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Women's Voices in Nineteenth-Century Medical Discourse: A Step toward Deconstructing Science

Nancy M. Theriot

FOR THE LAST DECADE, feminist scholars from various disciplinary perspectives have been reconceptualizing the ways in which medical science affects gender categories and is itself a gendered practice. Women's historians have moved away from the victimization model that dominated early studies of women patients and the male medical establishment and have begun to view medicine as more complicated and less villainous than previous studies had assumed. Similarly, the notion that nineteenth-century medicine was tainted by its maleness and that women patients could expect a different kind of care from women physicians has been challenged, particularly by the work of Regina Morantz-Sanchez. Feminists working in literary criticism also have pointed out how historically medical discourse has been a gendered discourse and, along with theorists working from the perspective of philosophy, have suggested ways to view the interaction between a dominant male discourse and women's minority-positioned subjectivities.

In spite of this work on the relationship between gender and science, however, each of us has a disciplinary blind spot that renders unseeable the best insights of our colleagues in other fields. Among many literary critics and philosophers, for example, the victimization model and the perception of medicine as a male system of knowledge/power still persist (see Showalter 1981, 1987; and Digby 1989). And, because history is perhaps the most antitheoretical of the disciplines, few women's historians make use of the theoretical models developed by critics, philosophers, and anthropologists that would allow us a way to problematize language and bodies.[1]

I want to thank my colleagues Ann Allen, John Cumbler, and Julia Dietrich for reading earlier drafts of this essay and the University of Louisville College of Arts and Sciences for providing grant support for this research.

[1] Women's historians who consciously make use of theoretical models include Jordanova 1980, 1989; Smith-Rosenberg 1985; Riley 1988; and Scott 1988.

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For the past few years I have been reading nineteenth-century medical texts on women's nervousness and mental illness within an eclectic and evolving theoretical framework. I began with the assumption that medical writing would both reflect the ideas of the extramedical culture and prescribe a narrow field for sane or "normal" female behavior: in other words, that gender shapes science, which then reinforces gender. I also assumed that women patients were not "victims" of medical science but instead were able to use it to their advantage in their domestic power struggles. Both of these assumptions were conclusions of Carroll Smith-Rosenberg's early study of hysteria (1972), and I wanted to elaborate upon them by looking at a larger sample of medical writing. I read systematically through articles and monographs on women's insanity and nervousness as well as the editorials and book reviews in the major psychiatric, gynecological, and neurological journals of nineteenth-century American medicine. And the more I read, the more I doubted the simplicity of my original assumptions. The medical establishment did not present the unity I expected, women physicians differed more from their male colleagues than I anticipated, and, most surprising of all, women patients took on a presence of their own through physicians' recordings of their voices in case studies. My reading of nonhistorians such as Mary Poovey, Susan Bordo, Michel Foucault (whom many historians do not consider a "real" historian), Donna Haraway, Brian Turner, and Arthur Kleinman—to name a few—gradually led me to create another framework for a more complex and satisfying reading of the nineteenth-century material.[2]

Looking, then, at the late nineteenth-century medical discourse on women's insanity and nervousness from an interdisciplinary as opposed to a narrowly historical perspective, my purpose is to suggest that nineteenth-century medical science was a site of competing definitions of both gender and science and that women participated in the gender/science interaction as physicians and, more significantly, as patients. Specifically, I will argue that there was lively debate among nineteenth-century physicians over both gender and science; that women physicians, for professional, gender-specific reasons, articulated a self-interested view of women's insanity and nervousness; and that women patients were active participants in the process of medicalizing *woman*.

This reading of nineteenth-century medical discourse as a set of complex, multiauthored texts depends on an understanding of illness and disease as separate, mutually influential categories. Although Smith-Rosenberg and other feminist writers have treated illness and disease as

[2] See Foucault 1967, 1972, 1973, 1980; Kleinman 1980, 1986; Turner 1984; Poovey 1988; Bordo 1989; Haraway 1989a, 1989b.

distinct categories, Arthur Kleinman's work on neurasthenia as a diagnostic category in modern China has been more influential in my thinking about nineteenth-century insanity and nervousness (1980, 1986). Kleinman's interactive theory of illness and disease allows each to be considered separately but also provides a way to see their dynamic interconnection. Following Kleinman, I view illness as a self-defined state of less-than-optimum health, and disease as a form of knowledge that seeks to explain illness-affected behavior or physiological changes in the human organism. While illness is a matter of personal (and sometimes group) physiology and psychology, disease is a matter of representation. Disease is a scientific representation of illness that involves both a sorting of symptoms into discrete entities and a theorizing about causation and cure. As such, disease is not discovered but created. And any particular disease is never fixed but always open to constant redefinition, always dependent on changing representational practices. The representation of a particular illness pattern as a specific disease takes place in medical discourse, a discourse that not only is embedded in the larger, "extramedical" culture but also is shaped by time- and place-specific medical practices such as the constraints of doctor-patient interactions, the existence of medical institutions and technology, and the politics of medical specialization.[3] The nineteenth-century representation of women's nervousness and mental illness involved three specialties' border disputes, women physicians' special interest in the question, and women patients' illness narratives. Gender was both cause and effect in this representational process.

An article written in 1887 by Alice May Farnham, assistant physician at the Willard Asylum for the Insane in New York, provides an introduction to my three major points. Farnham's article appeared in *Alienist and Neurologist* and was titled "Uterine Disease as a Factor in the Production of Insanity." (*Alienist* was an earlier name for *psychiatrist.*) She began the article by reminding her readers of an "edict" popular "not so many years ago" among physicians and among the general public "that nearly all of those ills to which feminine flesh is heir are due either to disorders of the female reproductive organs, or so influenced by these organs as to constitute a peculiar class of diseases" (532). According to Farnham, the result of this widespread belief was that "the alienist and neurologist beheld his hysterical, melancholic and maniacal patients torn from his grasp and, by the wave of public opinion, cast into the hands of his brother practitioner, the gynaecologist" (532). Farnham went on to

[3] I am using the term *discourse* to mean a dialogue limited by discursive and nondiscursive practices that provide a context for meaning making. See Foucault 1967, 1972, 1973, and 1980. Scholars whose work on Foucault have been important in my thinking are Dreyfus and Rabinow 1982; Weedon 1987; Gutting 1989; and Sawicki 1991.

present case studies from the Willard Asylum to illustrate her conclusion that "uterine disease alone is seldom or never the cause of mental alienation [insanity]" (536).

Farnham's article indicates that the medical discourse on women's insanity and nervousness was multivocal, that women physicians (although a small minority in the profession) had a distinct professional voice, and that nonmedical voices were part of the discourse as well. First, and most obvious, Farnham's article was part of an ongoing struggle between gynecologists on the one hand and neurologists and alienists on the other for the right to define the nature of women's mental illness and nervousness. Second, Farnham was a woman physician attacking a narrow definition of womanhood, not as a scientific outsider but in the name of science. Finally—and this is most complex and interesting—Farnham alluded to "public opinion" and in her cases described patients and patients' family and friends as having significant input into the formation of medical ideas. Farnham's article was part of a medical dialogue in which women physicians and women patients influenced both the gendered construction of nervous disease and mental illness and the particular way *woman* was medicalized in the nineteenth century.

Professional turf battles

In the mid- to late nineteenth century, general practitioners, gynecologists, alienists, and neurologists saw women patients with mental or nervous complaints. Medical specialization was just beginning and required no formal examination, certification, or society membership until the twentieth century. Instead, a specialist was one who confined his or her cases to a certain group of people or to parts of the body or types of illnesses. Gynecologists specialized in the diseases of women, alienists specialized in mental illness and ran state or private insane asylums, and neurologists specialized in diseases of the nervous system. While these three categories might seem fairly straightforward and unproblematic, the boundaries of these specialties were sites of professional conflict in the nineteenth century. These three groups formed themselves into societies, held meetings, and published journals in order to define their subdisciplines.[4] A scientific understanding of gender was part of the knowledge each specialty created as its own.

In her 1887 article, Farnham challenged the gynecological definition of women's insanity and nervous disease, a definition she aptly characterized as obsessed with the notion that all of woman's illnesses were trace-

[4] For more information about these specialties in the nineteenth century see Blustine 1979, 1981; Sicherman 1980; Bynum 1985; Grob 1988; and Moscucci 1990.

able to her reproductive organs.[5] Although medicine from the late eighteenth century through the nineteenth century espoused an organicist notion of the individual/environment relationship—a notion stressing the entire life setting as an essential component of the patient's illness—gynecologists expressed a more mechanical, body-centered idea of women's illness than their contemporaries in other specialties (Jordanova 1989; Moscucci 1990). Horatio Storer, a mid-century Boston gynecologist, was representative of his fellow specialists when he asserted that "be the cases of insanity in females more or less in number [than in males], they are in great measure of reflex character, their exciting cause capable of being localized, and therefore, in a large proportion of cases, of being removed by treatment" (1864, 197). For Storer, the local causes of women's insanity were injured or dysfunctional reproductive organs that could be treated by the gynecologist with pessaries, applications of leeches or caustic chemicals, or, later in the century, surgery. Storer, like most other gynecologists, saw the uterus and ovaries as responsible for women's nervousness and mental illness. In an 1891 article titled "Can the Gynecologist Aid the Alienist in Institutions for the Insane," I. S. Stone outlined the position of gynecologists and then focused on the controversy between the gynecologists and the neurologists and alienists over the cause of women's insanity. Stone sent letters to alienists asking about the connection between gynecological problems and insanity in their patient populations. His extensive quotations from the letters, many very hostile, indicate that alienists found no causal relationship between women's reproductive organs and their mental alienation, yet Stone found it "logical" that "disease of the organs peculiar to women, which so much more than the corresponding organs in men, have to do with her physical and mental conditions, may cause psychical derangement" (1891, 873). Stone simply concluded that most of the alienists were incorrect in their evaluation of their patients. A professor of gynecology in Omaha, W. O. Henry, put it more succinctly: "A large majority of all insane women have some pelvic disturbance as an important, if not a chief causative factor" (1900–1901, 312).[6]

On the simplest level, gynecologists' physiological explanation for women's nervous complaints and insane behavior can be seen as stemming from economic self-interest. Just as they attempted to medicalize childbirth to drive out competition from midwives, gynecologists argued for a

[5] Moscucci 1990 found this assumption to be true of British gynecologists, but in the United States women gynecologists and some of their male colleagues differed from this dominant view.

[6] These physicians were representative of others in their specialty. Here, and throughout this article, I am citing only a small sample of the medical literature I found supporting my point.

theory of women's mental illness that held the gynecologist to be the specialist of choice to deal with women's nervousness and insanity. Although economics is always a factor in professional boundary disputes, the gynecological definition of women's insanity was prompted by much more than professional self-interest. Gynecologists saw women patients (and women) differently than nongynecologists did. Moscucci, in her 1990 study of British gynecology, has noted how the speculum influenced gynecological perception of women's illnesses. This new tool encouraged an anatomical representation of women's complaints partially because previously invisible problems, some serious and some benign, suddenly became viewable (Moscucci 1990, chap. 4). But even before the speculum, nineteenth-century gynecologists shaped a specialty around the otherness of woman; it was woman's difference, the "essential" femaleness of woman, that was the object of gynecological knowledge. It is no wonder that men who were in the process of creating a scientific specialty devoted to unveiling women's otherness would see all of their complaints as rooted in their ovaries and uterus. Horatio Storer, in the concluding part of his article, explained the logic of the gynecological view of woman's otherness. He marveled at woman's "possession of an inner mechanism, a central force, around which all her other systems and functions turn, and to which they are in reality, to a certain extent, but subsidiary," and reasoned that this mechanism is "so subtle and so easily disarranged by even slight external causes, that the real wonder is not that so many women are invalid, but that any are well" (1864, 199–200). George H. Rohe, a Maryland gynecologist, applied this logic more specifically to women's mental and nervous complaints and reasoned that women's reproductive organs rendered them unstable for their entire adult lives. He wrote, "Women are especially subject to mental disturbances dependent upon their sexual nature at three different epochs of life: the period of puberty when the menstrual function is established, the childbearing period, and the menopause" (1896, 802). The practice of gynecology in the nineteenth century encouraged male practitioners to define their specialty to include all of women's problems and therefore to define woman as inherently pathological.

In claiming women's physical and mental illness as gynecological territory, gynecological medical science collapsed the distinction between gender and sex: all of woman's complaints were reduced to her reproductive organs, her sex. When applied to women's mental illness and nervous complaints, gynecological medicine suggested that women were mentally ill or nervous simply because they were female and that their symptoms could be handled with physiological cures that, to late twentieth-century readers, appear to range from mildly punitive to un-

mistakably sadistic. As the early work of Smith-Rosenberg (1972) and Ann Douglas Wood (1973) has demonstrated, the gynecological view of women's sex-determined physical and mental debility—the woman-as-womb idea—was very influential in the early and mid-nineteenth century. According to physicians inside and outside of the specialty, this way of seeing women's nervousness and mental illness was widely shared by general practitioners as well as gynecologists.[7] But this point of view was neither universal nor uncontested within the medical community. Even while the gynecological view held sway, a spirited discourse among alienists and neurologists articulated a very different set of assumptions about the nature of women's mental illness and nervousness and a very different framework for understanding gender.

An 1882 editorial in *Alienist and Neurologist* judged "untenable" the "gynaecological reasoning which discerns through the speculum special and exclusive channels of communication with the brain, not revealed by physiological or anatomical research, and never dreamed of in regard to the other sex" (1882b, 133). The editor was writing specifically about removal of healthy ovaries for nervous complaints or insane behavior, but alienists and neurologists also argued against all "local" gynecological treatments for women's mental symptoms.[8] While they conceded that gynecological problems should be treated, the alienists and neurologists maintained that such problems were not the cause of women's mental complaints and symptoms. Instead, their theory of causation stressed the role of what today we would call sociological or environmental factors in the etiology of mental illness and nervousness.

In general, alienists and neurologists believed that a hereditary predisposition to insanity/nervousness was the root cause of mental problems in both women and men and that insanity was produced by a brain lesion not yet observable by medical science. Similar to the gynecologists' focus on their organs of specialty, the female reproductive organs, alienists and neurologists argued that the central nervous system was the body's control center for physical and emotional health. Like gynecologists' accolades to women's mysterious and powerful generative apparatus, neurologists and alienists described the central nervous system as the center that "intimately blended with all the other organs, controlling their actions and thus uniting

[7] I found a dozen examples of physicians from different specialties asserting that this view of the gynecological cause of women's mental and nervous complaints was widespread among gynecologists and general practitioners.

[8] This view was axiomatic among neurologists and alienists and was expressed in every review of gynecological texts appearing in *Alienist and Neurologist* and the *Journal of Nervous and Mental Disease*. It seems to be one of the few things about which alienists and neurologists agreed. For an excellent review of the nongynecological view, see Dwyer 1984.

them all in one harmonious whole" (Teed 1874, 139). According to these specialists, the "exciting cause"[9] of insanity or nervousness in either sex could be physical problems or situational ones, both of which could trigger insanity or nervousness through the nervous system. Most neurologists and alienists vigorously denied that women's reproductive organs were overinvolved in female insanity, and they heaped ridicule on the gynecological perspective. Representative of this neurological complaint was a review in *Alienist and Neurologist* that argued "modern gynecology ... maintains that the uterus is the woman. As well say the testes, etc., is the man, for the nervous connections are about as intimate with the whole of his organism and testes as with the female uterus and ovaries" (1884, 735).[10] Most alienists and neurologists argued that female physiology contributed to women's mental problems only in that women had "finer tuned" nervous systems than men, so that physical or situational problems of any type were more likely to result in nervous breakdown in women than in men. These specialists conceded that gynecological problems, as well as other kinds of physical problems, could trigger a nervous response in women, but they maintained that once the reaction set in, the problem was one of nerves and not of reproductive organs. While they granted that the organic problem, reproductive or otherwise, should be treated, they argued that a cure was possible only by treating the nervous condition itself, usually with some combination of rest, massage, diet, exercise, and electricity.[11]

Some neurologists and alienists offered an even greater contrast to gynecological thinking, stressing women's gender role as the "exciting cause" of insanity or nervous symptoms. The demands of child rearing or nursing a sick family member, disappointment in love, boredom, an abusive husband, a lack of exercise or activity because of the restrictions of dress—all these were seen as causes of lowered physical and psychological resistance. In a person with "hereditary predisposition" to insanity or

[9] Physicians thought of the "exciting cause" as a necessary but not sufficient cause of the insanity or nervousness. The "exciting cause," although temporally related to the outbreak of the illness, could not produce the illness alone.

[10] Although this criticism was nearly universal among alienists and neurologists, there were some who argued for a special connection between woman's reproductive organs and her nervous system. For example, see Hersman 1899.

[11] Two of the most famous neurologists of the late nineteenth century, Beard and Mitchell, recommended complicated treatments including electricity, diet, rest, and exercise. Both believed physical problems, including problems of the reproductive organs, brought on nervous collapse, but neither singled out women's reproductive organs as particularly problematic. Most of Beard's work focusing on reproductive organs was with male patients (1879, 1898). Mitchell's infamous "rest cure" was first developed for male neurotics, not to "punish" women patients; his discussion of female neurotics clearly indicates his belief in sociological causes of women's nervous breakdowns (Mitchell 1871, 1879, 1900). Although both men, along with most of their generation of Americans, believed women and men to be more different than alike, neither argued for a gynecological theory of women's nervous disease.

nervous disease, such life situations were capable of producing a chain reaction that could end in slight nervousness or severe mental illness. Perhaps the most poignant explanation of this connection between women's life situations and nervous disease was given by E. H. Van Deusen, a Michigan physician who first used the word *neurasthenia* to name this condition. "The early married life of the wives of some of our smaller farmers seems especially calculated to predispose to this condition," he wrote. He went on to describe what he thought of as a typical situation:

> Transferred to an isolated farmhouse, very frequently from a home in which she had enjoyed a requisite measure of social and intellectual recreation, she is subjected to a daily routine of very monotonous household labor. Her new *home,* if it deserve the name, is . . . deprived of everything which can suggest a pleasant thought: not a flower blooms in the garden; books she has, perhaps, but no time to read them. Remote from neighbors . . . she sees only her husband and the generally uneducated man who shares his toil. . . . Her daily life, and especially if she have also the unaided care of one or two ailing little children, is exhausting and depressing to a degree of which but few are likely to form any correct conception. [1868–69, 447]

Similarly, physicians Joseph Collins and Carlin Phillips attributed the neurasthenia in their urban women patients to gender-related problems: "The entailments of marriage—anxiety concerning the material welfare of mate and offspring, incompatibility of partners, dread and depression attending sickness and death, the assumption of marital and maternal obligations, etc.—are contributing to the occurrence of this neurosis" (1899, 413). C. F. Folsom, the visiting physician for nervous disease at Boston City Hospital, went so far as to suggest that more education as well as "more physical exercise, more knowledge how to take care of themselves, more opportunities in every direction" would result in less nervous disease in women (1886, 185).

While the contrast between the gynecological view and the neurological and psychiatric view of women's nervousness and mental illness is important to note, I want to stress that nineteenth-century physicians, no matter what their specialty, assumed that women and men were more different than alike and that the physiological differences between the sexes translated "naturally" to different social roles.[12] In spite of all of

[12] For more about physicians' construction of women's otherness, see Jordanova 1986, esp. "Introduction" and "Naturalizing the Family: Literature and the Bio-Medical Sciences in the Late Eighteenth Century."

their complaints about gynecologists, most alienists and neurologists agreed with their gynecologist colleagues that women's reproductive organs dictated that women should restrict their activities and aspirations. In a review of Edward H. Clarke's *The Building of a Brain,* the *Psychological and Medico-Legal Journal* reviewer praised Clarke for writing "so forcibly, so overpoweringly, so thoroughly logically against the claims of some women to corporeal and mental identity with man" (1874, 401).

Although the gynecological view may appear more crude and more easily refutable with "scientific" evidence, the neurological/psychiatric view also rested on the assumption of difference at a more invisible level. As mentioned earlier, neurologists and alienists assumed that women had finer-tuned nervous systems than men. In fact, they imaged the nervous system as female. Illustrations of the nervous system in the nineteenth century were of female bodies, whereas illustrations of the muscular system were of male bodies. Nerves were inherently feminine, and women were inherently prone to nervousness and to manic, depressive, or hysterical responses to life's difficulties (see Jordanova 1989). While the gynecological view of women's problems was based on the reproductive organs—and therefore open to clinical refutation—the neurological/psychiatric view was based on the invisible femininity of the nervous system—and therefore closed to clinical refutation. Ironically, the neurological and psychiatric point of view was supported by women physicians in the name of clinical science.

Women physicians' professional position

The contribution of women physicians to the professional discourse on women's insanity and nervousness formed part of the neurological and psychiatric case against gynecological thinking, although most women physicians who participated in the discourse were technically gynecologists (i.e., most treated the diseases of women). While accepting as a truism the idea that mind and body interact and that all organs affect each other, women physicians drew broader and narrower conclusions about the nature of the interaction than did gynecologists. Amelia Gilmore, resident physician at the Philadelphia Hospital for the Insane, asserted that "all conditions of the body—all diseases, organic or specific,—may lead to insanity" (1893, 558). Likewise, Alice Bennett, working in the Norristown, Pennsylvania, asylum, noted that "it is understood, of course, that no organ or system of organs acts independently; that there can be no absolute separation of the study of one from the study of another" (1890, 569). Both women did studies of the relationship of kidney disease and insanity in their asylum populations, challenging the gynecological

notion that women's reproductive organs were the only ones implicated in women's insanity.

Other women physicians focused on the relationship between women's reproductive organs and insanity but disputed gynecological views of cause and effect. Anne Hazen McFarland, medical superintendent of the Oak Lawn Retreat for the Insane (Illinois), ridiculed the gynecological hypothesis as "dull" and as serving the economic interest of physicians "who otherwise should have to take to a change of occupation to earn a livelihood" (1895, 115). Several women physicians employed in asylums as gynecologists conducted studies of the female patients specifically to test the gynecological hypothesis. Like Alice May Farnham, these women concluded that there was no cause-and-effect relationship between women's mental illness and diseases of the reproductive organs, although they conceded that physical problems should always be treated to make the patients more comfortable. One study of 450 asylum patients, coauthored by Mary E. Bassett, concluded that although many of the patients had some kind of pelvic disease, there was "no apparent relation between the pelvic disease and the mental disturbance" (Tomlinson and Bassett 1899, 831).[13] Designing empirical studies to refute the gynecological argument, women physicians "out-scienced" their male gynecologist colleagues; that is, women physicians argued their points from what they assumed to be a superior, more empirical, and therefore more scientific perspective. In arguing this way, women physicians also contributed to the scientific ammunition of neurologists and alienists.

The subject of gynecological surgery was very much a part of the debate over the origins and proper treatment of women's insanity and nervousness. Neurologists and alienists argued that when surgery of any kind "cured" insanity or nervousness, it was due to the power of suggestion and not to the physiological effect of the surgery.[14] Women physicians overwhelmingly supported the neurological and psychiatric point of view on the removal of women's reproductive organs in cases of insanity and nervousness. E. M. Roys Gavitt, a woman physician from Toledo and editor-in-chief of the *Woman's Medical Journal,* complained that "a desire to experiment has led ambitious surgeons to perform ovariotomy to cure insanity, nervous disorders and functional disturbances too numerous to mention." She went on to say that such surgery will be of no benefit "unless the woman has been under the influence of some

[13] Other women physicians who did empirical investigations or cited specific cases to demonstrate the invalidity of the gynecological hypothesis include Jacobi 1886, 399; Farnham 1887; Dr. Grace Peckham, cited by an unnamed author in *Alienist and Neurologist* 1888, 274; Davenport 1895, 368–70; and Gardner 1900.

[14] See, e.g., *Alienist and Neurologist* 1882a, 296; 1883, 499–500; and 1901, 737.

ambitious medical counselor, who has a mania that every pain and ache suffered by a woman is caused by some disturbance of the genital organs, *and the removal of the ovaries from the pelvis removes them from the head*" (1893, 123–24; emphasis in original). McFarland echoed Gavitt's opinion of physicians who perform ovariotomies as "ambitious and pretentious" and asserted that the "chief medical error of the present day is the mistaking of brain disease for pelvic disease" (1893, 146; 1894, 41). Mary Dixon Jones, a gynecologist who argued in favor of gynecological operations on diseased organs and in favor of the possible cure of insanity and nervousness by the removal of women's reproductive organs, insisted that the surgery should be done only when the physician suspected that the organs were physically diseased (1894a).[15] However, another woman physician, Flora Aldrich, complained that medical men misjudged women's nervous and mental illness as always related to the uterus and ovaries. She boasted of successfully treating "countless women" whose symptoms would have "doomed them to the knife" had they trusted their care to male physicians, many of them "young and thoughtless operators, aided if not by greed of gold, with errors in diagnosis" (1894, 107). Medical women consistently supported the neurological and psychiatric position against the gynecological essentialism that tied women's nervous and mental illness to their reproductive organs.

The women physicians who participated in this debate articulated a situational theory to explain women's mental illness and nervousness. Grace Peckham, a New York City physician, asserted that "many women are physically cripples from lack of use of their muscles, and the same is true of mental forces" (1887, 47). The assistant physician at the Iowa State Hospital for the Insane, Jennie McCowen, voiced a similar position that women's lives contributed to their mental problems. She wrote that one cause of insanity was "monotony of work and thought," "the treadmill of ceaseless care and toil to which so many conscientious souls are self-condemned" (1882–83, 17). She went on to say that "the largest numbers of victims to this cause is found among the mothers of the land" and gave a case study of a woman who was a "most domestic woman" much praised by her husband for her devotion to home and family (17). McCowen confidently asserted that the woman would not have gone insane had she been less domestic. A well-known New York neurologist, Mary Putnam Jacobi, similarly linked hysteria to women's life condi-

[15] Although Jones warned against too-aggressive surgery on women, she herself performed countless ovariotomies. I am grateful to Regina Morantz-Sanchez for sharing with me her unpublished paper (1992) in which Jones is a major character. Morantz-Sanchez found Jones to be a very active gynecological surgeon who was accused of not listening closely enough to her female patients, and she argues that this lack of feminine empathy was partially responsible for Jones's professional demise.

tions. Jacobi judged hysteria to be due ultimately to a brain lesion, but she argued that the narrow life of most women was the most frequent cause of the brain problem. "When hysteria develops," Jacobi wrote, "it implies that the mechanisms associated with the inmost individuality have succumbed to the accidents and calamities of life" (1886, 401). She went on to quote a male author who attributed hysteria to the "social conditions to which [women] are subject" that confine them to "a narrow and trivial existence" (401).[16]

In a similar vein, other women physicians argued that more education and greater freedom of life choices would prevent most cases of female insanity and nervousness. Women physicians took issue with their male colleagues who blamed women's nervousness on education. Jones, in a review of a gynecological textbook, praised the text in general but spent two pages of the five-page review chiding the author for his mistaken ideas about the detrimental effects of study on women's physical development. "As a woman, I must, especially, take exceptions to the above remarks," she wrote (1895b, 19). She went on to explain, "Developing or improving one part of the body certainly does not dwarf another, weaken it, deprive it of nerve power, or cause it to be diseased. . . . Certainly mental labor or assiduity in study does not produce disease" (21). Jones cited empirical, experiential evidence to prove her point, arguing that the best-educated women were generally "strong and vigorous" (23). Similarly, a series of editorials in the *Woman's Medical Journal* poked fun at medical authors opposing coeducation or higher education of women (1904a, 1904b, 1904c). Instead of education, women physicians blamed women's narrow life choices and self-sacrificial domesticity for women's nervousness and insanity and argued that opportunities and self-care would work wonders for women's mental health. Mary A. Spink argued that the most common cause of women's neurasthenia was the "lack of definite object in life. Eternal waiting and longing for something, they know not what, . . . disappointment and unhappiness from whatever cause" (1896, 36). She noted that women's colleges, women's clubs, the new permission for women to fence, cycle, play golf and tennis, and the new emphasis on proper clothing for exercise were all contributing to women's mental health (37). McFarland similarly linked women's nerves to domestic burdens. She recommended rest, the friendship of women, and having "something to do" as a cure (1895, 114). She particularly recommended against "misplaced self-denial" and urged women "to secure independence of thought and conduct, to pursue personal studies and interests" (116–17).

[16] Morantz-Sanchez (1985, 220–25) also notes that women physicians argued for an environmental view of women's insanity and nervousness.

Women physicians who stressed women's life situation, like those who did empirical studies of the relationship between uterine disease and insanity, were not unique in the profession. The point is not that they expressed views contrary to those of male physicians but that medical opinion about female insanity and nervousness was divided and women physicians contributed to the discourse almost entirely as opponents of the gynecological perspective. As women physicians, they had a professional as well as a personal stake in defeating the gynecological definition of gender. After all, many gynecologists argued throughout the nineteenth century that women's menstrual cycles rendered them biologically unfit to practice medicine.

In addition to being a part of the debate between the gynecologists and the alienists and neurologists, women physicians were participants in the discourse between alienists and neurologists over asylum politics. Alienists, who were asylum managers as well as physicians and who admitted only asylum superintendents into their small, male group, were opposed to other physicians' having access to asylum patients. Neurologists criticized alienists for sloppy asylum management, for keeping asylums closed to studies by other physicians, and basically for having wrong ideas about the nature of insanity. Women physicians entered this debate by siding with neurologists on points of contention, and, more important, by insisting that women asylum patients needed the care of women physicians. Louise Robinovitch, a New York City neurologist, expressed an almost territorial view of women asylum patients: "Insane women are the legitimate wards of the woman physician, and it is time that the woman physician entered into the practice of her art as applied to insane women" (1903, 74).[17] From a more patient-centered perspective, Calista Luther wrote that "it has long been recognized by a few professional men and women that the welfare of insane women demands that they should not only be treated by their own sex, but that none but women should be admitted to their presence" (1900, 39). Luther cited another woman physician, Margaret Cleaves, who supported her position, arguing that women patients who had gynecological problems would not be likely to tell male doctors of their distress. Cleaves also asserted that women asylum patients often misinterpreted gynecological treatment by male doctors and that the misinterpretation added to their mental illness. The *Woman's Medical Journal* suggested that the controversy over the relationship of pelvic disease and insanity was nearer a solution thanks to

[17] Further indication that women physicians saw the care of insane women as their special domain was the *Woman's Medical Journal's* publishing the names and positions of women physicians in asylums in each issue as the news was gathered, as well as two articles about such women (1894; and Coveny 1901). For more information about women physicians employed in asylums, see McGovern 1981 and MacKenzie 1983.

"more careful methods of research" established by "the introduction of medical women into the hospitals for the insane." The journal urged that "more medical women are needed in this work" (1900, 428). Amelia Gilmore, the resident physician to the Insane Department of the Philadelphia Hospital, went so far as to assert that a major symptom of puerperal insanity (insanity of childbirth) was prompted by male caretaking; she confidently wrote that "the tendency to eroticism [in behavior and language], is not provoked when the patients are under the medical care of women" (1892, 411).[18]

These women physicians were supported by many male neurologists who were interested in greater access to asylum patients, and as a result of their efforts several states passed laws by the end of the century that required that women physicians be appointed to state asylums to care for women patients. These laws were victories for neurologists and for all physicians who were not among the small group of asylum superintendents. In this controversy between neurologists and alienists, as in the controversy with gynecologists, women physicians were vocal, "inside" participants in a medical discourse about the nature of sex and gender. Sandra Harding has argued that the central "science question" in feminism is not one of "good" versus "bad" science but that it concerns instead the epistemology stemming from the scientist's position (1986). This is very much my point about nineteenth-century physicians: their specialties and genders determined the epistemological position upon which their different sciences depended. Like their male colleagues, nineteenth-century women physicians' ideas about women's insanity and nervousness expressed their gender and class situation. The knowledge that women physicians created about the female body and female consciousness was not "good science" as opposed to men physicians' "bad science"; instead, both women and men physicians formulated concepts of women's mental illness from their different positions in the medical and gender power structures, positions that limited their vision even as their vision helped define their positions.

While women physicians' gender set them apart from their male colleagues and contributed to their unique perception of women's insanity and nervousness, women physicians' middle-class professional position separated them from their women patients and prompted them to interpret women's illness in a particular way. Women who were physicians saw their lives as living testimony against the "woman-as-womb" idea. They likewise saw the domestic lives of the majority of women as oppressed with physical labor and psychological worry that was happily

[18] Three other women physicians who disagreed with male colleagues about the erotic nature of puerperal insanity were Burnet 1899; Hutchins 1900; and Cadwalader 1905.

absent from most of their lives. Women physicians' privileged class position encouraged them to see the lives of less privileged women as physically grueling and lacking in intellectual stimulation. Similarly, women physicians saw the lives of upper-class women as frivolous and empty. Because of their unique gender/professional situation, women physicians "saw" their women patients' complaints as environmental and not essentially female—as related to gender role and not to biology. Their working-class patients worked too hard, their upper-class patients had no purpose in life, and neither group exercised their mental powers.

This vision, however, did not prompt a structural critique of gender; women physicians treated women's mental alienation as a personal problem that women could develop the "will" to overcome. In the turn-of-the-century period, women physicians welcomed psychological and psychoanalytical approaches to hysteria and neurasthenia that involved isolating women patients from "sympathetic" friends, allowing patients to talk to only the doctor, forcing them to "rest," showing no sympathy for their symptoms, and encouraging the restoration of "mental control."[19] One New York City physician, Evelyn Garrigue, wrote in favor of a psychotherapy aimed at "re-education." "The self-centered neurasthenics with their hyperfatigability and the self-deceiving hysterics with their hypersuggestibility are specimens of abnormal development," she wrote; "they need instruction how to make themselves normal" (1909a, 28). The reeducation consisted of teaching these patients "to face the truth about themselves," to understand that their symptoms or phobias are "nothingness," and to develop habits of "industry and intelligently directed energy" (30). While Garrigue believed that reeducation "regarding the complex relationship of the sexes" was needed, she cured her women patients by giving them the "pluck and courage" to go back into their domestic troubles with a "self-respecting power to cope with life's difficulties" (32). Women physicians' professional and gender position encouraged them to see women's nervousness and mental illness as situational, not biological, but also as indicative of a failure of will or energy. Women patients, however, interpreted their illnesses differently.

Women patients' voices in medical discourse

Let me return to my earlier point about the difference between illness and disease. If we think of women patients, their family and friends, and their chosen physicians as participants in a dialogue about symptoms, a dialogue in which symptoms of illness were transformed into disease entities, we can begin to hear the voices of women patients in the medical

[19] For example, see Brown 1895; Coone 1904a, 1904b; *Woman's Medical Journal* 1908, 1909; Garrigue 1909a, 1909b, 1910; and Mackie 1909.

discourse on sex and gender. Like women physicians, women patients participated in the medical discourse on insanity and nervousness but in a more substantial, if less overt, manner. Although women physicians accounted for a tiny minority of medical writing about female insanity and nervous disease, women patients were present in almost every case study. In order to hear their voices in the discourse, however, we need to listen with an interactive theory of disease formation.

There were two subjects dominating the dialogue between medical practitioners and patients with nervous and mental complaints: the symptoms themselves and the perceived cause or causes of the symptoms. Many historians and critics of contemporary psychiatry have pointed out that symptoms of insanity vary depending on time and place and that attaching names to peculiar behavior can be seen as the medical community's medicalization and labeling of inappropriate behavior as disease.[20] According to this line of criticism, people displaying peculiar behavior are victimized by this medicalization. At first glance, this interpretation seems particularly fitting of nineteenth-century women's insane behavior, as the behavior was so gender-specific. The symptoms of nineteenth-century women's nervous and mental illnesses were numerous and varied, but the common characteristic of the symptoms was the unfeminine nature of the behavior or feeling. Insane and nervous women were described as antimaternal, selfish, willful, violent, erotic—all of these inappropriate in terms of nineteenth-century definitions of womanhood. Leaving aside for a moment the question of what the behavior labeled as insane meant in women patients' lives, we are concerned here with the question of how certain behavior and emotions were attached to the notion of insanity and nervousness within medical discourse. Case studies indicate that women patients and their families and friends were as responsible as physicians for linking unfeminine behavior with insanity and nervousness.[21] In many cases women came to physicians asking to be committed or to be given medication for behavior the patients themselves described as insane or nervous, including lack of interest in husband and family, violent feelings toward their children, and continual sadness or suicidal urges in spite of being well taken care of by husband or family.[22]

[20] See, e.g., Zola 1972; Waxler 1974; and Engelhardt 1975.

[21] A very small minority of the cases I read were cases named by physicians as *sexual inversion,* which, in the early twentieth century, was translated as *homosexual.* There are not enough of these cases in my sample for me to set them apart; however, these cases conform to my general point. The behavior seen as deviant by physicians and patients was not sexual behavior but was cross-dressing and performing "male" work (i.e., unfeminine behavior). This is the same conclusion drawn by Chauncey 1989.

[22] For example, Whitomore 1879 quotes a woman who related her second hysterical attack to her anger with her mother (522). Another woman's list of nervous symptoms included brooding, being unhappy, and having thoughts of suicide although married to a good man. See *Post-Graduate* 1896.

Most patients did not name their own behavior and feelings as nervous or insane; more frequently the connection was made by a family member or close friends. Husbands brought in wives for a variety of unwomanly offenses. Women who disagreed too vocally, lost interest in personal appearance, or neglected their children were brought to physicians by husbands who saw this behavior as insane or nervous. One woman was brought to the Boston Insane Hospital by her husband because she had begun going out, refused to say where she had been, came home smelling of whiskey, and neglected her children and household affairs (Boston Insane Hospital 1890–91a). Another husband brought his wife to a physician because "at uncertain, unexpected intervals of a few weeks, sometimes months . . . she would go into a paroxysm of scolding, fault-finding and vituperation, lasting a few hours" (Russell 1884, 467). A previously "refined wife and mother" was brought to a physician by her husband because she had developed a noticeable "coarseness not present before, and a tendency to malicious mischief toward her husband, whose sense of propriety she took an especial delight in outraging" (*Alienist and Neurologist* 1886, 505). The husbands of these women thought of them as insane or nervous because the women acted in ways a "normal" woman would not.

Even more numerous than cases of husbands bringing wives to physicians were cases of mothers bringing daughters. Girls and young women who were insubordinate, sexually promiscuous, or not interested enough in socializing were brought to physicians by anxious mothers. One fifteen-year-old was presented to Dr. J. Workman by her mother, "who gave . . . a terrorizing history of the daughter's misdeeds." Although Workman thought the deeds "savoured more of moral delinquency than of mental infirmity," he told the girl's mother he would admit her to the Toronto Asylum for the Insane if the mother could find three physicians to agree that the girl was insane; the mother obtained the necessary signatures (1883, 301). A New York City physician reported a case of "Insanity of Pubescence" involving a sixteen-year-old girl who had displayed "strange and willful" behavior since the age of twelve. "She would strike back if punished for any misdemeanor, and speak of those 'damn people,' although she had been carefully and religiously brought up"; she would not stay in school, and she displayed "very erotic" tendencies (Mann 1884, 503). In another case, an adolescent whose mother reported that "she had given her family much trouble" was brought to a physician by her mother (Arnold 1879, 118).

Behavior problems that threatened feminine propriety were often seen by mothers as evidence of mental or nervous illness. In a study titled "Insanity in Young Women," physician Clara Barrus listed "contradictoriness" as a major symptom (1896, 366), and physician G. R. Trow-

bridge also found erotic and willful behavior to be a symptom of insanity in young women (1891, 349). C. H. Hughes, a St. Louis physician, reported a case that included many of the symptoms listed thus far. The case appeared in *Alienist and Neurologist* as an extended quotation from a letter sent to Hughes by the mother of a twenty-seven-year-old woman. The mother cited her daughter's use of vile language as "a most striking sign of insanity" given that "all her life she has been surrounded by the most pure and lovely influences" (Hughes 1882, 519). Her daughter also made up "scandalous stories" about her younger sister, threw buckets of ash on the carpet, destroyed pictures, made scenes in public, and refused to help her mother take care of the home and family (520–21). All of this behavior was seen as insane by the mother, who wrote, "It is absurd to think a lady brought up as she has been . . . would act in that manner were she not insane. . . . Were she not mentally afflicted, knowing our circumstances and that I am trying to keep a home for my children, she would try to help me keep that home instead of destroying its peace and happiness and disgracing her family. . . . She has almost broken our hearts" (522–23).

Although a mother or husband was the most common person to accompany a woman to a physician's office or an asylum, sometimes other family members or the woman's friends were involved. A brother brought his "peculiar" thirty-six-year-old sister to the Boston Insane Hospital. He reported that her "irritable and unreasonable disposition" made her impossible to live with (Boston Insane Hospital 1884). Another young woman was brought in after she attacked her friend and pulled her hair, and a clergyman brought his daughter to a physician seeking to have her declared insane because of sexual misconduct (Fisher 1865a; *American Journal of Insanity* 1882–83). Many times a woman's friends accompanied her to a physician's office, explaining that the woman was troubled with crying spells, neglected her household when previously she had been an excellent housekeeper, or suddenly distrusted her husband. Isabel M. Davenport, assistant physician and gynecologist to the Eastern Illinois Hospital for the Insane, cited a case in which a woman's friends brought her to the asylum after the woman spent "three weeks of fearful debauchery in one of the large cities" (1895, 369). In all of these cases, certain unwomanly traits were linked by women patients, their families, or friends to the concept of insanity or nervousness.

Physicians recorded women's self-reported and other-reported symptoms, sometimes word for word and other times paraphrasing, and then translated those symptoms into various diseases: mania, melancholia, puerperal insanity, hysteria, neurasthenia, moral insanity. Even more significant, physicians' theories about the cause or causes of these insane and nervous symptoms echoed the patients' and patients' families' or

friends' claims about causation. Women who went to general practitioners, gynecologists, and neurologists with nervous and insane symptoms linked their symptoms most frequently to physical problems with their reproductive organs. Doctors' theories about nervous and insane women, whether gynecological and related directly to the body or neurological and based on women's nervous sensibility, were formed from the testimony of their women patients and their patients' families and friends.

With and without prompting about the cause of their symptoms, women most often related their illness to their female bodies. A woman patient would report that she first noticed the nervous symptoms after the birth of her last child, or that they occurred at a particular time in her menstrual cycle, or that they were due to foolish behavior during her period, or that they were causally related to a physical problem with her reproductive organs.[23] The editor of *Alienist and Neurologist* complained in 1882 that the typical woman patient has "the imaginary notion that her womb is diseased" (1882a, 296). One of George Beard's patients attributed her neurasthenia to taking cold while on a mountain climb at the time of her menses (1877, 659), and another woman neurasthenic explained her submission to gynecological treatment thus: "I had a feeling, which many women I know also have, that the womb is the weak point and is the cause of most of their nervous ills" (*Post-Graduate* 1896, 364). In remembering her years as a woman physician to young college women in the 1890s, Lilian Welsh reported that "there was scarcely a student . . . with a neurotic history or a neurotic tendency whose mind was not fixed upon her reproductive organs as the source of all her troubles" (1925, 119).

Not only did women themselves relate their nervous and mental problems to their female bodies, but the friends and families of women patients also voiced similar theories about the cause of women's nervous and insane symptoms. Often a friend or family member of a patient related the patient's insane or nervous behavior to the onset of puberty or menopause or to dysfunctional menstruation.[24] One physician reported that for most of the women patients in the asylum where she worked, "the cause most frequently assigned by the friends and attending physician is 'pelvic disease' " (Davenport 1895, 368), and another physician similarly complained, "I am continually being asked by the friends of the insane, 'Is there not some uterine trouble?' " She went on to say, "People

[23] I found ten articles with case study examples of women who dated their nervous or mental symptoms from childbirth or who related them to menstrual irregularities, to their menstrual periods themselves, or to foolish activities during menstruation. These do not include cases defined as "puerperal insanity."

[24] Cases in which the friends or family of a woman attributed the woman's symptoms to menstruation or to menopause can be found in Boston Insane Hospital 1881a, 1882–83, and 1890–91b; Reed 1888–89; and Vinton 1899.

think that all mental disorder springs from uterine trouble. They forget that there are more insane men than insane women, so the uterus cannot be held responsible for all insanity" (Robinovitch 1903, 78).

However much women physicians resisted this physical explanation, women patients and their families and friends undoubtedly believed that the uterus was responsible for most nervous and mental symptoms. Even families more oriented toward the patient's life situation as the root of her problems reported "over-study" and "disappointment in love" as causes of women's symptoms, causes that were seen as inherently feminine.[25] Some families and friends of women patients gave "domestic trouble" as the cause of the woman's nervous or mental illness, but the domestic trouble was always accompanied by some physical cause as well.[26]

At a time when the medical wisdom held heredity responsible for mental illness and nervous disease, it is understandable both that families would resist the idea of hereditary "taint" and that physicians of all specialties would settle on something more tangible as a "secondary" or "exciting" cause of mental and nervous illness. In terms of treatment, heredity was untouchable, yet physicians definitely were expected to treat their nervous and insane patients. As I have pointed out earlier, both neurologists and gynecologists believed heredity was the root cause of insanity, although both treated nervous and insane women as if their female bodies were defective. The most dramatic examples of this treatment philosophy were "local" treatments and sexual surgery. If the symptoms of nervous and mental illness were unwomanly behavior and feelings, and if the causes were rooted in the female body, then the cures must produce some change in the woman patient's reproductive organs to change the woman's behavior. Women patients and their families and friends were vocal advocates of this line of reasoning.

The most popular form of surgery performed on nervous and insane women was removal of one or both ovaries. The vast majority of women with nervous and insane symptoms were not operated on, but many of those who underwent operations did so at the request or insistence of family or friends or, more frequently, at their own request. Mary Dixon Jones reported a case in which "the patient, as well as the relatives, were very anxious for an operation" to cure hystero-epilepsy (1895a, 5), and Isabel Davenport reported a case in which a patient's friends wanted an

[25] Cases in which patients' families/friends attributed the nervous symptoms to overstudy can be found in Boston Insane Hospital 1881b, 1890–91c; Hurd 1882–83. Cases in which friends and families of women patients related their insanity and nervous symptoms to life disappointments associated with the feminine role can be found in Barrus 1896. About the influence of families in women patients' admission to asylums, see Fox 1978 and MacKenzie 1983.

[26] Cases in which domestic trouble was seen by family or friends as a cause of symptoms can be found in Fisher 1865b; Boston Insane Hospital 1881c; Lane 1901.

ovario-hysterectomy performed to cure the woman's puerperal mania (1895, 369); the first operation was a success, but the second one was not.[27]

More common than family and friends influencing treatment, countless women patients also demanded or requested surgery to relieve their nervous symptoms. Jones had another patient who suffered from extreme pain and occasional seizures during her periods. When an operation was mentioned as a possibility, "eagerly she seized the idea at once and repeatedly urged that it should be done, and even grew angry that I delayed" (1895b, 23). Other physicians reported similar cases of women demanding surgery, hoping an operation would cure a physical or nervous problem.[28] Many times, physicians described themselves as reluctant operators, such as Edward Reynolds, whose neurasthenic patient "had become absolutely convinced that her only prospect of health lay in a cure of her local ailments." Although Reynolds was opposed to surgery, he reported that "after the complete failure of general treatment, and with her mento-nervous condition growing rapidly worse, I opened her abdomen" (1910, 114). Reynolds found nothing wrong, but the surgery had an immediate positive effect on his patient's nervous symptoms, and after a relapse she eventually recovered completely.

C. B. Burr, a physician from Pontiac, Michigan, even suggested that many women requested surgery for contraceptive reasons. Addressing the Michigan Medical Society in 1894, Burr said, "I do not believe that there is a man in this room . . . who has not been approached by patients to be operated upon for the purpose of bringing on an early change of life and preventing the bearing of children" (481). It is possible that other women were not as straightforward as the ones Burr referred to and instead came to their physicians with nervous and mental symptoms in order to request surgical treatment they knew would render them sterile. Whether to relieve emotional or behavioral symptoms or to end their childbearing potential, many women sought operations. Physicians reported that these operations cured many cases of nervous and mental illness, even among women in asylums.[29]

It is possible to argue that women patients and their families and friends were totally under the influence of selfish, ambitious physicians who persuaded these helpless victims that nervous and mental problems were caused by women's reproductive organs and could therefore be cured by surgery. In fact, some physicians (neurologists) accused other

[27] See also Clarke 1859 for a case in which the patient's friends were influential in the physician's use of medication.

[28] Additional cases of women patients demanding or requesting surgery can be found in Sims 1878; *Alienist and Neurologist* 1890, 1904; Jones 1894b; Davenport 1895.

[29] For examples of surgical cures and cures from other "local" treatments, see Scott 1871; Cross 1877; Sims 1878; Reed 1888–89; Burr 1894; Davenport 1895; Hall 1900; Hanley 1900–1901; Henry 1900–1901.

physicians (gynecologists and general practitioners) of being the cause of women patients' womb-centeredness.[30] However, this interpretation does not take seriously the interaction between doctor, patient, and family. General practitioners and specialists had to account for women's reproductive organs within their theories of insanity and nervous disease because women themselves, as well as their families and friends, related their emotional problems to reproductive dysfunction. In the nineteenth century, before sophisticated diagnostic techniques, women patients' self-reported symptoms and perceptions of causes formed the primary data of medical theorizing. Whether reproductive organs or life situation was stressed, the medical discourse elaborating the theory contained a chorus of professional, patient, and patient-advocate voices, with the professionals taking the other two perspectives as the raw material, the empirical basis of diagnosis. As we have seen, the specialty area as well as the sex of the doctor determined which set of patient-reported symptoms and causes the practitioner would take seriously, but neither the translation of symptoms into disease categories nor the theorizing about cause was the work of doctors alone.

A phenomenon illustrating this mixture of voices in the creation of a disease category was puerperal insanity, a disease defined in the nineteenth century by the medical community in general—alienists, neurologists, gynecologists, women physicians, and men physicians—from the illness behavior of women who believed childbirth itself could/would produce maniacal symptoms.[31] Women diagnosed by general practitioners and specialists as having puerperal insanity developed symptoms within hours or days of childbirth, and these symptoms included such behavior as suicidal tendencies, homicidal tendencies toward the baby or husband, talking incessantly and mostly incoherently, the inability to sleep, the refusal of food, and (according to male physicians) indecent language and sometimes indecent exposure. These symptoms were side effects of both normal and difficult labors and corresponded to no common set of physical or environmental factors. It is beyond the scope of this essay to speculate about the meaning of such behavior for women, but clearly the set of symptoms, unique and ubiquitous in the nineteenth century, translated by physicians into the disease category "puerperal insanity," illustrates the dependence of physicians on patient- or other-reported symptoms in the creation of disease categories. Physicians listened to their patients' stories and took seriously their patients' and their

[30] This point of view was expressed by *American Journal of Insanity* 1881, 1884; Robinovitch 1903; Reynolds 1910.

[31] One form of puerperal insanity was called "lactation insanity" and corresponds to what in the late twentieth century we call "postpartum depression." For a more complete discussion of puerperal insanity, see Theriot 1990.

patients' families' linking of symptoms to cause. The physician was not responsible for designating certain behavior as "symptoms" of nervous disease and insanity nor for linking "mad" or nervous behavior to women's reproductive organs. Instead, the interaction of physician, patient, and family and friends created symptoms, causes, and cures.

* * *

A reproductive theory of women's insanity and nervous disease dominated the nineteenth century partially because women experienced their reproductive lives as troublesome. Toward the end of the century, women physicians joined male neurologists and alienists to offer rebuttal to the gynecological theory. Ironically, the later environmental theory that we applaud today as a step toward an enlightened view of women's insanity and nervousness was based less on women patients' perceptions and more on empirical, "objective" studies that condemned patient perceptions as hopelessly subjective. As the gynecological theory, burdened by clinical refutation, lost professional support, it was replaced by a neurological/psychiatric theory of invisible femininity, insulated from the voices of women patients and immune to clinical evidence. Seen in this light, the neurological/psychiatric theory supported by women physicians led easily to the growing acceptance in the early twentieth century of a psychiatric point of view that totally discounted the perceptions of women patients in favor of a male-developed theory of repression. Freud's denial of the reality of Dora's sexual abuse was in keeping with the pattern established in the nineteenth century by women and men neurologists who combated the gynecological theory of women's insanity and nervous disease by increasingly disregarding women patients' self-reported symptoms and perceptions of causes.

The nervous symptoms and deviant behavior of nineteenth-century women patients were shaped by the constraints of gender and then were medicalized and therefore legitimized by medical representation as disease. The voices of women patients in case studies reported in medical periodicals and monographs indicate that women patients, as well as their family and friends, played a significant role in representing unfeminine behavior as nervous or insane and also in linking female insanity to women's reproductive organs. Although physicians' representations of women's illness varied by specialty, women's biological difference from men played some part in each specialty's explanatory scheme. Women physicians, unlike women patients, attempted to undermine the gynecological, organ-based explanation of female insanity and nervousness by empirical investigation and logical argument. Throughout the nineteenth century, medical science was shaped by women's "subjugated knowledge" just as it created a medicalized female subjectivity. Noticing wo-

men's voices in medical discourse, as patients and as physicians, forces us to reevaluate the unitary, male image of medical science and allows us to see gender and science as mutually constituting.

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