



HYSTERIA:

MEDICINE AS A VEHICLE FOR GENDERED SOCIAL CONTROL

This paper analyzes the historical phenomenon of hysteria, a psychiatric label once commonly applied to female patients to explain a variety of physical ailments and deviant behaviors. Beginning with an examination of its ancient historical roots, the paper then focuses on hysteria's application in Victorian England. Hysteria can be viewed as both cause and consequence of a male-dominated society and medical profession, used as a means of enforcing traditional gender roles and expectations for feminine sexuality. By emphasizing and pathologizing the female reproductive organs, diagnoses of hysteria reinforced cultural ideas about women's reproductive role and the male physician's right to regulate that role. In these ways, hysteria is a compelling example of the socially contingent nature of illness and the power of medicine as a tool of social control.

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Today, the term ‘hysteria’ is typically taken to mean uncontrollable or irrational emotion or fear, particularly in a collective sense (for example, ‘mass hysteria’). A century and a half ago, however, hysteria was known as a diagnosable psychiatric condition—one peculiar to women. Its manifestations were many and varied, including symptoms of somatization (conversion of a mental state into physical symptoms without an organic cause), overdramatic behavior, dysfunctional appetite, depression, anxiety, abnormal sexuality, defunct reproductivity, irregular menstruation, and epileptic-like fits; hysteria was thus a broad category, and its exact definition was contested and variable over time.¹ In another sense, the disease itself seemed to be a symptom of a male-dominated society, serving as both a cause and effect of cultural and medical sexism. In this paper, I analyze perceptions of hysteria over time, beginning with its ancient roots and then focusing on Victorian England as a case study of how hysteria was used as a means of enforcing traditional gender roles and expectations for feminine behavior.

Many historians locate the origins of hysteria in ancient times. Specifically, the term hysteria—which comes from the Greek word *hystera* meaning womb, the same root from which we obtain the word hysterectomy—is frequently attributed to Hippocrates.² However, recent historians have argued that this reading and translation of the ancient Greek and Egyptian texts was heavily influenced by the biases of nineteenth-century academics, to whom hysteria was already an established disease.³ Especially considering the socially-contingent nature of this illness, and its broad and variable symptoms, it is not fruitful to treat it as an objective disease category which has existed unchanged throughout history; rather, we must recognize how its diagnosis and definition have shifted depending on time and place and culturally dominant ideas and prejudices. However, one can still analyze ancient medical thought as an important precursor for the way hysteria was eventually conceptualized in Victorian England.

The roots of hysteria can be traced back to an Egyptian text known as the Kahun Gynaecological Papyrus, dated at around 1825 BC, and the Ebers Papyrus, dated at around 1600 BC—some of the oldest medical texts known to history.⁴ Based on these texts, the Egyptians seemed to believe that disorders of the womb, such as starvation or displacement, were connected to other conditions in the female body, ranging from toothaches and blindness to a woman who “wishes to lie down” and will not get up. Various treatments were recommended, including massages with oil and fumigation of the nasal and vaginal canals with fragrant materials, which were believed to make the womb “return to its proper place.”⁵ The Ancient Greeks elaborated upon and specified the Egyptians’ ideas. The Greeks incorporated their own humoral theory—which believed illness to be caused by imbalances in body fluids known as humors—by postulating that hysterical behavior was caused by an accumulation of poisonous humors within the womb. This accumulation was

thought to be caused by a lack of sexual intercourse with men; intercourse was believed to provide the uterus an opportunity to expel those poisonous humors. Thus, virgins and widows were most at risk for the disease. Plato, for instance, claimed that the uterus grows melancholy when it does not have intercourse and bear children. Hippocrates agreed with the Egyptians that uterine movement was to blame, and recommended marital sex as a means of expelling the poisonous humors which were apt to develop within the illness-prone uterus. Fumigation continued to be recommended as a way of forcing the uterus back into place. Preeminent physicians in Ancient Rome such as Galen agreed with their Greek teachers about hysteria—with the notable exception of Soranus, considered one of the ancient founders of gynecology, who actually recommended sexual abstinence as its cure.⁶ This ambivalence about the role of female sexuality in the disease is a theme repeated throughout history. The most significant contribution to the idea of hysteria by these ancient thinkers is the emphasis on the uterus as determinant of female physical and mental health, as well as the emphasis on marital sex and reproduction as critical to a woman's well-being.

While ancient Greek theory laid the foundation for medical thought in Victorian England, the Middle Ages and the Enlightenment era undoubtedly shaped Victorian morality and culture. During the Middle Ages, Europe was dominated by Christian theology and the Church, which was heavily paternalistic in nature. Women were believed to be spiritually inferior to men and therefore more susceptible to the influence of sin and demonic possession, both of which could cause hysterical behavior and might require treatment with a religious exorcism. At one point, hysterical behavior was even associated with sorcery and witchcraft.⁷ Enlightenment-era Europe moved away from ideas such as dark magic, and towards theories of reason, empiricism, philosophy, and morality. Prominent Enlightenment thinkers such as Rousseau and the physician-philosopher Pierre Roussel argued for a direct connection between the moral and physical worlds; women were the weaker sex physiologically and therefore also morally. Rousseau and Roussel believed that one's biological role naturally equated to one's social role, and that women were bound to their essential nature and biological destiny—that is, reproduction. Within this line of thought, hysterical behavior was a pathology that resulted from women not adhering to their natural role.⁸

An important development in the etiology of hysteria was the beginning of the new field of neurology in the seventeenth and eighteenth centuries. Some physicians began to postulate that hysteria was a disease not of the uterus but of the nervous system; however, hysteria was still viewed as primarily a woman's disease—at the time, it was believed that female nerves were more delicate than male nerves, and thus more prone to disruptions that could cause hysterical behavior. Hysteria came to be categorized under the wider term of 'female nervous disorders.' However, the

uterine etiology remained very influential; many physicians simply incorporated these new ideas by claiming that the uterus was connected to the rest of the body via nerves, and this ‘sympathetic’ association allowed the pathological uterus to affect other areas of the female anatomy.⁹ Though the exact organic cause of hysteria was debated—one of the frustrating hallmarks of hysteria was that physicians were often unable to find any organic cause—it was believed to be rooted in the very nature of being female.

The first usage of the word ‘hysteria’ in the English language (‘hysterical’ appeared earlier in English, and both appeared even earlier in French) is attributed to a London medical journal in 1801; thus, hysterical behavior can be viewed as an ancient sociomedical category, while the specific diagnosis of hysteria was relatively new to England under the reign of Queen Victoria, from the years 1837 to 1901.¹⁰ Still, Hippocratic and Galenic thought remained very influential in this time period. For example, most ladies carried around with them a bottle of smelling salts, which were used to wake a woman up after swooning, as women were prone to do. It was believed that fainting was caused by a displaced uterus, and that the odor of the smelling salts caused the organ to shift back into place, allowing the woman to regain consciousness—closely reflecting the ancient Egyptian and Greek beliefs about the wandering womb and their recommendations for herbal fumigation.¹¹ The uterine etiology in hysteria remained prominent, as evidenced by the great emphasis placed on the uterus as central to women’s health by English gynecologists in their medical writings during this time period. Eminent obstetrician Dr. W. Tyler Smith, for example, wrote that the uterus is the largest muscle in the female body, connected to the entire body via nerves, and in fact controls the entire anatomy outside of the conscious will of women. Dr. Smith believed that hysteria was in part caused by disruptions of the menstrual cycle—in fact, if you were a hysterical patient, likely the first question your doctor would ask you would be whether your periods were regular. It only makes sense that the uterus was believed to be behind a variety of physical and mental/emotional disorders in women; the womb—the sacred birthplace of man—was the center of the female body and believed to be her single most important organ. Dr. M. L. Holbrook, as quoted by Poovey, wrote that the female body was organized “as if the Almighty, in creating the female sex, had taken the uterus and built up a woman around it,”¹² in part reflecting the continuing influence of religious thought on the public perception of a woman’s naturally ordained role.

The ovaries, too, were emphasized by physicians of this era as somewhat of the headmasters of the female reproductive system (in what has been called by some “The Psychology of the Ovary”).¹³ In fact, “ovariotomy”—the term used for surgical excision of the ovaries at the time—was commonly practiced as a treatment for female mental and emotional disorders. Clearly, the great emphasis placed on

reproductive organs as the most important determinants of a woman's health is reflective of the social importance placed on reproduction; a woman's value as a member of society was entirely dependent on her ability to bear children, and an intrinsic connection between a woman's reproductive and mental health was simply taken for granted. An example of the great importance placed on reproduction can be seen in the Conservation of Energy Theory. This theory—drawing from contemporary developments in the fields of physics and chemistry—postulated that the human body was a closed system with a set amount of energy. In females, a substantial portion of that energy must be devoted to the reproductive systems, leaving less energy available for other parts of the body, such as the muscles and brain, than is available in the male anatomy.¹⁴ For instance, Henry Maudsley, an eminent Victorian-era English psychiatrist, argued that education was harmful to women's reproductive health because it diverted energy from the reproductive organs to the brain in a zero-sum game manner—a sentiment famously echoed by Harvard president Edward Clarke in 1873.¹⁵

This reminds us that medicine is not only a personalized endeavor for the sake of individualized healing, but also a collective industry for the purpose of maintaining a socially and economically functioning society.

Undoubtedly, medicine and science helped legitimize and reinforce social views about reproduction as a woman's most important social and biological purpose. Male obstetricians and gynecologists were able to exert control over that social role by framing reproductive processes and female anatomy as inherently pathological. For example, Dr. W. Tyler Smith (who was referenced earlier) wrote that childbirth and menstruation are “at the boundary between physiology and pathology.”¹⁶ Dr. Thomas Laycock, another prominent physician of the Victorian era, called this phenomenon the “doctrine of crisis,” wherein a woman's body is in a constantly changing, volatile state, and any disruption in this unstable system could cause hysteria.¹⁷ Dr. Isaac Ray put it the most bluntly: “With women, it is but a step from extreme nervous susceptibility to downright hysteria, and from that to overt insanity.”¹⁸ As these quotes illustrate, women are seen as walking a razor's edge between normal and abnormal, healthy and sick; even her natural cycles and bodily functions are viewed as inherently pathological and requiring constant medical intervention and treatment from male doctors. Her very nature and anatomy predispose her to illness of the body and mind. This pathologization allowed for the social regulation of women's bodies and reproductive activities. An American civil rights advocate of this time period, Mary Livermore, noticed this trend, calling it “the monstrous assumption that woman is a natural invalid,” and decrying “the

unclean army of ‘gynecologists’ who seem desirous to convince women that they possess but one set of organs—and that these are always diseased.”¹⁹ Though brave and astute, Livermore—quoted here from a 1970s feminist pamphlet—appears to be an exception rather than the rule; most men and women alike accepted physicians’ word as gospel.

Perhaps the most controversial and well-known example of the treatment of hysteria in Victorian England is the case of Dr. Isaac Baker Brown, a well-respected gynecological surgeon who practiced in London. In 1866 he published a book called *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*. Dr. Brown viewed hysteria as being caused by a loss of “nerve power” as a direct result of masturbation (“peripheral excitement of the pudic nerve”).²⁰ He viewed the disease as having a specific chronological trajectory: it began with hysteria (including symptoms of menstrual irregularity and, interestingly, indigestion), then spinal irritation, hysterical epilepsy, cataleptic fits, epileptic fits, “idiotcy” [sic], mania, and finally death.²¹ Considering this grave prognosis, it was critical to catch and treat the disease early on. Brown claimed that most, if not all, female nervous disorders could be cured via clitoridectomy, the surgical excision of the clitoris—a surgery he called a harmless procedure which he performed dozens of times throughout his career. Not to be accused of taking credit for a well-established procedure, Dr. Brown makes it clear in his book that he is not claiming to introduce a new surgery, but rather advocating its usefulness and for his particular method—in fact, Brown provides a long list of colleagues who he says share his views and whose work he was influenced by. Through the case studies in the book, Brown portrays his procedure as a miracle cure for a variety of ills ranging from indigestion, insomnia, and back pain to melancholy, nervousness and even sterility. The patients’ return to health is described in reference not only to the patient herself—she was now able to get a good night’s sleep, her periods became regular, her appetite returned to normal, her aches and pains disappeared, and so on—but also in reference to others. Through the woman’s return to proper social function, she would become “a good wife” or a “useful member of the community.”²² This reminds us that medicine is not only a personalized endeavor for the sake of individualized healing, but also a collective industry for the purpose of maintaining a socially and economically functioning society.

Once a hysterical or otherwise afflicted woman was brought into Dr. Brown’s office—often by her husband—Brown would perform a physical examination, whereby he would be able to determine by the genitals’ appearance if the woman was in fact a masturbator and therefore a good candidate for his surgery. Masturbation was viewed as pathological because it implied a female sexuality that was active and solitary; women were not, after all, supposed to possess a sexuality independent of heterosexual intercourse (note that this was a highly heteronormative era and

homosexuality itself was viewed as a psychiatric disease) within the confines of marriage.²³ Clitoridectomy quite literally restricted a woman's sexuality to the purposes of childbearing—though Dr. Brown confidently denied that the surgery at all affected her ability to feel “the normal excitement consequent on marital intercourse.”²⁴ It was a common belief at the time that hysteria could result from hypersexuality, or nymphomania. However, it was also commonly believed that hysterical women were frequently sexually ‘frigid.’²⁵ The fact that these contradictory views were able to coexist reflects the ambivalence towards the topic of female sexuality in general during this era; Victorian minds seem to have been morbidly fascinated by it, yet it was not a topic allowed to be discussed in polite circles. Sexuality was of great concern to a woman's morality, and male doctors who dealt with a woman's intimate anatomy were highly aware of this; the *British Medical Journal* in 1867 is quoted as saying: “Obstetricians, beyond other men, are not only the guardians of life, but, by force of circumstance, often also the guardians of female honour and purity.”²⁶

In addition to being an example of medical violence and regulation of sexual norms, the story of Dr. Brown is also a clear example of the medicalization of a social problem. While some of the women diagnosed with hysteria undoubtedly did suffer from some mental or neurological disorder, it is likely that many hysterical women were only labeled as diseased because of their socially deviant behavior. In his book, Brown describes the classic symptoms to look for in an afflicted woman, including becoming “restless and excited, or melancholy . . . and indifferent to the social influences of domestic life.”²⁷ The sick woman may also be “desiring to escape from home,” want to get a job, or have a “distaste for marital intercourse.”²⁸ In one illuminating case study, Dr. Brown describes a woman who had “a great distaste for her husband,” attributed by Brown to her menorrhagia, causing her to leave the home and live apart from him.²⁹ After receiving the operation, she reportedly returned home, got pregnant, and “became a happy and healthy wife and mother.”³⁰ Dr. Brown goes so far as to confidently postulate that many other cases of women leaving their husbands were actually the result of diseased genitalia, and that these “domestic miseries” could be easily cured with his surgery.³¹ In general, physicians reported a high incidence of hysteria among women who felt overwhelmed by the burdens of pregnancies, child-rearing, and housekeeping.³² Clearly, many of these women were not sick, but rather rebelling against or expressing displeasure with their marriages, domestic burdens, and restrictive social roles. This is especially salient in the context of Victorian England, a time when despite great social and economic change related to industrialization and urbanization, women's roles and expectations for behavior remained rigid. Some feminist historians have argued that hysteria was a medicalized argument for keeping women confined to the domestic sphere in the context of industrialization and especially the women's rights movement of the late Victorian era.³³



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The medicalization of this social problem illustrates doctors' often-overlooked but significant power to define what is normal and abnormal, acceptable and deviant, and to define these concepts in terms of health and disease; illness is not, then, simply an objective state of being, but also always a social construct. Beyond being a disease, hysteria was also a label, and one that had social consequences; for example, 'hysterical' was used as a derogatory term to demean the actions of women activists such as the suffragettes in the early twentieth century.³⁴ Hysteria is an interesting case in that it was sometimes used to force a diseased label upon women who did not identify as sick—for example, in the cases of women defying gendered expectations—while in other cases it was used to belittle the experiences of women who did identify as sick. Hysterical women were frequently described as lazy or dramatic or attention-seeking hypochondriacs by frustrated physicians who believed that the patient was exaggerating her symptoms and suffering; for example, the DSM-II, published in 1968, has this to say about hysterical patients: "Often the patient shows an inappropriate lack of concern . . . about these symptoms, which may actually provide secondary gains by winning him sympathy or relieving him of unpleasant responsibilities."³⁵ Other women may have actually embraced the label and accompanying sick role as a rare opportunity to seize some measure of power that was unavailable to them before, through the ability to demand physician visits and time off from domestic chores.³⁶

It is important to note that Dr. Brown's book was actually denounced by the British medical community, and that Brown himself was disgraced by his peers following the book's publication. The reasons for his fall from grace, however, are particularly revealing. Other English physicians criticized Brown's failure to back up his bold claims with scientific evidence, as well as his failure to obtain proper patient consent for his procedures (it seems likely that many of his patients—or victims, as some might prefer to call them—did not fully understand what exactly Dr. Brown was going to do to them before they went under chloroform and the knife).³⁷ Interestingly, the medical community also vehemently disapproved of how Dr. Brown had written openly about masturbation in his book, thereby causing the public to think about this indecent topic. They did not, however, refute the underlying theories behind Dr. Brown's practice; it continued to be widely assumed that female emotional disorders were caused by some dysfunction of the genitalia or reproductive organs, and ovariectomies continued to be commonly performed as a cure.³⁸

It is important to note, too, that some historians have argued for the usage of critical race theory in our understanding of hysteria. Hysteria seemed to have been most commonly diagnosed in white women of the urban middle or upper class—perhaps reflecting anxieties about the indulgences of modern, urban life during this time period of social and economic change. This disease of "overcivilization" did not

as readily apply to women of lower classes or women of color, who were viewed as less socially evolved, especially in the context of colonialism and social Darwinism. Wealthy white women were viewed as constitutionally weaker and more susceptible to nervousness than their hardier counterparts in the working classes and non-white races. In addition, hysteria was often associated with a dysfunctional reproductive system; lack of fertility was of far greater concern in a white, upper-class woman than in a lower-class woman or immigrant.³⁹ This is particularly salient in the context of a society which would, in the early twentieth century, become the birthplace of the eugenics movement. Some physicians even cited the use of contraceptives as a cause in their patients' hysterics, reflecting the perceived duty of well-off white women to continue reproducing members of their preferable sector of the population. In a more physical and concrete sense, one of the looked-for indicators of hysteria at the time was an enlarged clitoris, which was also believed by doctors to be typical of prostitutes and African women—not at all acceptable for a white English woman of respectable society.⁴⁰ This reflects the deeply entrenched racism of this era, and how that racism intersected with classism and sexism.

In a general sense, the case of hysteria provides evidence for the idea of medicine as a vehicle of social control. Far from being an objective scientific pursuit external to society, medicine not only reflects the dominant social values of the culture it is embedded in, but actively creates and recreates those values. For centuries, doctors provided quasi-scientific explanations for why women were the lesser sex and should be confined to the domestic sphere, legitimizing broader misogynistic views which served to degrade and confine women while ensuring the power and privilege of men. Hysteria—as a social category, not a disease category—was a way of controlling female sexuality as well as enforcing traditional gender roles, reinforcing prevalent conceptions of femininity. In many ways, the hysterical patient was the stereotypical woman taken to the extreme; she was passive, dependent, unstable, narcissistic, and overly emotional—providing a direct foil to the active, independent, stable, logical male physician who embodied all of the paternalism of medicine in his efforts to diagnose and treat his female patients. The practice of diagnosing deviant women as sick and requiring disfiguring treatments such as clitoridectomies was both a physical and social means of keeping women in their place, and was surely successful in many cases. Perhaps the most compelling evidence for this is the dearth of primary sources offering the opinions and experiences of hysterical women themselves; as is the case with most of history, the literature is instead dominated by male words. This is illustrated by Dr. Brown's book on clitoridectomy, which includes only a few patient testimonials that were filtered through him, casting doubt on their accuracy and honesty.

In the late nineteenth and early twentieth centuries, the popular and scientific conception of hysteria was completely reoriented by the psychoanalytic revolution

and the writings of Sigmund Freud, who was heavily influenced by his teacher Jean-Martin Charcot and colleagues Pierre Janet and Josef Breuer. Freud was enraptured by the disease, which informed many of his theories, and believed that hysteria and hysterical neurosis were not caused by the uterus or genitalia, but rather by repressed sexual desires or repressed traumatic memories, particularly of childhood sexual abuse. These repressed psychological experiences would be unconsciously converted to somatic symptoms, resulting in neurosis. In an ironic spark of gender equality within his otherwise problematic theories, Freud popularized the idea of male hysteria, helping to dismantle the idea of hysteria as a strictly female disease. He recommended various psychoanalytic treatments such as free association and hypnosis.⁴¹

It is interesting to note the replacement of the term ‘hysterical’ with the term ‘histrionic’ within the diagnostic manuals The word hysteria does not appear in the DSM-5 at all.

Despite such intense interest in hysteria during the Victorian era and the time of Freud, the disease was discredited and abandoned in the late twentieth century. The disease category of hysteria was officially broken down into and supplanted by separate categories of somatoform disorders, dissociative disorders, factitious disorders, and histrionic personality disorder in the DSM-III (meaning, the third edition of the Diagnostic and Statistical Manual of Mental Disorders, the official, standardized diagnostic guide published periodically by the American Psychiatric Association), published in 1980, as psychiatrists came to believe that hysteria was actually a conglomeration of multiple psychiatric disorders.⁴² It is interesting to note the replacement of the term ‘hysterical’ with the term ‘histrionic’ within the diagnostic manuals. For example, the DSM-I, published in 1952, uses ‘hysteria’ or ‘hysterical’ 26 times, and ‘histrionic’ zero times, while the DSM-5, published in 2013 (and also six times as long as the first DSM), uses ‘histrionic’ 43 times and ‘hysterical’ only twice.⁴³ The word hysteria does not appear in the DSM-5 at all. Histrionic does not come from the same etymological root as hysterical (histrionic comes from the Latin word meaning actor), yet the two sound quite similar. The DSM-III officially replaced ‘hysterical personality disorder’ with ‘histrionic personality disorder,’ though the listed symptoms remain very similar. The DSM-II, published in 1968, describes patients with hysterical personality disorder as excitable, emotionally unstable, dramatic, attention-seeking, seductive, self-centered, and dependent.⁴⁴ The DSM-III, published in 1980, adds characteristics such as acting out a “role, such as the ‘victim’ or the ‘princess,’” having “irrational, angry outbursts or tantrums,” and being highly impressionable and manipulative.⁴⁵ The DSM-III describes histrionic patients as “typically attractive and seductive . . . Flights into romantic fantasy are common; in both sexes overt behavior often is a caricature of femininity . . . Some

individuals are promiscuous; others, naïve and sexually unresponsive; but still others have apparently normal sexual adjustment.”⁴⁶ The DSM-III adds that “when the disorder is present in men, it is sometimes associated with a homosexual arousal pattern. The disorder is apparently common, and diagnosed far more frequently in females than in males.”⁴⁷ The DSM-5, published in 2013, lists many of the same symptoms as the earlier editions (excluding the “homosexual arousal pattern”), but reports no significant difference in diagnosis based on gender in clinical settings.⁴⁸ Regardless, it is clear that many of the personality and behavioral traits of a histrionic patient today closely resemble those of a Victorian hysterical patient, illustrating the continued saliency of those stereotypes.

Though hysteria is no longer acknowledged or diagnosed as a legitimate disease, its underlying sexist ideologies continue to influence modern society. Women’s rights advocates have made great strides towards gender equality—with women obtaining legal rights, entering the workforce, and gaining significant political representation in many countries—but stereotypically hysterical female characters are still prevalent in modern media stories, and our culture still has rigid expectations of femininity as well as stigma around the female body and sexuality. Though a woman likely will not have mood swings blamed on a wandering uterus, it is quite common for her emotionality to be blamed on her hormones or periods, a phenomenon for which men face no analog; and though gynecology, and medicine in general, is increasingly a female profession, positions of power within medicine are still very much dominated by men. In order to better understand how gender roles continue to interact with our perception and practice of medicine, we must critically examine the lessons and mistakes of the past. A feminist analysis of the history of hysteria, particularly how it was employed in Victorian England, provides illuminating insights into the socially contingent and variable nature of illness. The power to diagnose, held by a select few actors, is also always the power to define—what is normal and what is sick, what is desirable and what is shameful, and how bodies ought to be treated and used.

NOTES

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6 Cecilia Tasca et al., “Women and Hysteria in the History of Mental Health,” *Clinical Practice and Epidemiology in Mental Health* 8, (Oct 2012), 110-119.

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9 Carroll Smith-Rosenberg and Charles Rosenberg, “The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth Century America,” *The Journal of American History* 60, no. 2 (1973), 334-336.

- 10 Micale, "Hysteria and its Historiography: A Review of Past and Present Writings," 231.
- 11 Tasca et al., "Women and Hysteria in the History of Mental Health," 114.
- 12 M. L. Holbrook, quoted in Poovey, Mary. "Scenes of an Indelicate Character": The Medical "Treatment" of Victorian Women." *Representations* 14 (1986): 145.
- 13 Elizabeth Sheehan, "Victorian Clitoridectomy: Isaac Baker Brown and his Harmless Operative Procedure," *Medical Anthropology Newsletter* 12, no. 4 (1981), 10.
- 14 Barbara Ehrenreich and Dierdre English, *Complaints and Disorders: The Sexual Politics of Sickness* (Old Westbury, NY: Feminist Press 1973), 11-12.
- 15 Marjorie Levine-Clark "'I Always Prefer the Scissors': Isaac Baker Brown and Feminist Histories of Medicine," in *Health Humanities Reader*, ed. Therese Jones, Delese Wear, and Lester D. Friedman (Piscataway: Rutgers University Press, 2014), 217; Laura Briggs, "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology," *American Quarterly* 52, no. 2 (2000), 248.
- 16 W. Tyler Smith, quoted in Mary Poovey, "'Scenes of an Indelicate Character,' 146.
- 17 Thomas Laycock, quoted in Mary Poovey, "'Scenes of an Indelicate Character,'" 146.
- 18 Isaac Ray, quoted in Mary Poovey, "'Scenes of an Indelicate Character,'" 146.
- 19 Mary Livermore, quoted in Barbara Ehrenreich and Dierdre English, *Complaints and Disorders: The Sexual Politics of Sickness*, 11.
- 20 Isaac Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, (London: Hardwicke, 1866), 7; vi.
- 21 Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, 7.
- 22 Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, 30, 13.
- 23 Marjorie Levine-Clark "'I Always Prefer the Scissors': Isaac Baker Brown and Feminist Histories of Medicine," 219.
- 24 Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, 9-10.
- 25 Carroll Smith-Rosenberg, "The Hysterical Woman: Sex Roles and Role Conflict in 19th-Century America," *Social Research* 39, no. 4 (1972), 663.
- 26 Elizabeth Sheehan, "Victorian Clitoridectomy: Isaac Baker Brown and his Harmless Operative Procedure," 14.
- 27 Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, 14.
- 28 Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, 15, 16.
- 29 Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, 84.
- 30 Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, 84.
- 31 Baker Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, 84.
- 32 Smith-Rosenberg, "The Hysterical Woman: Sex Roles and Role Conflict in 19th-Century America," 657.
- 33 Laura Briggs, "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology," 246.
- 34 Gilman et al., *Hysteria Beyond Freud*, 334.
- 35 *Diagnostic And Statistical Manual of Mental Disorders: DSM-II*. (Arlington: American Psychiatric Publishing, 1968).
- 36 Smith-Rosenberg, "The Hysterical Woman: Sex Roles and Role Conflict in 19th-Century America," 672.
- 37 Sheehan, "Victorian Clitoridectomy: Isaac Baker Brown and his Harmless Operative Procedure," 13-15.
- 38 Sheehan, "Victorian Clitoridectomy: Isaac Baker Brown and his Harmless Operative Procedure," 13-15.
- 39 Briggs, "The Race of Hysteria," 246-250.
- 40 Levine-Clark, "'I Always Prefer the Scissors': Isaac Baker Brown and Feminist Histories of Medicine," 223.
- 41 Tasca et al., "Women and Hysteria in the History of Mental Health," 115; Micale, "Hysteria and its Historiography: A Review of Past and Present Writings," 246-248.
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