s behaviour become increasingly less conventional, and thus “a lady will smoke, talk slang, or be extravagant in dress, and will declare her intention of doing as she likes.”²³ At this stage, Savage warned, love affairs and “like complications” are common, as well as “masturbation or unseemly language and gesture”.²⁴ Highly regarded amongst his peers, Savage’s ideas illustrate the way

¹⁹ G.Savage, *Insanity and Allied Neuroses* (London: Cassell and Co., 1896) p.81.

²⁰ Thomas Savill, *Lectures on Hysteria and allied vaso-motor conditions* (London: Henry J. Glaiser, 1909) p.6.

²¹ George Savage, *Insanity and Allied Neuroses*, p.83.

²² George Savage, “Mania”, in C.Allbutt, H.Rolleston (eds.), *A System of Medicine by Many Writers*, vol.8, 2nd ed. (London: Macmillan and Co., 1911) p.896.

²³ *Ibid.*, p.893.

²⁴ *Ibid.*

behaviour previously deemed nymphomania was regarded as a symptom of a loss of self-control that was itself the decisive aspect of a host of mental disorder and aberrant conduct.

Many late nineteenth century psychiatric physicians considered an individual's capacity for control as the determinant in their mental health. A lack of such control was considered a sign of mental disorder and the cause of the wide array of behaviour associated with such states. While the concern with self-control might suggest physicians were shifting away from somatic explanations of disorder, the fact is they remained deeply committed to them. Despite acknowledging the important role strong emotions could have on an individual's mental health, physicians continued to cling to organic conceptions to account for their excess. Within this context, the increasing causal significance accorded a woman's self-control ultimately stressed the importance of the organ of the mind, namely the brain, rather than the organs of women's sexual body in their aberrant conduct. While such explanations often defied material analysis they nonetheless also provided the illusion of a somatic and thus legitimate, scientific explanation.

The control of the brain

The role late nineteenth century psychiatric physicians' accorded the brain in an individual's mental disorder was a not new idea. British mad-doctors and alienists had been arguing such a connection for a century.²⁵ The scientific study of phrenology that began with the anatomical research of Viennese physician Franz Joseph Gall (1758-1828) at the turn of the century, was of particular importance to the development of psychiatric thinking about the brain over the first half of the nineteenth century.²⁶

²⁵ Janet Oppenheim, *Shattered Nerves: Doctors, Patients, and Depression in Victorian England* (Oxford: Oxford University Press, 1991) p.31.

²⁶ For a long time phrenology was dismissed as mere quackery however, more recent scholarship has sought to illustrate its importance to psychiatry and neurology especially ideas of cerebral localisation. On phrenology in Britain see William F. Bynum, 'Rationales for therapy in British psychiatry, 1780-1835', *Medical History* 18 (1974): 317-334; G.N. Cantor, 'The Edinburgh Phrenology Debate: 1803-1828', *Annals of Science* 32 (1975): 195-218; David de Giustino, *Conquest of Mind: Phrenology and Victorian Social Thought* (London: Croom Helm, 1975); Roger Cooter, 'Phrenology and British Alienists, ca. 1825-1845', in A. Scull, (ed.), *Madhouses, Mad-doctors & Madmen* (London: Athlone Press, 1981): 58-104. On Gall see Owsei Temkin, 'Gall and the phrenological movement', *Bulletin of the History of Medicine* 44

Phrenology stressed the brain was the organ of the mind, that it consisted of a number of separate regions each related to a distinct mental faculty, and the size of each region equated with the power of its associated faculty.²⁷ By the late 1850s, the development of staining techniques in microscopic examinations led to the further development of the idea of specific functions linked to specific regions of the brain.²⁸ In the 1860s and 1870s, leading British neurologists David Ferrier (1843-1928) and John Hughlings Jackson (1835-1911), along with their French and German counterparts, demonstrated specific cerebral lesions could be directly linked to various defects of speech and movement.²⁹ These neurologists considered the array of behavioural aberrations psychiatrists witnessed in the asylums as manifestations of neurological disorder. Hughlings Jackson wrote that for medical men, such “psychical symptoms” were merely “signs of what is wrong in a material system”.³⁰ Such a physiological fact gave neurologists and psychiatrists alike a definite and unique organic aetiology to account for mental disorder, and saw a neuropsychiatric approach develop within the psychiatric domain.

For some time there was a close connection between psychiatry and neurology in Britain. This was perhaps best represented in the journal *Brain*, which was founded in 1878 by Ferrier, Jackson and psychiatrists James Bucknill and James Chrichton-Browne.³¹ Scottish born Chrichton-Browne, an avid supporter of phrenology, was particularly keen to unite psychiatry with neurology, and encouraged neurological research in the laboratories of the West Riding Asylum. It was here that Ferrier undertook his groundbreaking research on cerebral localisation. Like many other psychiatrists of his

(1970): 297-314; R.M.Young, *Mind, Brain, and Adaptation in the Nineteenth century: Cerebral Localization and its Biological Context from Gall to Fourier* (Oxford: Oxford University Press, 1970).

²⁷ Janet Oppenheim, *Shattered Nerves*, p.55.

²⁸ *Ibid.*, p.30.

²⁹ Along with Ferrier and Jackson, the work of Frenchman Paul Broca and that of the Germans Eduard Hitzig, Gustav Fritsch, and Karl Wernicke demonstrated the localisation of function in the cerebral cortex. On this see J. Oppenheim, *Shattered Nerves*, p.30-31; William. F. Bynum, ‘The nervous patient in eighteenth-and nineteenth century Britain: the psychiatric origins of British neurology’ in W.F.Bynum, R.Porter, M.Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol.I* (London: Tavistock, 1985): 89-101.

³⁰ Michael Clarke, ‘The Rejection of psychological approaches to mental disorders in late nineteenth century British psychiatry’ in A.Scul (ed.), *Madhouses, Mad-Doctors and Madmen* (London: Althone Press, 1981): 271-301; p.283.

³¹ W. F. Bynum, ‘The nervous patient in eighteenth-and nineteenth century Britain’, p.96.

time, including fellow Scot Thomas Clouston, Chrichton-Browne believed the brain was vital to an individual's mental state and was directly affected by an individual's way of life.³² Indeed, the importance both these physicians accorded an individual's lifestyle on the health of their brain eventually led them to the 'mental hygiene movement' which argued healthy living ensured healthy brains and thus a sane and safe society. Michael Neve suggests the importance accorded the brain and the idea of ensuring its health was the "crucial context" for why, up to 1914, Scottish psychiatry was "more intellectually ambitious than its English counterpart".³³ Both Clouston and Chrichton-Browne, prominent members of the Scottish psychiatric fraternity, became committed adherents of mental hygiene, particularly with regard to the nurturing of young adolescent brains. As shall be shown, their concerns with mental hygiene were not only for the sake of the individual but in order to save the British race.

For Thomas Clouston, the role of the brain was crucial to the process of 'mental inhibition' which he believed was the determining factor in an individual's mental health, or lack thereof. Clouston argued mental inhibition was the physiological process of self-control, and was "the essence of soundness of mind, while the lack of it is the most distinctive feature of mental unsoundness".³⁴ Influenced by ideas of cerebral localisation and neurological function propounded by Ferrier and Hughlings Jackson, Clouston reasoned certain portions of the brain and nervous ganglia were devoted to the function of control—so called "inhibitory centres" which give an individual the power of inhibition.³⁵ One's degree of control was thus dependent upon the state of the brain, and as Clouston acknowledged, "different brains have different degrees of controlling power".³⁶ Any sort of dysfunction in the inhibitory centres causing their arrest or destruction resulted in a lack of control, morbid impulses, irritability of the mind, and "lawless action".³⁷ Clouston argued the functioning of the brain was affected by causes

³² Michael R. Neve, 'The Influence of Degenerationist Categories in Nineteenth Century Psychiatry, with Special Reference to Great Britain', in *History of Psychiatric Diagnoses: Proceedings of the Sixteenth International Symposium on the complete history of medicine* (1991): 141-163; p.157.

³³ Ibid., p.155. On Scottish psychiatry see Tom Walmsley, 'Psychiatry in Scotland', in G.E.Berrios and H.Freeman (eds.), *150 Years of British Psychiatry 1841-1991* (London: Gaskell, 1991): 294-305.

³⁴ Thomas Clouston, *Unsoundness of Mind* (London: Methuen, 1911) p.179.

³⁵ Ibid., p.181.

³⁶ Ibid., p.144.

³⁷ Ibid.

“within or without the organism.”³⁸ An individual’s way of life, including what they consumed, the intellectual and physical activities they undertook, as well as certain functions or cycles of the body, all directly affected the healthy workings of the brain, the capacity for control, and thus one’s mental state.

By the 1880s, the concept of inhibition had acquired increasing explanatory significance amongst physicians in the psychiatric domain. Given the epistemological rigidity within nineteenth century medical thinking, especially the insistence on somatic explanations, the conception of inhibition inevitably proved attractive because it provided the illusion of an organic foundation for irrational behaviour. One of the greatest challenges psychiatric physicians faced in accounting for mental illness was making seemingly invisible forces visible. In this sense, the concept of inhibition assisted “in the difficult task of formulating neuro-physiological concepts capable of characterizing the physical basis of mind.”³⁹ Clouston himself acknowledged the doctrine “has done very much to definitise (sic) our notions in regard to the mental workings of the brain.”⁴⁰ This is not to suggest it was a concept supported by clinical observation and demonstration. As Clouston admitted, there was “no positive proof of mental inhibitory centres”. However, he accepted inhibition existed as a function and “a function always implies an organ of some sort.”⁴¹

In wider terms, inhibition can be linked to the Victorian preoccupation with order, control and moral behaviour. This concept reinforced the hierarchical relations between brain and body and in so doing, gave legitimacy to the belief order and control were fundamental properties of the human organism. It not only attributed restraint to the normal workings of the body, but in turn, reinforced the pathological nature of their antithesis. Roger Smith suggests inhibition was also caught up in the preoccupation with the functioning of the will.⁴² The will was the pivotal concept in Victorian psychiatry. It was conceived as having a supervisory function over all the activities of the mind including ideas, sensory impressions, emotions and desires as well as the lower impulses

³⁸ Thomas S. Clouston, ‘The Study of Mental Disease’, *Edinburgh Medical Journal* 25 (1879): 1-20; p.16.

³⁹ Roger Smith, *Inhibition: History and Meaning in the sciences of mind and brain* (London: Free Association books, 1992) p.229.

⁴⁰ Thomas S. Clouston, *Clinical Lectures on Mental Disease* (London: J.A.Churchill,1883) p.335.

⁴¹ Ibid.

⁴² Roger Smith, ‘The meaning of “inhibition” and the discourse of order’, *Science in Context* 5 (1992): 237-263; p.243.

or instincts. Yet as Janet Oppenheim argues, it also straddled the “irresolvable tension between mental and somatic interpretations of neurotic illness”.⁴³ The physiological conception of inhibition overcame the scepticism directed at a purely psychological explanation of the relationship between the mind and body, yet also retained such an elusive concept.⁴⁴ As Clouston acknowledged, “the physiological word ‘inhibition’ can therefore be used synonymously with the psychological and ethical expression ‘self-control’ or with the ‘will’.”⁴⁵

While the theory of inhibition was not Clouston’s brainchild, he was one of its leading advocates in late nineteenth century English psychiatric discourse. Clouston devoted a great deal of his medical writing to inhibition especially its important role in understanding and conceiving a variety of disorder. In his position as University lecturer, he instructed his medical students that any evidence suggesting a lack of self control represented mental incapacity that could be formally classified as “states of defective inhibition” which had many ‘varieties’ including nymphomania.⁴⁶

Thomas Clouston and nymphomania as defective mental inhibition

Thomas Clouston (1840-1915) received his MD from Edinburgh University in 1861, a year after he gained the licence of the Royal College of Surgeons of Edinburgh. Following his graduation, the young Clouston was appointed assistant physician at Scotland’s prestigious Royal Edinburgh Asylum, Morningside. Clouston remained at Morningside for four years under Dr David Skae until his appointment as medical superintendent at the Cumberland and Westmorland Asylum at Carlisle. In 1873, the year Clouston was elected a fellow of the Royal College of Physicians of Edinburgh, he was offered the late Dr Skae’s position at Morningside. Clouston remained at the Royal Asylum until 1908, presiding over a number of changes that established his name not only in the history of that institution, but Edinburgh psychiatry in general.⁴⁷ Under Clouston’s direction, Morningside was said to “stand for all that was good scientifically

⁴³ J. Oppenheim, *Shattered Nerves*, p.44.

⁴⁴ On the negative perception of psychological explanations see Michael J. Clark, ‘The Rejection of psychological approaches to mental disorders in late nineteenth century British psychiatry’.

⁴⁵ T. S. Clouston, *Clinical Lectures on Mental Disease* (1883) p.337.

⁴⁶ Ibid.

⁴⁷ On Clouston’s career and influence see, Allan Beveridge, ‘Thomas Clouston and the Edinburgh School of Psychiatry’, in G.E.Berrios and H.Freeman (eds.), *150 Years of British Psychiatry, 1841-1991* (London: Gaskell, 1991): 359-388.

and medically, as well as for all that was humane and efficient, in the treatment of mental diseases and in the management of the inmates.”⁴⁸ In 1879 Clouston was appointed University lecturer in Mental Diseases at the University of Edinburgh, the first position of its kind, which saw him playing a leading role in both the teaching of psychiatry and the academic recognition of the study of mental diseases.⁴⁹ Unlike their English colleagues, Scottish psychiatrists enjoyed considerable support in the universities and the Royal College of physicians, to which Clouston was elected president in 1902.⁵⁰ While renowned amongst his students and peers for his brilliant lecturing style, Clouston also cemented a wider reputation as a leader in his field through the tremendous amount of written material he contributed to medical journals, newspapers, pamphlets, asylum reports, as well as his many textbooks. In 1911, Clouston’s substantial achievements and contributions to psychiatry were formally acknowledged when King George V conferred a knighthood upon him.

Clouston’s philosophy of mental health and his understanding of disorder were distilled in his early years in Edinburgh. At Edinburgh University, Thomas Laycock, who advocated a ‘scientific cerebral psychology’, taught Clouston that through the principles of physiology, a clinical method could be used in the study of the mind. In later years under the direction of David Skae and influenced by neurology, especially the work of David Ferrier, Clouston accepted the supposition that mental disease was first and foremost evidence of brain disease. He argued all varieties of mental disease “find their origin and flow out of excess, defects, and irregularities in the physiological functions of the brain.”⁵¹

Like his mentor Skae, Clouston was interested in the classification of mental diseases. As a committed somaticist, Skae was drawn to the physical symptoms observed in mental disease and this structured the classificatory system both he and then Clouston utilised at

⁴⁸ ‘Obituary’ *British Medical Journal*, April 24, (1915): 741.

⁴⁹ Allan Beveridge, ‘Thomas Clouston and the Edinburgh School of Psychiatry’, p.369.

⁵⁰ On Scottish psychiatry see Tom Walmsley, ‘Psychiatry in Scotland’ in G.E.Berrios and H.Freeman (eds.), *150 Years of British Psychiatry*: 294-305; D.K.Henderson, *The Evolution of Psychiatry in Scotland* (Edinburgh: Livingstone, 1964).

⁵¹ T. S. Clouston, *The Neuroses of Development being the Morisonian Lectures for 1890* (Edinburgh: Oliver & Boyd, 1891) p.330.

Morningside.⁵² In fact, beyond some modifications, this system which Clouston claimed “seizes on the bodily and constitutional relationships of the mental symptoms and groups them accordingly”, directed his diagnostic practice throughout his term at the asylum.⁵³ In 1869 a committee of the Medical-psychological Association had been set up with the intention of devising a standardised method of recording clinical information of patients admitted to the asylums. Both Clouston and Skae were members of the committee and recommended the adoption of Skae’s system of classifying mental disease for all asylums. In the end the committee proposed using two existing schemes, one suggested by the International Congress of Alienists that relied on classifying disorder according to concepts such as mania, dementia, imbecility and melancholia. The other system was that devised by Skae which was based on the bodily causes and natural history of a disease and also included categories of disturbance based on stages occurring in the life cycle such as adolescence, the climacteric, and childbirth.⁵⁴

In his *Clinical Lectures on Mental Diseases* (1883), a standard Victorian psychiatric textbook, Clouston outlined his symptomatological classification system based on those symptoms which “are most important and stand out in dignity and character from the ordinary symptoms of other diseases”.⁵⁵ He grouped these under eight categories, each of which included a variety of aberrant states and behavioural symptoms. All the varieties of disorder were attributed to the one physical cause, namely, dysfunction of the brain, which, as Alan Beveridge notes, effectively established it as an “inventory of brain disorders”.⁵⁶ One of the eight categories included within Clouston’s classificatory system was ‘States of Defective Inhibition’ which referred to those conditions or cases where there is a “want of inhibitory mental power without marked depression, exaltation,

⁵² Some suggest Clouston’s loyalty to Skae distorted his judgement regarding the latter’s classification system for which Clouston received much criticism from his peers, especially Chrichton-Browne. On this issue see, Alan Beveridge, ‘Thomas Clouston’, p.371; A.D.T Robinson, ‘A Century of delusions in South West Scotland’, *British Journal of Psychiatry* 153 (1988): 163-167.

⁵³ Allan Beveridge, ‘Madness in Victorian Edinburgh: a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873-1908, Part II’, *History of Psychiatry* 6 (1995): 133-156; p.133.

⁵⁴ Allan Beveridge, ‘Madness in Victorian Edinburgh: a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873-1908, Part I’, *History of Psychiatry* 6 (1995): 21-54; p.27.

⁵⁵ Symptomatological Classification system was divided into; States of Mental Depression, States of Mental Exhaustion, States of Regularly Alternating mental Conditions, States of mental Enfeeblement, States of Fixed and Limited Delusion, States of Mental Stupor, the Insane Diathesis, and States of Defective Inhibition. T.S. Clouston, *Clinical Lectures on Mental Disease* (1896) p.10-11.

⁵⁶ A. Beveridge, ‘Thomas Clouston’, p.377.

delusion, or enfeeblement.”⁵⁷ Clouston suggested such a state might also be called “impulsive insanity” or “uncontrollable impulse”. The chief varieties of defective inhibition were ‘moral insanity, suicidal impulse, general impulsiveness, homicidal impulse, kleptomania, pyromania and animal, sexual and organic impulse’. Clouston argued that in cases of defective inhibition, where in some individuals there was an uncontrollable impulse to violence, or destructiveness or drinking, for others it was “acts to sexual gratification” which, he noted, had been distinguished elsewhere by other names such as nymphomania or satyriasis.⁵⁸

In his descriptions of ‘animal, sexual and organic impulse’, Clouston listed “exhibitions of excessive erotic impulse” including “a woman rushing towards any man she sees”, and a girl “who rubs her thighs together to produce sexual excitement the moment she sees a man”.⁵⁹ In this section Clouston also listed erotomania, which was defined as “an intensely morbid desire towards a person of the opposite sex, without reference to the sexual act”.⁶⁰ For Clouston, the issue of most importance in all cases of impulsive insanity was the general want of self-control. Unlike much mental disease in which such a loss of control was simply “part of a general mental affection”, Clouston argued the impulsive behaviour was “the chief and by far the most marked symptom”.⁶¹ Thus, by including nymphomania in this section, it can be seen it was not the excess of erotic impulse per se that constituted the disease, rather, the “want of controlling power or impulsive tendencies”.⁶² In this sense, a woman’s erotic excess was not a specific disorder suggesting an inherent dysfunction of her sexual desire and sexual organs. Rather, it was just one of many manifestations of a woman’s lack of control.

Clouston did not limit nymphomania to varieties of defective inhibition. In the case notes of patients under his care at Morningside and in his *Clinical Lectures*, terms such as hysterical, and nymphomania, along with details of excessively erotic behaviour, were often used to describe a variety of different cases including the ubiquitous ‘hysterical insanity’. With such cases, Clouston wrote, the physician could expect “a morbid

⁵⁷ T. S. Clouston, *Clinical Lectures on Mental Disease*, 4th ed. (1896) p.10.

⁵⁸ T. S. Clouston, *Clinical Lectures on Mental Disease*, 6th ed. (1904) p.337.

⁵⁹ *Ibid.*, p.350.

⁶⁰ *Ibid.*

⁶¹ *Ibid.*, p.337.

⁶² *Ibid.*, p.333.

orientation of sexual and uterine symptoms” or “marked erotic symptoms” or “a morbid waywardness”.⁶³ One woman admitted to Morningside in 1887 Mrs Edith W, was described as “hysterically peevish” and “very emotional”. She was also said to be “very erotic in the presence of persons of the opposite sex, whom she attempts to kiss and embrace at every opportunity.”⁶⁴ Another patient, Hannah J admitted in 1889, was noted for ecstatic behaviour that was likened to “French nymphomaniacs”. Margaret M was said to indulge in “fancied contortions and makes sucking noises with her lips”. Her excitement was also “much increased in the presence of males” causing “the rhythmical throwing about of the body”.⁶⁵ These cases illustrate the way a woman’s erotic symptoms were no longer considered a specific diagnosis. Where once they could have legitimately been taken as evidence of nymphomania, for physicians such as Clouston, they were first and foremost proof of a patient’s lack of control, or more specifically, brain disorder.

In accounting for states of defective inhibition and uncontrollable impulse, Clouston accorded primary causality to the “excesses, defects and irregularities” of the brain functions.⁶⁶ With regard to his ideas about a woman’s lack of control over her sexual feelings, there is a great deal of similarity with the neurological theories of David Ferrier. Ferrier argued nymphomania was evidence of the way the sexual appetite could be “morbidly excited by pathological irritation of the cerebral paths and cerebral centres”.⁶⁷ In a similar vein, Clouston accorded causal significance to the excitation or “overdevelopment of energy” of certain portions of the brain.⁶⁸ He also attributed responsibility to “a loss of controlling power in the higher regions of the brain” which in women, he argued, was a product of their weaker brain. In turn, women’s weaker brains were attributed to the effect of their “great crises of life”, as well as evolution specifically, women’s failure to adapt to the environment to the same extent as men.⁶⁹

In the *Neuroses of Development* (1891), Clouston described the different development of the male and female brain beginning from puberty, as well as the differentiation between men and women’s mental types occurring between the ages of eighteen and twenty-five.

⁶³ T. S. Clouston, *Clinical Lectures on Mental Disease*, 6th ed., p.533.

⁶⁴ A. Beveridge, ‘Madness in Victorian Edinburgh: Part II’, p.142.

⁶⁵ Ibid.

⁶⁶ T.S. Clouston, *Clinical Lectures on Mental Disease*, 4th ed. p.339.

⁶⁷ David Ferrier, *The Functions of the Brain* (London: Smith &co., 1876) p.262.

⁶⁸ T. S. Clouston, *Clinical Lectures on Mental Disease*, 4th ed. p.337.

⁶⁹ Ibid., p.339.

Men's mental development was characterised by action, cognition, and duty, and directed towards the higher imagination. Conversely, women's mental development took the direction of emotion, and was characterised by a "protective instinct" and a craving for "admiration and worship" and "an ideal hero to be loved and worshipped in return."⁷⁰ Such a gendered conception of the brain and mental character was not isolated to Clouston. Throughout the nineteenth century, physicians conceived of the brain and its functions in inherently gendered and unequal ways. As one of Clouston's mentors, English psychiatrist Henry Maudsley (1835-1918), declared, "there is sex in mind as distinctly as there is sex in body."⁷¹

From the early nineteenth century, psychiatrists, anthropologists, and comparative psychologists had been fascinated with the information supposedly revealed by cranial measurements and the weight of brains.⁷² The study of phrenology initiated the idea that the cranium was an accurate reflection of the development of particular organs of the brain, and thus the strength of the faculties associated with them.⁷³ The contour of the skull, as well as the weight of the brain, were taken as an accurate indication of an individual's intelligence.⁷⁴ From such thinking arose the hypothesis women's smaller skull was evidence of their inferior or limited mental capacity.⁷⁵ Eventually craniology, like phrenology, was discredited, although the idea of women's different brain functions and mental capacity remained entrenched within late nineteenth century conceptions of sexual difference. From the autopsies he performed on inmates at the West riding asylum, Chrichton-Browne concluded the different size and weight of men and women's brain were not simply a result of their relative size differences, but rather, "a fundamental sexual distinction".⁷⁶ This declaration from such an influential and authoritative figure in

⁷⁰ T. S. Clouston, *The Neuroses of Development*, p.112-113.

⁷¹ Cited in Elaine Showalter, *The Female Malady*, p.122. Henry Maudsley, *Responsibility in Mental Disease* (London: Henry King, 1874) p.7.

⁷² On this see, Cynthia Eagle Russett, *Sexual Science: The Victorian Construction of Womanhood*. (London, Harvard University Press, 1991) p.31-39.

⁷³ Michael Shortland, 'Courting the Cerebellum: Early Organological and Phrenological views of sexuality', *British Journal of the History of Science* 20 (1987): 173-199; p.177.

⁷⁴ Allan Beveridge, 'On the Origins of Psychiatric Thought: The contribution of Edinburgh, 1730-1850' in H. Freemans and G. E. Berrios (eds.), *150 Years of British Psychiatry Volume II: the Aftermath* (London: Athlone Press, 1996): 339-366, p.355.

⁷⁵ On this see Elizabeth Fee, 'Nineteenth-century craniology: the study of the female skull', *Bulletin of the History of Medicine* 53 (1979): 415-433.

⁷⁶ J. Oppenheim, *Shattered Nerves*, p.185.

the psychiatric domain lent the idea much legitimacy. Indeed, by the late nineteenth century there was a general consensus regarding the specific mental faculties women lacked in comparison to men. This view was given further support from contemporary theories of evolutionary biology that asserted women were evidence of an arrested form of cerebral evolution.

The impact of evolutionary thinking on late Victorian neurology saw the advancement of a hierarchical conception of the nervous system. In this scheme, the operation of the highest centres, in particular the faculty of control, was only possible in the most evolved.⁷⁷ Thus the exercise of reason and control represented the highest stage of all animal development, while its antithesis was evidence of an individual's lower place on the evolutionary map. Given women were believed to possess an incomplete or less fully evolved cerebral development that placed them at "a past or lower state of civilisation", it is easy to see how this type of rationale provided yet further proof of women's inherent lack of control, and thus inferiority.⁷⁸

The difference posited between men and women's environments, needs, and struggle for survival, were considered so vast as to constitute a plausible explanation for their different adaptation and thus capacities.⁷⁹ While for psychiatry, women's lack of control was the product of her neurology, this was a discourse that essentially perpetuated the type of determinism observed in the gynaecological domain. By virtue of their femaleness women were unable to achieve the degree of self-discipline that arose from the action of the higher nervous centers over the lower ones. Like so much thinking before it, this simply reinforced the view that all women were not only more prone to disorder, but in greater need of control. Clouston declared woman "has not attained through civilisation that adaptation to environment to the same extent as men."⁸⁰ For this

⁷⁷ Hughlings Jackson was largely responsible for the idea of a three-tiered nervous system in which he argued that a hierarchy of lower, middle and higher levels had developed during the course of animal history. In this scheme the most complex activities of the human brain were possible in the most evolved. On this see J. Oppenheim, *Ibid.*, p.274.

⁷⁸ Charles Darwin, *The Descent of Man, and Selection in Relation to Sex*, 2 vols., (London: John Murray, 1871) 2: 327.

⁷⁹ C. Eagle-Russett, *Sexual Science*, p.84-85.

⁸⁰ T.S. Clouston, *Unsoundness of Mind*, p.210.

reason he warned that women must “be ever on the alert, to exercise more cunning in a good sense, and to repress certain instincts in a way which is often exhausting.”⁸¹

While psychiatry believed the brain accounted for women’s particular disorders and incapacities, this in no way detracted from the influence accorded the reproductive system. In fact, the functions and cycles of women’s sexual system were believed to have an enormous impact on the functioning of their brain. Like most nineteenth century physicians, Clouston regarded the effects of menstruation, maternity, lactation and parturition, along with puberty and the climacteric, as potentially “ruinous” to women because of the strains exerted on their constitution. In his *Clinical Lectures* he had separate chapters detailing ‘Uterine or Amenorrheal Insanity’, ‘Ovarian Insanity’, ‘Puerperal insanity’, and the array of disorder connected to women’s menstruation.⁸² Clouston suggested there was often a tendency towards a lack of mental inhibition as well as “perversions of the great instincts and appetites” just before the commencement each month of the menstrual cycle.⁸³ Like most neurologists Clouston also believed the greatest impact of women’s physiological periods and processes was their effect on the brain, specifically the process of inhibition. In *The Functions of the Brain* (1876), Ferrier claimed women’s reproductive organs “form such a preponderant element in their bodily constitution, they must correspondingly be more largely represented in the cerebral hemispheres”, evidence for which lay with women’s “greater emotional excitability”.⁸⁴ Similarly, Clouston argued that for women, puberty, adolescence, pregnancy, menstruation and the climacteric were “morbid tendencies” that accounted for their greater ‘brain excitability’ and states of defective mental inhibition, as seen in cases of ‘mania, sleeplessness, erotic trains of thought, sexual excitement, and masturbation’.⁸⁵

The notion of women’s greater brain excitability arising from the functioning of their sexual system reinforced the view that regulation and control were not the natural domain of woman. As such, ideas about women’s innate susceptibility to disorder that so pervaded the gynaecological domain, were simply given new idiom in psychiatric

⁸¹ T.S. Clouston, *Unsoundness of Mind*, p.208.

⁸² T.S. Clouston, *Clinical Lectures on Mental Diseases* 4th ed. p.521-544.

⁸³ *Ibid.*, p.521.

⁸⁴ David Ferrier, *The Functions of the Brain* (London: Smith &co.,1876) p.263.

⁸⁵ T. S. Clouston, ‘Puberty and adolescence medico-psychologically considered’, *Edinburgh Medical Journal* 26 (1880): 5-17; p.16.

conceptions of the effects of the female body on the workings of the brain. Yet Clouston also made important distinctions in regards to this susceptibility that suggests he did not believe all women were affected in the same manner or to the same degree simply by virtue of their femaleness. Certainly, he believed the reproductive body and cycles of the female body subjected women to particular strains that were conducive to disorder and which placed them in a different if not inferior position to men. Yet he also suggested the risks from menstruation, maternity, lactation, conception and parturition to the mental functions of the brain were far greater in those who have “the slightest original predisposition to derangement”.⁸⁶ An individual’s susceptibility or predisposition was in turn, determined by their heredity. Those individuals who inherited “a widespread departure from the normal physiological condition of the whole body” were, Clouston argued, condemned to a more primitive type of brain and mind which, as shall be shown, effectively established some women more than others as innately doomed to disorder, including nymphomania.⁸⁷

Dangerous inheritance

In the nineteenth century, heredity was the subject of increased attention and consideration by numerous psychiatrists. Interest in this subject began in France with alienist Phillipe Pinel, and was subsequently given much greater emphasis by his pupil Jean-Etienne Esquirol, who stressed the role of heredity in mental illness.⁸⁸ In England, the work of physician Joseph Adams (1756-1818), *A Treatise on the Supposed Hereditary Properties of Diseases* (1814), appeared not long after Pinel’s work.⁸⁹ In the text Adams argued that while diseases were not directly transferable along familial lines, there was certainly evidence to suggest an inherited susceptibility or predisposition which could result in illness.⁹⁰ By mid-century, the most significant contribution on the role of an inherited pre-disposition to disease and disorder was provided with the publication of *Traité des dégénérescences physiques, intellectuels et morales de l’espèce humaine*, (1857) the work of French psychiatrist Benedict-Augustin Morel (1809-1873). This text, which became one of the most influential of the nineteenth century, not only

⁸⁶ T. S. Clouston, ‘Puberty and adolescence medico-psychologically considered’, p.9.

⁸⁷ T. S. Clouston, *Unsoundness of Mind*, p.144.

⁸⁸ Phillipe Pinel, *A Treatise on Insanity* (Sheffield: Todd, 1806) p.145-146; Jean Etienne Esquirol; *Mental Maladies: A Treatise on Insanity* (Philadelphia: Lea & Blanchard, 1845) p.49-54.

⁸⁹ Joseph Adams, *A Treatise on the Supposed Hereditary Properties of Diseases* (London: J.Callow, 1814)

⁹⁰ Eric T. Carlson, ‘Medicine and Degeneration: Theory and Praxis’, in S. Gilman, J.E.Chamberlain (eds.), *Degeneration: The Dark Side of Progress* (New York: Columbia University Press, 1985) p.126.

advanced the role of heredity in mental disease, but pioneered the idea of degeneration as a distinct pathological deviation from the norm attributable to an individual's inferior inheritance.⁹¹

Initially Morel's concern with degeneration arose out of his studies on cretinism, an interest which itself emerged while studying the psychiatric practices of various European countries, and which continued on his return to France in his position as director of an asylum.⁹² Morel perceived the cretin as a kind of original example of human degeneracy, and the *Traite* reported his findings on such individuals. Yet the enormous influence of Morel's ideas saw degeneration accorded to much more than cretinism, and as a result, degeneration theory acquiring much wider implications in nineteenth century medical and scientific thought.

Of all Morel's ideas, it was his theories on hereditary transmission or 'law of progressivity' that most captured the interest of the psychiatric world. It described the progressive generational decline arising from the transmission of "bad seed" which saw each new generation receiving a more destructive dose of the evil influence.⁹³ Lamarckian evolutionary theory so named after the French botanist and zoologist Jean Baptiste Lamarck (1744-1829) was central to the idea of degeneration. In the early nineteenth century, Lamarck endorsed the idea that characteristics acquired by the parent during their lifetime were passed onto their offspring in some form.⁹⁴ In the next generation this inferior inheritance would express itself in new and more horrifying ways, so that alcoholism in one generation could be neurosis in the next, and then idiocy in the one after that. The emphasis on inheritance meant degeneration signified a type of retrograde evolution an idea that was endorsed and greatly expanded in later years by Charles Darwin whose work was especially influential on late Victorian medical and scientific thinking. One physician who was particularly taken with both Darwin's work and degeneracy theory was Henry Maudsley, generally considered responsible for

⁹¹ On this see Daniel Pick, *Faces of Degeneration: a European disorder, c. 1848-1918* (Cambridge: Cambridge University Press, 1989), p.44-50; Eric T. Carlson, 'Medicine and Degeneration: Theory and Praxis'; Michael R. Neve, *The Influence of Degenerationist categories in Nineteenth-century Psychiatry, with Special reference to Great Britain*.

⁹² Eric T. Carlson, 'Medicine and Degeneration: Theory and Praxis', p.121.

⁹³ *Ibid.*, p.122.

⁹⁴ On Lamarckian evolutionism see C. Eagle-Russett, *Sexual Science*, p.65.

introducing into English medical thinking the concept of degeneration as it derived from the work of Morel.⁹⁵

As a firm supporter of Morel's work, Maudsley stressed the progressive nature of degeneration arising from the ongoing transmission and inheritance of certain defects. Maudsley talked of the "insane temperament" which, "in its most marked form ... represents the beginning of degeneracy". He declared that if such decline was not checked, it will "go on increasing from generation to generation and end finally in the extreme degeneracy of idiocy."⁹⁶ Maudsley was also a committed social Darwinist, believing degeneration was evidence of an individual's more primitive stage of development. He argued in many cases of mental disorder the physician could observe "all the lower elements of the human kind, all those it shares with the monkey and other animals".⁹⁷ This was particularly the case with certain 'savage and primitive feelings', especially those of an erotic nature.

In *Descent of Man* (1871), Charles Darwin proposed that the frequent repetition of an action established patterns of behaviour which, modified over time, tailored behaviour to environmental pressures and enabled organisms to progress.⁹⁸ For Darwin, expression of emotions became ever more complex with time, evolving into the sorts of refined feelings and sense of beauty witnessed in his own society.⁹⁹ In this sense, nineteenth century middle class ideals and norms were posited as the highest form of progressive

⁹⁵ On Henry Maudsley see Trevor Turner, 'Henry Maudsley: Psychiatrist, philosopher and entrepreneur', in W.F. Bynum, R. Porter, M. Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry. Vol. III*, (London: Tavistock, 1988): 151-189; Elaine Showalter *The Female Malady: Women, Madness and English Culture 1830-1980*. (New York: Penguin, 1985) esp. Chapter 4; W. F. Bynum, 'Themes in British psychiatry J.C. Pritchard to Henry Maudsley', *The University of Western Ontario Series in Philosophy of Science* 21 (1980): 225-242.

⁹⁶ Henry Maudsley, *Responsibility in Mental Disease* (London: King, 1874) p.46-48.

⁹⁷ Henry Maudsley, *The Physiology of Mind* (London: Macmillan, 1876) p.367.

⁹⁸ On this see C. Eagle-Russett, *Sexual Science*, p.87.

⁹⁹ On Darwin's ideas about the relations between the sexes especially the courtship like narrative he imposed on his depictions of sexual selection, see Nancy Armstrong, *Desire and Domestic Fiction: A Political History of the Novel* (New York: Oxford University Press, 1987) p.221-224; Ruth Bernard Yeazell, *Fictions of Modesty* (Chicago: Chicago University Press, 1991): 219-228; Rosemary Jan, 'Darwin and the Anthropologists: Sexual Selection and Its Discontents', in Andrew H. Miller and James Eli Adams (eds.), *Sexualities in Victorian Britain* (Bloomington: Indiana University Press, 1996): 79-95.

evolutionary development from an original uncivilised 'savage' state of being.¹⁰⁰ In *The Physiology of Mind* (1876), Maudsley appeared to echo Darwin's ideas describing the superior evolutionary status of the "well born individual", who "in the most cultivated nation in the most civilised age is capable of feeling emotions which it would be impossible to arouse in the mind of a low savage".¹⁰¹ Thus for Maudsley, the cultivated emotions of the respectable classes, especially those between men and women, was evidence of human evolutionary progress. What concerned him was the fact that such refinement, especially in terms of sexual desire, could be thwarted by any dysfunction or defect in the brain's functioning. He reasoned, "given an ill constituted or imperfectly developed brain at the time when the sexual appetite makes its appearance, and what is the result? None other than that which happens with the lower animal, where love is naked lust".¹⁰² Alternatively, a naturally well constituted brain saw the refinement of such "coarse energy" and the development of "all those delicate, exalted and beautiful feelings of love".¹⁰³

In women's case, Maudsley argued that evolution had brought "graceful tricks of modesty, the innocent coqueties, the shy, half retreating advances, the half beseeching repulses" that ensured their decency and respectability by covering their "animal nakedness" and raising their "human dignity".¹⁰⁴ Thus women's exhibition of particular middle class ideals, especially the restraint of their sexual desire, was a mark of their civilisation or evolutionary progress. Once these were lost, "when all the decent drapery of sex has been torn away by disease", their desires and feelings were exposed "in coarse form".¹⁰⁵ Maudsley effectively established contemporary societal norms as an evolutionary fact that worked to reinforce the view that exhibitions of lust and strong passion by a woman were not only the result of some pathology, but evidence of her link to a lower stage of human development. While this reinforced the view that such behaviour was abnormal, pathological, and not a rational and conscious act, it also changed the meaning accorded a woman's excessive eroticism. A woman in such a state

¹⁰⁰ On this see Roy Porter, *Enlightenment: Britain and the Creation of the Modern World* (London: Penguin, 2000) p.440-441.

¹⁰¹ *Ibid.*, p.366.

¹⁰² *Ibid.*, p.356.

¹⁰³ *Ibid.*

¹⁰⁴ H. Maudsley, *The Pathology of the mind. A study of its distempers, deformities and disorders*. (London: Macmillan & co., 1879) p.244.

¹⁰⁵ *Ibid.*

was no longer simply ill, and her condition treatable by the physician, rather, she represented an evolutionary throwback whose behaviour suggested her more primitive nature.

Thomas Clouston greatly admired Henry Maudsley, whose “eloquence, his boldness of thought (and) his philosophical insight” he described as “creating a new literary era in our department”.¹⁰⁶ In 1872 Clouston was co-editor with Maudsley of the *Journal of Mental Science*. This appointment was not only another important advance in Clouston’s career, but obviously influenced his medical thinking, because, like Maudsley, he too became a firm advocate of the role of heredity, especially the detrimental effects of a tainted inheritance on an individual’s brain functioning.¹⁰⁷ In *Clinical Lectures on Mental Diseases*, Clouston acknowledged his support for Maudsley’s conception of the “insane temperament” which linked an individual’s potential for disorder to a “hereditary neurosis” in the brain. Clouston argued such an inheritance resulted in the “unconformable” and “unstable and eccentric” functions of the brain. This then manifested itself in the range of extraordinary and unusual states of feeling and conduct that seem “incapable of volitional regulation.”¹⁰⁸ Clouston believed individuals subject to a defective inheritance were doomed to an incomplete development of the brain, and thus an inherent lack of control. Clouston described how weaknesses in the process of an individual’s brain development could be effected from the transmission of hereditary defects, including a parent’s alcoholism, immodesty, vice, shamelessness, lack of morality and “perversion of the moral sense or power of control”. The “bodily equivalents” arising from such “misdevelopments” ranged from awkward body movements through to nervous and mental derangements, hysteria, and “strong and perverted sexual ideas and practices.”¹⁰⁹

As a concept, morbid heredity constituted a type of invisible functional lesion providing the illusion of a somatic foundation. It offered legitimacy to a wealth of otherwise perplexing behaviour defying material analysis, or certainly lacking a strong organic

¹⁰⁶ A. Beveridge, ‘Thomas Clouston’, p.364.

¹⁰⁷ Clouston’s belief in the importance of heredity can be seen in the admission notes on patients entering the Royal Edinburgh Asylum where he devoted a section to recording whether any relations of the patient were or had been mentally afflicted. On this see A. Beveridge, ‘Madness in Victorian Edinburgh: Part II’.

¹⁰⁸ T. S. Clouston, *Clinical lectures on Mental Diseases*. 6th ed., p.10.

¹⁰⁹ T. S. Clouston, *The Neuroses of Development*, p.116.

aetiology, such as nymphomania. Roy Porter suggested that faced with the absence of organic proof to explain an individual's affliction, the family history became "a display of lesions dredged up from the past".¹¹⁰ Through this scheme, an array of behaviour was accounted for by simply being termed constitutional, hereditary, or degenerative. Such a causal scheme overcame the thorny issue of locating specific lesions to account for behaviour that was increasingly troublesome for psychiatry.¹¹¹ Instead, aberrant behaviour such as impulsive erotic behaviour, was said to constitute a highly visible degenerate sign which, Janet Oppenheim notes, meant autopsies were unnecessary because they "proclaimed the fact" of a real somatic disease.¹¹² Clouston declared that sexual desire in excess was the "mental stigmata of degeneracy".¹¹³ Similarly, in a series of lectures given to students attending the Royal College School of Medicine in Edinburgh, psychiatrist John Macpherson (1855-1928) also declared nymphomania and an "abnormal desire" for coitus or masturbation were "absolute proof of cerebral disorder" and thus "psychical stigmata of degeneration".¹¹⁴ Macpherson suggested to his students that this was the case whether or not the intellectual faculties appeared to be weakened.¹¹⁵ The common factor in such cases, and the determining sign, was "the besetment of the mind by the sexual idea, and the presence of an impulse which drives the victim".¹¹⁶

Towards the later nineteenth century, the influence accorded an individual's heredity was not limited to Clouston and Maudsley, but played a determining role in Victorian psychiatrists' conceptions of mental and nervous illness. As a scientific explanation, morbid heredity played a decisive role in the way physicians accounted for those women exhibiting an excessive erotic desire and associated behaviour. Such was the determining influence accorded this causal scheme, some physicians suggested it explained the presence of nymphomania in girls as young as three. In 1898, in an article on insanity in children, physician to West End Hospital for Nervous Diseases, Fletcher Beach (1845-

¹¹⁰ R. Porter, 'The Body and Mind, the Doctor and the Patient: Negotiating Hysteria', in S. Gilman (ed.), *Hysteria Before Freud* (Berkeley: University of California Press, 1993): 225-285; p. 256.

¹¹¹ J. Oppenheim, *Shattered Nerves*, p. 287.

¹¹² *Ibid.*

¹¹³ T. S. Clouston, *Unsoundness of Mind*, p. 282.

¹¹⁴ John Macpherson, *Mental Affections: An Introduction to the Study of Insanity* (London: Macmillan, 1899) p. 46.

¹¹⁵ *Ibid.*, p. 316.

¹¹⁶ *Ibid.*

1929) attributed nymphomania, erotomania, and satyriasis in children to the influence of their heredity.¹¹⁷ In one case, the child's affliction was characterised as nymphomania because she was found "throwing herself into the most indecent attitudes and indulging in the most licentious movements".¹¹⁸ Interestingly, there was no discussion as to whether or how the three year-old girl could consciously experience any form of sexual desire or impulse. Moreover, the child's behaviour was not explained by recourse to the state of her sexual body or the state of her mind. Rather, her behaviour arose from the unnaturally exalted state of her sensibility, itself the result of the defective nature of her parents.

It was not just physicians in the psychiatric realm who accorded significance to ideas of morbid heredity. Many gynaecological practitioners embraced the idea of an inherited pathological disposition transmitted from parent to offspring. This manifested itself in an array of disorder, including that of an erotic kind, as well as accounting for the detrimental effects of the sexual feelings in some women's mental alienation. For former President of the British Gynaecological Society, Henry Macnaughton-Jones, the role of heredity was decisive in a woman's erotic disorder. Jones wrote "some victims are such by congenital transmission", and this accounted for the presence of aberrant sexual behaviour in women who have "no immoral tendencies whatever".¹¹⁹ The congenital nature of what Jones termed 'morbid sexual instinct', also accounted for the presence of such desire and its associated behaviour in children. In early childhood, Jones argued, one could frequently see "the traits of temperament which clearly foretell the future". Among the tell-tale characteristics were capriciousness, irritability, restlessness and excitability.¹²⁰ For Jones, this inherent aspect of nymphomania explained why clitoridectomy failed to effect a cure, ignoring as it did the central origin of such behaviour.¹²¹ In such cases Jones doubted "if they are ever completely cured and saved from nymphomania, save by the legitimate call on the natural physiological response that alone healthily satisfies the sexual demand."¹²²

¹¹⁷ Fletcher Beach, 'Insanity in Children', *Journal of Mental Science* 44 (1898): 459-474; p.467.

¹¹⁸ Ibid.

¹¹⁹ Henry Macnaughton Jones, *Practical Manual on the Diseases of women* 7th ed., (London: Bailiere, Tindal & Cox., 1897) p.215.

¹²⁰ Ibid.

¹²¹ Ibid. p.224.

¹²² Ibid.

Theories of degeneration, and the causality accorded one's heredity, presented new ways of accounting for nymphomania, as well as contributing new ideas about who was likely to exhibit such excessive behaviour. The increasing emphasis on the causal role played by the diseased person, as opposed to some organic lesion, was crucial to the idea of nymphomania as the domain of certain individuals or 'types' exposing their inherent deficiency. Where once children were regarded as sexually innocent, by the end of the nineteenth century, the influence of ideas about morbid heredity meant belief in a child's inherent predisposition to lasciviousness, especially those from 'tainted' stock, had assumed credibility in the eyes of many medical and legal commentators.¹²³ Positing nymphomania as the stigmata of degeneracy was in many respects, simply a new way of suggesting it was the product of dysfunction and disorder. Yet such an explanation also shifted away from the idea that all women were susceptible to this behaviour by way of their femaleness. This is not to suggest however, that the idea of women's inherent potential for disorder disappeared. While a woman's excessive eroticism was now posited as the sign of a more primitive state of being and defective inheritance, the 'fact' remained that all women were already doomed to a more primitive position on the evolutionary map. Although theories of morbid heredity and degeneracy established that nymphomania was abnormal behaviour in a civilised society, and evidence of some inherent defect, the age-old view of all women's inferiority and thus susceptibility to such aberration, remained as pervasive as it had always been.

The spectre of nymphomania

By the end of the nineteenth century, nymphomania had receded from the medical lexicon as a distinct disorder and was effectively extended or absorbed into the symptomatology of many afflictions. Yet the themes it supported about woman continued, as did the notion of women's excessive behaviour as an aberration and a threat. What shifted in this discussion was the sort of danger woman now posed. Growing fears and anxieties about the future of the British race meant ideas about women's potential for disorder provided yet more reason for women's control.

By 1895, when Hungarian born physician Max Nordau's popular book *Degeneration* was published in English, the theme and threat of Britain's racial decline arising from such

¹²³ On this see Mary Spongberg, *Feminising Venereal Disease: The Body of the Prostitute in Nineteenth-Century Medical Discourse* (London: Macmillan, 1997) especially chapter six 'Pathologizing Children'; Louise L. Jackson, *Child Sexual Abuse in Victorian England* (London: Routledge, 2000).

deterioration already occupied the medical and scientific world. Between 1873-1896 the effects of the great depression on Britain not only undermined tightly held beliefs regarding capitalism and the inevitability of progress, but witnessed all the social conditions associated with such upheaval. The poverty, alcoholism, prostitution, and crime increasingly confronting Britain's urban and industrial world were regarded as dangerous degenerative influences that posed a threat to the sanctity of civilised society.

Many middle class fears about the deterioration of society were focused on the state of their own health, especially the future purity and thus authority of their 'racial stock'. In his 1892 report from the asylum at Morningside, Clouston blamed "city life, high wages, alcohol and riotous living" on the rising incidence of mental disease. He concluded such "vices of urban life" were leading to "national degeneracy".¹²⁴ British psychiatrists believed that the conscious indulgences in vice or excess by a healthy person could lead to the development of particular degenerative traits that would then be passed onto their offspring.¹²⁵ Clouston was particularly concerned about the effects of increasing overcrowding and vice on Britain's youth. He warned that if enough of Britain's young were exposed to modern society's pollutants, it would be "the very death of the race".¹²⁶

Like Henry Maudsley and William Bevan Lewis (1847-1929), Clouston regarded any sort of sexual excess including masturbation, as especially threatening to the young because it could exacerbate or lead to, the acquisition of certain degenerative traits.¹²⁷ With the stress on the inheritance of acquired characteristics, degeneracy theory warned of the progressive deterioration arising from such sexual activity. Given ongoing beliefs about women's potential for such disorder, this type of thinking caused particular anxiety about women's sexual behaviour. As the future bearers of the nation's stock, women could lead society into a spiral of deterioration through their excess. Clouston felt that given women's inferior adaptation to their environment, coupled with their weaker nervous and mental organisation, the physician's role was to guard women from their

¹²⁴ A. Beveridge, 'Madness in Victorian Edinburgh: Part II', p.139.

¹²⁵ On this see J. Oppenheim, *Shattered Nerves*, p.286.

¹²⁶ T. S. Clouston, *The Neuroses of Development*, p.378

¹²⁷ T.S. Clouston, *Neuroses of Development*, p. 116-118. See also William Bevan Lewis, *A Textbook of Mental Diseases* (London, Charles Griffin & co., 1889) p. 355.

own demise.¹²⁸ Such a view was greatly influenced by his commitment to the cause of mental hygiene in the later years of his career.

The term mental hygiene had been in use for several decades, though in the later years of the nineteenth century it acquired greater emphasis through the mental hygiene movement in America, and Max Nordau's work, both of which Clouston was familiar with.¹²⁹ In *Degeneration* Nordau argued the only hope for those coming into contact with a degenerate individual was a "hygiene of the mind" that would ward off the mental 'germs' capable of infecting and corrupting a healthy organism.¹³⁰ Clouston was particularly concerned with ensuring the mental hygiene of Britain's future race. The increasing attention on the physical and mental health of children and youth largely initiated by the mental hygiene movement of the late nineteenth century, reflected a new approach in medical thinking that emphasised prevention, and linked social progress to the quality of early life.¹³¹ Yet it also contained and reinforced, gendered distinctions about men and women's inherent capacity for such control.

The philosophy of mental hygiene suggested the mentally healthy were those who, in achieving the optimum balance between thought and will, had complete control over their emotions. Against the backdrop of a perception of society's disorder and decline, mental hygiene provided yet more 'scientific' proof that the progressive advancement of society could only be secured by cultivating those attributes in the individual. The triumph of the controlled, altruistic and moral individual represented on a smaller scale the same struggle of civilised society to assert order and authority over the chaos it faced. Yet given the distinction between men and women's capacity for such control, this triumph was always going to be a masculine privilege. In this scheme, the significance and authority accorded control represented on a smaller scale, the inherent inequalities women continued to face, and the authoritative position man naturally assumed.

¹²⁸ For Clouston's views about women's inferior capacity for mental inhibition see, T. S. Clouston, *The Hygiene of the Mind* (London: Methuen & co., 1906) p.211.

¹²⁹ Having married an American Clouston made many trips to the United States. On this see Alan Beveridge, 'Thomas Clouston', p.379. On the American Hygiene Movement see Barbara Sicherman, 'The Paradox of Prudence: mental health in the gilded age' in A. Scull (ed) *Madness, Mad-Doctors, and Madmen. The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981), 218-240.

¹³⁰ Max Nordau, *Degeneration* translated from the 2nd edition (London: T.Fisher Unwin, 1895) p.12.

¹³¹ On this see Theresa Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada* (Albany: University of New York Press, 1989).

Throughout the nineteenth century, order and discipline were major cultural and medical concerns in Britain. By the end of the century such qualities took on new significance in a society increasingly perceiving its world as one of disorder and chaos. With the British Empire under threat both at home and abroad, control assumed added significance. In the medical domain, control over the body was used to distinguish between the healthy and disordered, the civilised and the uncivilised, the superior and the inferior, and it seems, between men and women. Increasing importance accorded effective inhibition meant the self-regulated individual was not only one of good character, but healthy body and mind. In this context, women remained cast in an inferior position with conceptions of their lack of control assuming as much scientific authority as they had throughout previous discussions of nymphomania.

The preoccupation with society's decline generated by the discourse on degeneration, coupled with the increased emphasis on the need for people's control, altered the types of concerns physicians expressed about women's inherent incapacities. With the significance accorded an individual's inheritance and the transmission of certain degenerative traits, scientific credibility was given to the view that a woman's lack of control could directly impact on the fate of society. Such thinking appeared to provide some commentators with further justification for the necessity of women's strict adherence to particular middle class norms and ideals that could thwart their dangerous potential, yet which were, by the close of the nineteenth century, under threat.

At the close of the nineteenth and turn of the twentieth century, the calls by many women for greater independence, further education, and changes to traditional marriage patterns, were met with vociferous replies. Eugenicists, social puritans, and many medical commentators such as Clouston, all stressed the threat such changes posed to women's role as the bearers of the nation's racial stock.¹³² Elice Hopkins, the doyenne of England's social purity movement, declared that the British Empire "can only be saved" by "a solemn league and covenant of her women to bring back simplicity of life, plain living,

¹³² On Eugenic concerns about motherhood and sexuality of women, see George Robb, 'The Way of All Flesh: Degeneration, Eugenics and the Gospel of Free Love', *Journal of the History of Sexuality* 6 (1996): 589-603; 'Race Motherhood: Moral Eugenics vs Progressive Eugenics, 1880-1920', in C.Nelson and A.Sumner Holmes (eds.), *Maternal Instincts: Visions of Motherhood and Sexuality in Britain, 1875-1925* (London: Macmillan, 1997): 58-74.

high thinking, reverence for marriage laws, chivalrous respect for all womanhood, and a high standard of purity".¹³³ Such was Clouston's concerns about the changing position of women, he devoted an entire text to the subject.¹³⁴ In *The Position of Woman Actual and Ideal* (1911), Clouston warned of the "serious dangers" to mankind arising from changes in "sexual relations, marriage, the birth and care of children, the legal status of women".¹³⁵ In many respects, his concern about any changes to women's position was the product of his own medical thinking. Faced with the spectre of his conceptions of woman, particularly their potential for excess and disorder, Clouston ultimately feared any change that might loosen the control he and others believed women's marital and maternal destiny ensured.

Clouston based his arguments for retaining the status quo on the inherent differences between men and women, especially in regard to their inhibitory faculty. He wrote that self-control was "the last result of evolution" and a certain lack of it was "almost expected in woman, and the highest degrees of it are not commonly expected in her".¹³⁶ Women could not deny this "psychology of sex" which accounted for the differences in their "affective, intellectual, inhibitory, moral and volitional faculties" as well as "the instincts and appetites".¹³⁷ For this reason, he argued, women must embrace the role nature has intended for them which ensured "the ideal society of the future".¹³⁸

Despite changing conceptions of nymphomania and its virtual withdrawal from the medical lexicon, the idea of all women as essentially prone to a lack of control remained a persistent theme in medical thinking. Against the backdrop of fears and anxieties about the evolutionary future of the race, this lack was posited as not only a potential threat to the future British race, but also the reason for maintaining the gendered status quo. While at the turn of the new century the conception of excessive eroticism as a distinct affliction no longer held much scientific weight, the ambivalence and anxiety it had revealed about women's sexuality and sexual potential certainly prevailed.

¹³³ Elice Hopkins, *The Power of Womanhood* (London: Wells Gardner, Darton & co., 1899) p.165.

¹³⁴ T. S. Clouston, *The Position of Women: Actual and Ideal* (London: James Nisbet & co., 1911)

¹³⁵ *Ibid.*, p.104.

¹³⁶ *Ibid.*, p.114.

¹³⁷ *Ibid.* p.105.

¹³⁸ *Ibid.*, p.117.

Conclusion

“Nymphomania lurks almost without exception, under the imposing outside of an apparent calm, and frequently hath acquired a dangerous nature, when not only its progress, but its beginnings elude our perception.” Bienville, *Nymphomania or, A dissertation Concerning the Furor Uterinus*, 1775.¹

Physicians in the nineteenth century inherited an enduring and pervasive set of beliefs about a woman's excessive erotic desire and its causes. The idea that such excess was a legitimate somatic condition continued throughout the century and underlay the medical authority nymphomania assumed. The expansive definition of nymphomania meant it embraced a wide array of conduct which provided physicians with a means of according unity and classificatory order to a great deal of disparate behaviour and symptoms. Over time, the factors accounting for such aberration changed eventually culminating in the changing status of nymphomania as a distinct affliction. By the late nineteenth century, physicians were faced with the reality that they could not provide a central origin or common cause to the range of conditions included within this entity. The ambivalence and disagreement surrounding nymphomania saw its status shift from a specific diagnosis to a descriptive term denoting a particular type of disordered conduct observed among a range of conditions. Despite these shifts, a woman's excessive eroticism remained a sign of disorder.

Medical interest in a woman's excessively erotic behaviour continued through the early decades of the twentieth century. Indeed the quest to quantify women's sexual desire and identify its source continued to foster a wealth of medical, scientific, and psychological

¹ M.D.T. Bienville, *Nymphomania, Or A Dissertation concerning the Furor Uterinus*, trans. Edward Sloane Wilmot (London: J.Bew, 1775) p.28.

research. The belief that a woman exhibiting impulsive and uncontrollable behaviour of an erotic kind (however defined), was the sign of some sort of disturbance also endured. New to the discourse on nymphomania were the types of behaviour it embraced, the explanations physicians' offered to account for such aberrant conduct, and the conception of the nymphomaniac. From the 1920s, developments in sex hormone research contributed new ideas about people's sexual behaviour and the source of their sexual desire or 'sex drive'. Out of such discussion emerged the nymphomaniac—a figure defined by her unnaturally intense 'sex drive' or 'libido'.

With the great shift in physiological thinking taking place in the early decades of the twentieth century, the endocrine glands came under particular scrutiny in accounts of women's excessive sexual desire. In 1931, British physiologist and endocrine researcher Sir Edward Sharpey-Schafer (1850-1935) asserted that bodily functions were not the result of the nervous system, but the chemical regulation of the body.² In regards to the female body, internal secretions from the ovaries were posited as exerting the greatest influence over the female organism. In this scheme, nymphomania was no longer deemed a neurological disorder. The nymphomaniac and her behaviour were deemed the product of some sort of endocrine imbalance, with the hormones now accorded central causal significance in explaining why a woman would act in such a way. Physiological explanations thus continued to dominate medical understanding of a woman's aberrant and 'abnormal' sexual behaviour with the ovaries yet again, assuming centre stage.³ Yet in reality, the sense of pathology defining the nymphomaniac in the twentieth century was, like the conception of nymphomania in the nineteenth century, as much a product of

² For discussion of this transition and the development of ideas about the endocrine glands see, Chandack Sengoopta, 'The Modern Ovary: Constructions, Meanings, Uses', *History of Science* 38 (2000) 425-473; p.425.

³ Ibid.

contemporary medical thinking about female sexuality as it was social and cultural norms about women's sexual expression. Together, these two factors continued for many more decades to support the idea that a woman's excessive or impulsive eroticism was evidence of a disorder, for which the medical world continued to offer various explanations.

By the second half of the twentieth century, physicians from the psychological domain were most preoccupied by the aetiology of nymphomania, offering up new ideas to account for such behaviour. In *Clinical Studies in Psychopathology* (1947) nymphomania was described as the "poetic name" for "female hyper-sexuality", a condition describing women unable to gain any pleasure from the sexual act. Such women were said to be "compelled" to seek out the "intimacy and promise of fulfilment" provided by sex, because "consciously they are unable to love". The author felt such cases were "really protesting against the feminine role and are in fact, trying to play the part of the male rake."⁴ The text also suggested that nymphomania was "probably part of the psychopathology of prostitution."⁵ In 1953, in the *Psychosomatic Approach to Gynaecology and Obstetrics*, American neuropsychiatrist Fritz Wengraf described a number of sexual 'types' amongst women, including 'the gold digger, prostitute, dominatrix and the nymphomaniac.' The latter was a woman who "constantly seeks gratification which can never be obtained." This pursuit was the nymphomaniac's dominating trait, with such women noted for their preference for married, widowed, inexperienced and uniformed men.⁶

⁴ Henry Victor Dicks, *Clinical Studies in Psychopathology: a contribution to the aetiology of neurotic illness* (London : E. Arnold, 1947) p.160.

⁵ *Ibid.*, p.161.

⁶ Fritz Wengraf, *Psychosomatic Approach to Gynaecology and Obstetrics* (Springfield: Charles C. Thomas, 1953) p.113.

By 1964 such was the interest in this psychological conception of a woman's excessive sexual behaviour, American clinical psychologists Albert Ellis and Edward Sagarin devoted an entire text to it: *Nymphomania: A Study of the Oversexed Woman*.⁷ Interestingly, Ellis and Sagarin were keen to establish a distinction between nymphomania as a legitimate medical disorder, and nymphomania as a social construction referring to little more than a promiscuous woman. They argued that the term nymphomaniac was often used simply to stigmatise a woman whose sexual behaviour transgressed the limits accorded her sex, yet which "would hardly be noticed if they were males".⁸ In their own examination of nymphomania the authors stated that the term would not be used to describe promiscuous behaviour, or a woman who "enjoys sex relations with a number of males."⁹ Their attempts to move away from the ancient belief that *any* woman's strong desire for sex was a sign of some sort of physical or mental abnormality certainly signals a change in the way women's ardent sexual desire was perceived. However, the idea that a woman's excessive erotic desire indicated some sort of problem did not entirely recede from view.

While Ellis and Sagarin sought to remove the pathology attributed to women who transgressed norms of propriety, they were still unwilling to let go of the idea that a woman's excessive sexual activity or desire was in some way evidence of a disorder. The authors continued to support a conception of the nymphomaniac as a woman whose excessive behaviour was the sign of serious psychological issues. Such a figure's "compulsion" for sex was, in their view, the result of her self-loathing, a desperate need for love and affection, and a failure to express love in 'normal' ways. Nymphomania was

⁷ Albert Ellis & Edward Sagarin, *Nymphomania: A Study of the Oversexed Woman* (New York: Gilbert Press, 1964)

⁸ *Ibid.*, p.27.

⁹ *Ibid.* p.29.

no longer the manifestation of a woman's lack of control over her desires, rather, the sense of pathology defining this disorder was based on a woman's lack of emotional connection. Even in the 1960s, when the sexual culture of the western world appeared to be undergoing serious change, the idea of women actively seeking to have a lot of sex without experiencing meaningful and lasting emotional connections with men, deeply challenged certain sensibilities. In fact, throughout the twentieth century, despite failing to find any cause for such aberrant behaviour, the medical world continued to believe that a woman's compulsion for sex signified her lack of emotional stability and capacity to love. It could be argued however, that such women simply approached sex in a manner many men had for years, for which they rarely attracted medical attention. Yet such gendered distinctions and disparities remained, with medical practitioners continuing to assert the aberrant nature of female sexual excess.

The aim of this examination was to trace the ways in which nineteenth century British medical discourse conceptualised nymphomania in order to understand how a woman's excessive erotic desire constituted a legitimate disorder. I originally believed that such an approach would provide more evidence of the male medical world's deliberate subjection of women. I soon came to the realisation however, that far more was involved and required in examining the idea of erotic desire as excessive and constituting a disorder. In tracing the medical conception of nymphomania, I discovered a train of complex socio-cultural and historical processes at work that established the validity of the idea that excessive or impulsive erotic desire in a woman was pathological. Hence, the examination became much more concerned with the long history of medical thinking about women's erotic desire and the legacy of this in nineteenth century medical conceptions of nymphomania. Rather than simply illustrating the highly constructed nature of nymphomania and its ideological intentions, far more clarity was needed in

understanding the way certain sensations and experiences were established as symptoms of disease with an accompanying authoritative aetiological discourse able to account for and explain their presence.

Throughout the period examined we have seen a persistent attitude toward women's sexuality. This has been largely governed by beliefs about the inherently pathological female body, especially its potential for disorder and excess. Yet the intention of this work was not to suggest that conceptions of the female body or women's erotic desire were ahistorical. It is certainly fair to suggest there is a long history of ambiguity and anxiety surrounding female sexuality. However, such apprehensions are always deeply embedded in the dominant social and cultural context in which they exist. Such an assessment is equally applicable to medical discourse, and this thesis has shown the ways in which medical thinking alters over time in accordance with both changes in the scientific world and wider societal forces. The examination of the first text entirely devoted to examining nymphomania illustrated the extent to which shifting cultural attitudes towards women's erotic pleasure and sexual subjectivity impacted on medical conceptions of excess. The dominant political, social, and sexual culture at the end of the eighteenth century was shown to be of great significance to changing ideas about nymphomania. Conceptions of women's erotic disorder were directed by a society increasingly repudiating any notion of women's ardency and autonomous sexual subjectivity. For Britain's increasingly hegemonic middle class, control of one's physical feelings was an integral aspect to their own moral authority, and the discipline and regulation of society. The preoccupation with order and control, especially over the sexual feelings, arose from a fear of the threat posed by their disorder. By the turn of the nineteenth century, expectations about men and women's appropriate sexual conduct were deeply embedded in the gendered and classed social order that eventually defined

the Victorian era. Within this scheme, ideals of women's morality, virtue, and chastity, and their maternal instinct, were conflated with their sexual subjectivity in a way that worked to negate a sexual identity outside those limits.

Tracing the changes to social norms and ideals about women's sexual expression over the nineteenth century was not intended to suggest women did not continue to experience fulfilling sexual lives. As Roy Porter declared, "only the most cocksure quantitative historian would assert that some societies achieve more pleasure than others, or are more pleasure-loving".¹⁰ Yet, as he also noted, "desire assumes different forms from era to era".¹¹ By the nineteenth century, a comparable system of dualities increasingly defined the middle class world-view in which women's natural passivity and weakness complemented man's activity, strength, and superiority. Conceptions of female sexuality were integral to this ideal of chaste, domesticated and subservient womanhood. In turn, this ideal was pivotal to the identity of man as public, rational, individual citizen from which stemmed his authority, and which defined his active sexual subjectivity. In assessing the shift from the eighteenth to the nineteenth century, this thesis showed that change to Britain's social structure and the politics of gender reshaped ideas about the limits of women's healthy and normal sexual expression. Whether this in any way altered the quality of women's sexual lives and experience of pleasure is a matter of pure conjecture. More certain is the fact there was a profound ambivalence and anxiety surrounding female sexuality in the nineteenth century, particularly in the idea of woman as an erotic pleasure seeker.

¹⁰ Roy Porter, *Enlightenment: Britain and the Creation of the Modern World* (England: Penguin, 2000) p.265.

¹¹ Ibid.

Medical conceptions of who and what was evidence of nymphomania illustrated the degree of uncertainty towards a woman's active sexual expression or articulation of her sexual needs. Such pathologisation of women's ardent eroticism reinforced many of the norms and ideals of the Victorian gendered social order. In fact, what little historical analysis there is of nymphomania tends to conclude it was designed to deliberately contain the meaning of those who deviated from dominant expectations of women. As such, this was a medical entity that reinforced particular behaviour as abnormal for respectable women. Yet in tracing the way physicians defined nymphomania, this idea of its 'ideological intentions' was shown to be somewhat problematic. Certainly, a respectable woman's insatiable erotic desire was regarded as morally reprehensible. Moreover, the behaviour embraced within the nymphomania diagnosis reinforced certain middle class expectations and limitations about women's conduct and sexual expression. This examination also suggested it was in men's interests to ensure women's adherence to the ideals and expectations of their sex, guaranteeing as they did, the very factors that defined men's superiority and authority. Despite all this, the thesis also argued that nymphomania was considered the sign of a somatic disease or bodily dysfunction whose aetiology actually contradicted many of the ideals and expectations of woman which ensured the gendered status quo. In one sense, conceiving nymphomania as an abnormality and a disorder could only make sense in reference to a cultural norm of 'passionless' womanhood. Yet the somatic conception of nymphomania also reiterated belief in the unruly and excessive female body that was subject to all manner of temptation and desire. Rather than providing yet more evidence of beliefs about women's sexual quiescence, this examination showed that women's sexual restraint was so important *because* they were extremely vulnerable to excesses of sexual desire.

Examining nymphomania, especially the contradictions its conception posed to dominant ideals of femininity, provided an insight into the complex nature of ideas about woman in the nineteenth century. Rather than reinforcing particular norms of the Victorian era, we saw the highly uneven and contrived nature of beliefs about womanhood. Most nineteenth century physicians approached the subject matter of women's sexuality from deep within a middle class position, and the values and ideals that informed their medical opinions generally only referenced the women of that class. In their theoretical discussions especially, it appears physicians mainly dealt with a stereotype they perhaps sought to reinforce more than they ever encountered. Despite their subscription to such archetypes, physicians in the nineteenth century were constantly dealing with female bodies that did not conform to wider societal expectations and ideals. Yet this was inevitable. Indeed, to suggest women's bodies could be naturally (self) controlled negated much of the approach and legitimacy of the science of woman. The gynaecological discourse that so pervaded nineteenth century British medical thinking was premised on a belief that the female body was inherently sick, and fundamentally in need of control. In delineating the contours of the unstable and potentially disordered female body on which the conception of nymphomania was based, physicians effectively reduced all women to such disorder. This is not to suggest that medical conceptions of women's sexuality reflected a reality, or a more accurate conception of women's sexual experience. It simply contests the notion that nineteenth century medical discourse was merely a product and instrument of ideology in complete unison with wider cultural forces.

Physicians in the nineteenth century did not suggest women's desires were non-existent. However, they did reinforce the view that female sexuality was inherently unstable due to woman's innately pathological and inferior corporeality. In this regard the ideal of

woman's inclination for virtue and modesty was maintained by attributing the expression of any sexual desire outside its appropriate context, to the unruly and dysfunctional female body. Such displacement was especially noted with regard to the clitoris. Conceptions of the clitoris detailed throughout this dissertation illustrate how particular anxieties about female sexuality constructed the meaning and identity this organ assumed. Much of the aberration and pathology attributed to a woman's clitoral stimulation reflected fears about women's autonomous sexual arousal and fulfilment, especially the danger it posed to the heterosexual, penetrative, and procreative imperative that so defined conjugal relations in the nineteenth century. Directly implicated in a woman's erotic disorder, the clitoris was both the source of a women's potential for excess, and a reminder to all women of the depths to which they could descend if they deviated from norms regulating their sexual conduct. Isolating a woman's potential for disorder to her clitoris served a useful purpose for physicians struggling with the glaring inconsistency between their beliefs about all women's disordered sexual potential and wider societal expectations. Yet at the same time, as with all organic conceptions of nymphomania, this discourse effectively established all women were potentially susceptible to such disorder by way of their femaleness.

When attempting to interrogate the logic underlying the medical conception of nymphomania in the nineteenth century, the historian is faced with many inconsistencies and contradictions. This work believed that priority should be given to identifying these complexities rather than seeking a consensus which incorrectly leads to the perception of a uniformity in attitudes. While woman's sexuality was considered prone to disorder and excess, at the same time, all women were expected to adhere or aspire to a model of virtue and respectability which made such a natural state antithetical. The inherent contradiction this posed meant that as a disorder of excess, nymphomania was defined in

relation to an ideal about women's sexual expression, yet it was also a legitimate disorder because of entrenched views about the workings of the female sexual system. Nymphomania was thus a complex entity made meaningful by wider social ideals about the limits of women's sexual expression, and a medical discourse that reduced all women to a body innately lacking control. As such, an examination of nymphomania provides evidence both of entrenched beliefs about the innate excess of women and all the inequalities this supported, as well as the inherent contradiction such thinking represented in terms of wider expectations about woman. Ultimately, nymphomania was a disorder given meaning and legitimacy by both dominant medical thinking about female sexuality and wider gender norms, yet in significantly different and often conflicting ways.

While nymphomania had its male equivalent, there was a real lack of discussion in the medical literature about men's erotic excess or lack of control over their desires. This was shown to be a consequence of both the pervasive belief in men's greater capacity for control, as well as the different attitudes toward their sexual impulsiveness. The inherently feminine coding of excessive erotic desire was of particular interest to this work because of the legacy it had not only to the conception of nymphomania, but female sexuality in general. The opposition between perceptions of the male and female body underscored the sense of uncontrollable desire as inherently feminine. Such a conception reinforced the view of the pathological potential of the female body, and the superior nature of the male body. Yet things were not nearly as clear cut as this. Indeed, this gendered polarity contained its own problems, especially the sense of defining men in opposition to women. Particular aspects of male sexuality and their close relation to definitions of masculinity, made sex as potentially problematic for Victorian men as it appeared to be for women. Victorian men's virility and self-control in sexual matters

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established the central place of sex in the definition of their manhood. Yet the idea that men were both lustful and agents of self-control was as inherently flawed as the idea that women were both sexually passive and innately prone to excessive desire.

Some historians have proposed that physicians incorporated the fantasies of their age within their medical discourse.¹² This work sought to extend that proposal by suggesting Victorian physicians were trapped in a complex web of their own fantasies about female sexual desire, a legacy of medical thinking about women's sexual ardour, and influences of their milieu that emphasised women's decorum and restraint. The fear and anxiety surrounding the idea of the naturally excessive sexual female perhaps reflected the threat such a figure posed to men. The concerns physicians expressed about woman's excessive erotic nature were linked to the challenge such insatiability presented to the status of man's reason, rationality, and self-control. In this sense, the feminine coding of erotic excess was not simply a matter of reducing all women to an inherently inferior corporeality, necessitating their subordination and control. Such thinking constructed woman as a temptation to man who was expected to be naturally able to prevent himself from being seduced. As such, conceptions of women also challenged the immutability of man's rational body and the self-control on which his authority was based. The idea that through her unruly sexual nature woman could pose a threat to hierarchical conceptions of sexual difference was vital to the anxieties and preoccupations surrounding gender that so pervaded the nineteenth century.

This examination illustrated the long historical legacy and complex medical discourse surrounding nymphomania and female sexuality in the nineteenth century. It argued that

¹² See for instance, Angus McLaren, *The Trials of Masculinity: Policing Sexual Boundaries, 1870-1930* (Chicago, University of Chicago Press, 1997) p.155. Mary Poovey, *Uneven Developments: The Ideological Work of Gender in Mid-Victorian England* (London: Virago, 1988), p.170.

the conception of nymphomania was a product of particular cultural, social and medical discourses that sustained the idea of a woman's excessive erotic desire as pathological and an aberration. Yet for the contemporary observer there is a certain resonance in many of the anxieties surrounding female sexuality and the way societal expectations directed perceptions of women's sexual behaviour in the nineteenth century. Ideas about women's sexual expression have undergone enormous change with women actively contesting limited conceptions of their sexual subjectivity. Despite this, gendered expectations and ideals about women's behaviour continue to define sexual norms. A woman's promiscuity and strong desire for sex is perceived in different ways to that of a man's, generally occupying ambivalent terrain in discussion of what is normal and appropriate. In many respects, this gender differential can be linked to the legacy of woman's child bearing role which directed dominant beliefs about womanhood in the past, and continues to in the present.

This thesis explored how in the nineteenth century, women's procreative role directed dominant perceptions of their sexual subjectivity and the status of their sexual desire. Such determinism contributed to the anomalous position of women's orgasm, as well as any sexual practice that deviated from the penetrative, reproductive norm, such as women's clitoral stimulation. While the function of women's orgasm is no longer a scientific issue, penetrative, vaginal sex remains the heterosexual norm, with women's clitoral orgasm continuing to assume ambivalent status. In fact, *Female Sexual Dysfunction* (FSD) is currently defined by a woman's lack of arousal and orgasm during penetrative, vaginal intercourse despite whether she is able to achieve such things through masturbation.¹³ While the effects of women's clitoral stimulation have been

¹³ Pharmaceutical companies are very keen to solve this 'problem' with the production of a female viagra. For discussion on the contemporary medicalisation of women's sexuality and current definitions of FSD see, R. Moynihan, 'The Making of a Disease', *British Medical Journal*, 326 (2003): 45-47.

known for several centuries now, its place in the conception of normal heterosexual coitus remains on the periphery suggesting that, in the scientific world at least, women's sexual normalcy is still defined by theories which privilege male sexual fulfilment.

As in previous centuries, women's child bearing role has continued to impact on conceptions of their sexual behaviour in different, yet equally limiting ways. Despite enormous change, society's perceptions of women's behaviour and psyche, remains dominated by their maternal role. As long as this is the case, women will always be judged more or less according to the extent to which their behaviour deviates from their nurturing, passive, self sacrificing and emotional nature. The history of nymphomania from the nineteenth century through to 1987, when the revised edition of the Diagnostic and Statistical Manual of mental disorders of the APA (DSM) officially dropped the term from its pages, illustrates the pervasiveness of such essentialism. While conceived in very different ways, for nymphomania to exist as a legitimate condition for as long as it did suggests the medical world continued to have definite ideas about women's healthy sexual behaviour that were largely defined by both cultural expectations and entrenched medial views of the time. Ultimately then, this work has furthered the historical record about a much neglected and worthy subject. In so doing, it has shown the way in which limited gender and sexual codes govern the perception of women's sexual behaviour and the definition of their excess.