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The Sexual Politics of Sickness

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When Charlotte Perkins Gilman collapsed with a "nervous disorder," the physician she sought out for help was Dr. S. Weir Mitchell, "the greatest nerve specialist in the country." It was Dr. Mitchell—female specialist, part-time novelist, and member of Philadelphia's high society—who had once screened Osler for a faculty position, and, finding him appropriately discreet in the disposal of cherry-pie pits, admitted the young doctor to medicine's inner circles. When Gilman met him, in the eighteen eighties, he was at the height of his career, earning over $60,000 per year (the equivalent of over $300,000 in today's dollars). His renown for the treatment of female nervous disorders had by this time led to a marked alteration of character. According to an otherwise fond biographer, his vanity "had become colossal. It was fed by torrents of adulation, incessant and exaggerated, every day, almost every hour. . . ."[1]

Gilman approached the great man with "utmost confidence." A friend of her mother's lent her one hundred dollars for the trip to Philadelphia and Mitchell's treatment. In preparation, Gilman methodically wrote out a complete history of her case. She had observed, for example, that her sickness vanished when she was away from her home, her husband, and her child, and returned as soon as she came back to them. But Dr. Mitchell dismissed her prepared history as evidence of "self-conceit." He did not want information from his patients; he wanted "complete obedience." Gilman quotes his prescription for her:

> "Live as domestic a life as possible. Have your child with you all the time." (Be it remarked that if I did but dress the baby it left me shaking and crying—certainly far from a healthy companionship for her, to say nothing of the effect on me.) "Lie down an hour after each meal. Have but two hours intellectual life a day. And never touch pen, brush or pencil as long as you live."[2]

Gilman dutifully returned home and for some months attempted to follow Dr. Mitchell's orders to the letter. The result, in her words was—

> . . . [I] came perilously close to losing my mind. The mental agony grew so unbearable that I would sit blankly moving my head from side to side. . . I would crawl into remote closets and under beds—to hide from the grinding pressure of that distress. . . .[3]

Finally, in a "moment of clear vision" Gilman understood the source of her illness: she did not want to be a *wife;* she wanted to be a writer and an activist. So, discarding S. Weir Mitchell's prescription and divorcing her husband, she took off for California with her baby, her pen, her brush and pencil. But she never forgot Mitchell and his near-lethal "cure." Three years after her recovery she wrote *The Yellow Wallpaper*[4] a fictionalized account of her own illness and descent into madness. If that story had any influence on S. Weir Mitchell's method of treatment, she wrote after a long life of accomplishments, "I have not lived in vain."[5]

Charlotte Perkins Gilman was fortunate enough to have had a "moment of clear vision" in which she understood what was happening to her. Thousands of other women, like Gilman, were finding themselves in a new position of dependency on the male medical profession—and with no alternative sources of information or counsel. The medical profession was consolidating its monopoly over healing, and now the

woman who felt sick, or tired or simply depressed would no longer seek help from a friend or female healer, but from a male physician. The general theory which guided the doctors' practice as well as their public pronouncements was that women were, by nature, weak, dependent, and diseased. Thus would the doctors attempt to secure their victory over the female healer: with the "scientific" evidence that woman's essential nature was not to be a strong, competent helpgiver, but to be a *patient*.

A Mysterious Epidemic

In fact at the time there were reasons to think that the doctors' theory was not so farfetched. Women were decidedly sickly, though not for the reasons the doctors advanced. In the mid- and late nineteenth century a curious epidemic seemed to be sweeping through the middle- and upper-class female population both in the United States and England. Diaries and journals from the time give us hundreds of examples of women slipping into hopeless invalidism. For example, when Catherine Beecher, the educator, finished a tour in 1871 which included visits to dozens of relatives, friends and former students, she reported "a terrible decay of female health all over the land," which was "increasing in a most alarming ratio." The notes from her travels go like this:

> Milwaukee, Wis. Mrs. A. frequent sick headaches. Mrs. B. very feeble. Mrs. S. well, except chills. Mrs. L. poor health constantly. Mrs. D. subject to frequent headaches. Mrs. B. very poor health . . .
>
> Mrs. H. pelvic disorders and a cough. Mrs. B. always sick. Do not know one perfectly healthy woman in the place. . . .[6]

Doctors found a variety of diagnostic labels for the wave of invalidism gripping the female population: "Neurasthenia," "nervous prostration," "hyperesthesia," "cardiac inadequacy," "dyspepsia," "rheumatism," and "hysteria." The symptoms included headache, muscular aches, weakness, depression, menstrual difficulties, indigestion, etc., and usually a general debility requiring constant rest. S. Weir Mitchell described it as follows:

> The woman grows pale and thin, eats little, or if she eats does not profit by it. Everything wearies her,—to sew, to write, to read, to walk,—and by and by the sofa or the bed is her only comfort. Every effort is paid for dearly, and she describes herself as aching and sore, as sleeping ill, and as needing constant stimulus and endless tonics. . . . If such a person is emotional she does not fail to become more so, and even the firmest women lose self-control at last under incessant feebleness.[7]

The syndrome was never fatal, but neither was it curable in most cases, the victims sometimes patiently outliving both husbands and physicians.

Women who recovered to lead full and active lives—like Charlotte Perkins Gilman and Jane Addams—were the exceptions. Ann Greene Phillips—a feminist and abolitionist in the eighteen thirties—first took ill during her courtship. Five years after her marriage, she retired to bed, more or less permanently. S. Weir Mitchell's unmarried sister fell prey to an unspecified "great pain" shortly after taking over housekeeping for her brother (whose first wife had just died), and embarked on a life of invalidism. Alice James began her career of invalidism at the age of nineteen, always amazing her older brothers, Henry (the novelist) and William (the psychologist), with the stubborn intractability of her condition: "Oh, woe, woe is me!" she wrote in her diary:

> . . . all hopes of peace and rest are vanishing—nothing but the dreary snail-like climb up a little way, so as to be able to run down again! And then these doctors tell you that you will die or *recover!* But you *don't* recover. I have been at these alterations since I was nineteen and I am neither dead nor recovered. As I am now forty-two, there has surely been time for either process.[8]

The suffereings of these women were real enough. Ann Phillips wrote, ". . . life is a burden to me, I do not know what to do. I am tired of suffering. I have no faith in anything."[9] Some thought that if the illness wouldn't kill them, they would do the job themselves. Alice James discussed suicide with her father, and rejoiced, at the age of forty-three, when informed she had developed breast cancer and would die within months: "I count it the greatest good fortune to

have these few months so full of interest and instruction in the knowledge of my approaching death."[10] Mary Galloway shot herself in the head while being attended in her apartment by a physician and a nurse. She was thirty-one years old, the daughter of a bank and utility company president. According to the New York *Times* account (April 10, 1905), "She had been a chronic dyspeptic since 1895, and that is the only reason known for her suicide."[11]

Marriage: The Sexual Economic Relation

In the second half of the nineteenth century the vague syndrome gripping middle- and upper-class women had become so widespread as to represent not so much a disease in the medical sense as a way of life. More precisely, the way this type of woman was expected to live predisposed her to sickness, and sickness in turn predisposed her to continue to live as she was expected to. The delicate, affluent lady, who was completely dependent on her husband, set the sexual romanticist ideal of femininity for women of all classes.

Clear-headed feminists like Charlotte Perkins Gilman and Olive Schreiner saw a link between female invalidism and the economic situation of women in the upper classes. As they observed, poor women did not suffer from the syndrome. The problem in the middle to upper classes was that marriage had become a "sexuo-economic relation" in which women performed sexual and reproductive duties for financial support. It was a relationship which Olive Schreiner bluntly called "female parasitism."

To Gilman's pragmatic mind, the affluent wife appeared to be a sort of tragic evolutionary anomaly, something like the dodo. She did not work: that is, there was no serious, productive work to do in the home, and the tasks which were left—keeping house, cooking and minding the children—she left as much as possible to the domestic help. She was, biologically speaking, specialized for one function and one alone—sex. Hence the elaborate costume—bustles, false fronts, wasp waists—which caricatured the natural female form. Her job was to bear the heirs of the businessman, lawyer, or professor she had married, which is what gave her a claim to any share of his income. When Gilman, in her depression, turned away from her own baby, it was because she already understood, in a half-conscious way, that the baby was living proof of her economic dependence—and as it seemed to her, sexual degradation.

A "lady" had one other important function, as Veblen pointed out with acerbity in the *Theory of the Leisure Class*. And that was to do precisely nothing, that is nothing of any economic or social consequence.[12] A successful man could have no better social ornament than an idle wife. Her delicacy, her culture, her childlike ignorance of the male world gave a man the "class" which money alone could not buy. A virtuous wife spent a hushed and peaceful life indoors, sewing, sketching, planning menus, and supervising the servants and children. The more adventurous might fill their leisure with shopping excursions, luncheons, balls, and novels. A "lady" could be charming, but never brilliant; interested, but not intense. Dr. Mitchell's second wife, Mary Cadwalader, was perhaps a model of her type: she "made no pretense at brilliancy; her first thought was to be a foil to her husband. . . ."[13] By no means was such a lady to concern herself with politics, business, international affairs, or the aching injustices of the industrial work world.

But not even the most sheltered woman lived on an island detached from the "real" world of men. Schreiner described the larger context:

> Behind the phenomenon of female parasitism has always lain another and yet larger social phenomenon . . . the subjugation of large bodies of other human creatures, either as slaves, subject races, or classes; and as a result of the excessive labors of those classes there has always been an accumulation of unearned wealth in the hands of the dominant class or race. *It has invariably been by feeding on this wealth, the result of forced or ill-paid labor,* that the female of the dominant race or class has in the past lost her activity and has come to exist purely through the passive performance of her sexual functions.[14] (Emphasis in original)

The leisured lady, whether she knew it or not and whether she cared or not, inhabited the same social universe as dirt-poor black sharecroppers, six-year-old children working fourteen-hour days

for subsubsistence wages, young men mutilated by unsafe machinery or mine explosions, girls forced into prostitution by the threat of starvation. At no time in American history was the contradiction between ostentatious wealth and unrelenting poverty, between idleness and exhaustion, starker than it was then in the second half of the nineteenth century. There were riots in the cities, insurrections in the mines, rumors of subversion and assassination. Even the secure business or professional man could not be sure that he too would not be struck down by an economic downturn, a wily competitor, or (as seemed likely at times) a social revolution.

The genteel lady of leisure was as much a part of the industrial social order as her husband or his employees. As Schreiner pointed out, it was ultimately the wealth extracted in the world of work that enabled a man to afford a more or less ornamental wife. And it was the very harshness of that outside world that led men to see the home as a refuge—"a sacred place, a vestal temple," a "tent pitch'd in a world not right," presided over by a gentle, ethereal wife. A popular home health guide advised that

> . . . [man's] feelings are frequently lacerated to the utmost point of endurance, by collisions, irritations, and dissappointments. To recover his equanimity and composure, home must be a place of repose, of peace, of cheerfulness, of comfort; then his soul renews its strength, and will go forth, with fresh vigor, to encounter the labor and troubles of the world.[15]

No doubt the suffocating atmosphere of sexual romanticism bred a kind of nervous hypochondria. We will never know, for example, if Alice James's lifelong illness had a "real" organic basis. But we know that, unlike her brothers, she was never encouraged to go to college or to develop her gift for writing. She was high-strung and imaginative, but *she* could not be brilliant or productive. Illness was perhaps the only honorable retreat from a world of achievement which (it seemed at the time) nature had not equipped her to enter.

For many other women, to various degrees, sickness became a part of life, even a way of filling time. The sexuo-economic relation confined women to the life of the body, so it was to the body that they directed their energies and intellect. Rich women frequented resortlike health spas and the offices of elegant specialists like S. Weir Mitchell. A magazine cartoon from the eighteen seventies shows two "ladies of fashion" meeting in an ornately appointed waiting room. "What, *you* here, Lizzie? Why, ain't you well?" asks the first patient. "Perfectly thanks!" answers the second. "But what's the matter with *you*, dear?" "Oh, nothing whatever! I'm as right as possible dear."[16] For less well-off women there were patent medicines, family doctors, and, starting in the eighteen fifties, a steady stream of popular advice books, written by doctors, on the subject of female health. It was acceptable, even stylish, to retire to bed with "sick headaches," "nerves" and various unmentionable "female troubles," and that indefinable nervous disorder "neurasthenia" was considered, in some circles, to be a mark of intellect and sensitivity. Dr. Mary Putnam Jacobi, a female regular physician, observed impatiently in 1895:

> . . it is considered natural and almost laudable to break down under all conceivable varieties of strain—a winter dissipation, a houseful of servants, a quarrel with a female friend, not to speak of more legitimate reasons. . . . Women who expect to go to bed every menstrual period expect to collapse if by chance they find themselves on their feet for a few hours during such a crisis. Constantly considering their nerves, urged to consider them by well-intentioned but short-sighted advisors, they pretty soon become nothing but a bundle of nerves.[17]

But if sickness was a reaction, on women's part, to a difficult situation, it was not a way out. If you have to be idle, you might as well be sick, and sickness, in turn, legitimates idleness. From the romantic perspective, the sick woman was not that far off from the ideal woman anyway. A morbid aesthetic developed, in which sickness was seen as a source of female beauty, and beauty—in the high-fashion sense—was in fact a source of sickness. Over and over, nineteenth-century romantic paintings feature the beautiful invalid, sensuously drooping on her cushions, eyes fixed tremulously at her husband or physician, or already gazing into the Beyond. Litera-

ture aimed at female readers lingered on the romantic pathos of illness and death; popular women's magazines featured such stories as "The Grave of My Friend" and "Song of Dying." Society ladies cultivated a sickly countenance by drinking vinegar in quantity or, more effectively, arsenic.[18] The loveliest heroines were those who died young, like Beth in *Little Women*, too good and too pure for life in this world.

Meanwhile, the requirements of fashion insured that the well-dressed woman would actually be as frail and ornamental as she looked. The style of wearing tight-laced corsets, which was *de rigeur* throughout the last half of the century, has to be ranked somewhere close to the old Chinese practice of foot-binding for its crippling effects on the female body. A fashionable woman's corsets exerted, on the average, twenty-one pounds of pressure on her internal organs, and extremes of up to eighty-eight pounds had been measured.[19] (Add to this the fact that a well-dressed woman wore an average of thirty-seven pounds of street clothing in the winter months, of which nineteen pounds were suspended from her tortured waist.[20] Some of the short-term results of tight-lacing were shortness of breath, constipation, weakness, and a tendency to violent indigestion. Among the long-term effects were bent or fractured ribs, displacement of the liver, and uterine prolapse (in some cases, the uterus would be gradually forced, by the pressure of the corset, out through the vagina).

The morbidity of nineteenth-century tastes in female beauty reveals the hostility which never lies too far below the surface of sexual romanticism. To be sure, the romantic spirit puts woman on a pedestal and ascribes to her every tender viture absent from the Market. But carried to an extreme the demand that woman be a *negation* of man's world left almost nothing for women to actually *be:* if men are busy, she is idle; if men are rough, she is gentle; if men are strong, she is frail; if men are rational, she is irrational; and so on. The logic which insists that femininity is negative masculinity necessarily romanticizes the moribund woman and encourages a kind of paternalistic necrophilia. In the nineteenth century this tendency becomes overt, and the romantic spirit holds up as its ideal—the *sick* woman, the invalid who lives at the edge of death.

Femininity as a Disease

The medical profession threw itself with gusto on the languid figure of the female invalid. In the home of an invalid lady, "the house physician like a house fly is in chronic attention"[21] and the doctors fairly swarmed after wealthy patients. Few were so successful as S. Weir Mitchell in establishing himself as *the* doctor for hundreds of loyal clients. Yet the doctors' constant ministrations and interventions—surgical, electrical, hydropathic, mesmeric, chemical—seemed to be of little use. In fact, it would have been difficult, in many cases, to distinguish the *cure* from the *disease.* Charlotte Perkins Gilman of course saw the connection. The ailing heroine of *The Yellow Wallpaper,* who is being treated by her physician-husband, hints at the fearful truth:

> John is a physician, and *perhaps*—(I would not say it to a living soul, of course, but this is dead paper and a great relief to my mind)—*perhaps* that is one reason I do not get well faster.[22]

In fact, the theories which guided the doctor's practice from the late nineteenth century to the early twentieth century held that woman's *normal* state was to be sick. This was not advanced as an empirical observation, but as physiological fact. Medicine had "discovered" that female functions were inherently pathological. Menstruation, that perennial source of alarm to the male imagination, provided both the evidence and the explanation. Menstruation was a serious threat throughout life—so was the lack of it. According to Dr. Engelmann, president of the American Gynecology Society in 1900:

> Many a young life is battered and forever crippled on the breakers of puberty; if it crosses these unharmed and is not dashed to pieces on the rock of childbirth, it may still ground on the ever-recurring shallows of menstruation, and lastly upon the final bar of the menopause ere protection is found in the unruffled waters of the harbor beyond reach of sexual storms.[23]

Popular advice books written by physicians took on a somber tone as they entered into "the female functions" or "the diseases of women."

> It is impossible to form a correct opinion of the mental and physical suffering frequently endured from her sexual condition, caused by her monthly periods, which it has pleased her Heavenly Father to attach to woman. . . .[24]

Ignoring the existence of thousands of working women, the doctors assumed that every woman was prepared to set aside a week or five days every month as a period of invalidism. Dr. W. C. Taylor, in his book *A Physician's Counsels to Woman in Health and Disease,* gave a warning typical of those found in popular health books of the time:

> We cannot too emphatically urge the importance of regarding these monthly returns as periods of ill health, as days when the ordinary occupations are to be suspended or modified. . . . Long walks, dancing, shopping, riding and parties should be avoided at this time of month invariably and under all circumstances. . . .[25]

As late as 1916, Dr. Winfield Scott Hall was advising:

> All heavy exercise should be omitted during the menstrual week . . . a girl should not only retire earlier at this time, but ought to stay out of school from one to three days as the case may be, resting the mind and taking extra hours of rest and sleep.[26]

Similarly, a pregnant woman was "indisposed," throughout the full nine months. The medical theory of "prenatal impressions" required her to avoid all "shocking, painful or unbeautiful sights," intellectual stimulation, angry or lustful thoughts, and even her husband's alcohol and tobacco-laden breath—lest the baby be deformed or stunted in the womb. Doctors stressed the pathological nature of childbirth itself—an argument which also was essential to their campaign against midwives. After delivery, they insisted on a protracted period of convalescence mirroring the "confinement" which preceded birth. (Childbirth, in the hands of the medical men, no doubt was "pathological," and doctors had far less concern about prenatal nutrition than they did about prenatal "impressions.") Finally after all this, a woman could only look forward to menopause, portrayed in the medical literature as a terminal illness—the "death of the woman in the woman."

Now it must be said in the doctor's defense that women of a hundred years ago *were,* in some ways, sicker than the women of today. Quite apart from tight-lacing, arsenic-nipping, and fashionable cases of neurasthenia, women faced certain bodily risks which men did not share. In 1915 (the first year for which national figures are available) 61 women died for every 10,000 live babies born, compared to 2 per 10,000 today, and the maternal mortality rates were doubtless higher in the nineteenth century.[27] Without adequate, and usually without any, means of contraception, a married woman could expect to face the risk of childbirth repeatedly through her fertile years. After each childbirth a woman might suffer any number of gynecological complications, such as prolapsed (slipped) uterus or irreparable pelvic tear, which would be with her for the rest of her life.

Another special risk to women came from tuberculosis, the "white plague." In the mid-nineteenth century, TB raged at epidemic proportions, and it continued to be a major threat until well into the twentieth century. Everyone was affected, but women, especially young women, were particularly vulnerable, often dying at rates twice as high as those of men of their age group. For every hundred women aged twenty in 1865, more than five would be dead from TB by the age of thirty, and more than eight would be dead by the age of fifty.[28]

So, from a statistical point of view, there was some justification for the doctors' theory of innate female frailty. But there was also, from the doctors' point of view, a strong commercial justification for regarding women as sick. This was the period of the profession's most severe "population crisis." The theory of female frailty obviously disqualified women as healers. "One shudders to think of the conclusions arrived at by female bacteriologists or histologists," wrote one doctor, "at the period when their entire system, both physical and mental, is, so to speak, 'unstrung,' to say nothing of the terrible mistakes which a lady surgeon might make under similar conditions."[29] At the same time the theory made women highly qualified as patients. The sickly, nervous women of the upper or middle class with

their unending, but fortunately non-fatal, ills, became a natural "client caste" to the developing medical profession.

Meanwhile, the health of women who were *not* potential patients—poor women—received next to no attention from the medical profession. Poor women must have been at least as susceptible as wealthy women to the "sexual storms" doctors saw in menstruation, pregnancy, etc.; and they were definitely much more susceptible to the hazards of childbearing, tuberculosis, and, of course, industrial diseases. From all that we know, sickness, exhaustion, and injury were routine in the life of the working-class woman. Contagious diseases always hit the homes of the poor first and hardest. Pregnancy, in the fifth- or sixth-floor walk-up flat, really was debilitating, and childbirth, in a crowded tenement room, was often a frantic ordeal. Emma Goldman, who was a trained midwife as well as an anarchist leader, described "the fierce, blind struggle of the women of the poor against frequent pregnancies" and told of the agony of seeing children grow up "sickly and undernourished"—if they survived infancy at all.[30] For the woman who labored outside her home, working conditions took an enormous toll. An 1884 report of an investigation of "The Working Girls of Boston," by the Massachusetts Bureau of Statistics of Labor, stated:

> . . . the health of many girls is so poor as to necessitate long rests, one girl being out a year on this account. Another girl in poor health was obliged to leave her work, while one reports that it is not possible for her to work the year round, as she could not stand the strain, not being at all strong.[31]

Still, however sick or tired working-class women might have been, they certainly did not have the time or money to support a cult of invalidism. Employers gave no time off for pregnancy or recovery from childbirth, much less for menstrual periods, though the wives of these same employers often retired to bed on all these occasions. A day's absence from work could cost a woman her job, and at home there was no comfortable chaise lounge to collapse on while servants managed the household and doctors managed the illness. An 1889 study from Massachusetts described one working woman's life:

> Constant application to work, often until 12 at night and sometimes on Sundays (equivalent to nine ordinary working days a week), affected her health and injured her eyesight. She . . . was ordered by the doctor to suspend work . . . but she must earn money, and so she has kept on working. Her eyes weep constantly, she cannot see across the room and "the air seems always in a whirl" before her . . . [she] owed when seen three months' board for self and children . . . She hopes something may be done for working girls and women, for, however strong they may be in the beginning, "they cannot stand white slavery for ever."[32]

But the medical profession as a whole—and no doubt there were many honorable exceptions—sturdily maintained that it was affluent women who were most delicate and most in need of medical attention. "Civilization" had made the middle-class woman sickly; her physical frailty went hand-in-white-gloved-hand with her superior modesty, refinement, and sensitivity. Working-class women were robust, just as they were supposedly "coarse" and immodest. Dr. Lucien Warner, a popular medical authority, wrote in 1874, "It is not then hard work and privation which make the women of our country invalids, but circumstances and habits intimately connected with the so-called blessings of wealth and refinement."

Someone had to be well enough to do the work, though, and working-class women, Dr. Warner noted with relief, were *not* invalids: "The African negress, who toils beside her husband in the fields of the south, and Bridget, who washes, and scrubs and toils in our homes at the north, enjoy for the most part good health, with comparative immunity from uterine disease."[33] And a Dr. Sylvanus Stall observed:

> At war, at work, or at play, the white man is superior to the savage, and his culture has continually improved his condition. But with woman the rule is reversed. Her squaw sister will endure effort, exposure and hardship which would kill the white woman. Education which has resulted in developing and strengthening the physical nature of man has

been perverted through folly and fashion to render woman weaker and weaker.[34]

In practice, the same doctors who zealously indulged the ills of wealthy patients had no time to spare for the poor. When Emma Goldman asked the doctors she knew whether they had any contraceptive information she could offer the poor, their answers included, "The poor have only themselves to blame; they indulge their appetites too much," and "When she [the poor woman] uses her brains more, her procreative organs will function less."[35] A Dr. Palmer Dudley ruled out poor women as subjects for gynecological surgery on the simple ground that they lacked the leisure required for successful treatment:

> . . . the hardworking, daily-toiling woman is not as fit a subject for [gynecological surgery] as the woman so situated in life as to be able to conserve her strength and if necessary, to take a long rest, in order to secure the best results.[36]

So the logic was complete: better-off women were sickly because of their refined and civilized lifestyle. Fortunately, however, this same lifestyle made them amenable to lengthy medical treatment. Poor and working-class women were inherently stronger, and this was also fortunate, since their lifestyle disqualified them from lengthy medical treatment anyway. The theory of innate female sickness, skewed so as to account for class differences in ability to pay for medical care, meshed conveniently with the doctors' commercial self-interest.

The feminists of the late nineteenth century, themselves deeply concerned about female invalidism, were quick to place at least part of the blame on the doctors' interests. Elizabeth Garrett Anderson, an American woman doctor, argued that the extent of female invalidism was much exaggerated by male doctors and that women's natural functions were not really all that debilitating. In the working classes, she observed, work went on during menstruation "without intermission, and, as a rule, without ill effects."[37] Mary Livermore, a women's suffrage worker, spoke against "the monstrous assumption that woman is a natural invalid," and denounced "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."[38] And Dr. Mary Putnam Jacobi put the matter most forcefully when she wrote in 1895, "I think, finally, it is in the increased attention paid to women, and especially in their new function as lucrative patients, scarcely imagined a hundred years ago, that we find explanation for much of the ill-health among women, freshly discovered today. . . ."[39]

. . . . . .

The Dictatorship of the Ovaries

It was medicine's task to translate the [nineteenth-century] evolutionary theory of women into the language of flesh and blood, tissues and organs. The result was a theory which put woman's mind, body and soul in the thrall of her all-powerful reproductive organs. "The Uterus, it must be remembered," Dr. F. Hollick wrote, "is the *controlling* organ in the female body, being the most excitable of all, and so intimately connected, by the ramifications of its numerous nerves, with every other part."[40] Professor M. L. Holbrook, addressing a medical society in 1870, observed that it seemed "as if the Almighty, in creating the female sex, *had taken the uterus and built up a woman around it.*"[41] (Emphasis in original.)

To other medical theorists, it was the ovaries which occupied center stage. Dr. G. L. Austin's 1883 book of advice for "maiden, wife and mother" asserts that the ovaries "give woman all her characteristics of body and mind."[42] This passage written in 1870 by Dr. W. W. Bliss is, if somewhat overwrought, nonetheless typical:

> Accepting, then, these views of the gigantic power and influence of the ovaries over the whole animal economy of woman,—that they are the most powerful agents in all the commotions of her system; that on them rest her intellectual standing in society, her physical perfection, and all that lends beauty to those fine and delicate contours which are constant objects of admiration, all that is great, noble and beautiful, all that is voluptuous, tender, and endearing; that her fidelity, her devotedness, her perpetual

> vigilance, forecast, and all those qualities of mind and disposition which inspire respect and love and fit her as the safest counsellor and friend of man, spring from the ovaries,—*what must be their influence and power over the great vocation of woman and the august purposes of her existence when these organs have become compromised through disease!*[43] (Emphasis in original.)

According to this "psychology of the ovary" woman's entire personality was directed by the ovaries, and any abnormalities, from irritability to insanity, could be traced to some ovarian disease. Dr. Bliss added, with unbecoming spitefulness, that "the influence of the ovaries over the mind is displayed in woman's artfulness and dissimulation."

It should be emphasized, before we follow the workings of the uterus and ovaries any further, that woman's total submission to the "sex function" did not make her a *sexual* being. The medical model of female nature, embodied in the "psychology of the ovary," drew a rigid distinction between reproductivity and sexuality. Women were urged by the health books and the doctors to indulge in deep preoccupation with themselves as "The Sex"; they were to devote themselves to developing their reproductive powers and their maternal instincts. Yet doctors said they had no predilection for the sex act itself. Even a woman physician, Dr. Mary Wood-Allen wrote (perhaps from experience), that women embrace their husbands "without a particle of sex desire."[44] Hygiene manuals stated that the more cultured the woman, "the more is the sensual refined away from her nature," and warned against "any spasmodic convulsion" on a woman's part during intercourse lest it interfere with conception. Female sexuality was seen as unwomanly and possibly even detrimental to the supreme function of reproduction.

The doctors themselves never seemed entirely convinced, though, that the uterus and ovaries had successfully stamped out female sexuality. Underneath the complacent denials of female sexual feelings, there lurked the age-old male fascination with woman's "insatiable lust," which, once awakened, might turn out to be uncontrollable. Doctors dwelt on cases in which women were destroyed by their cravings; one doctor claimed to have discovered a case of "virgin nymphomania." The twenty-five-year-old British physician Robert Brudenell Carter leaves us with this tantalizing observation on his female patients:

> . . . no one who has realized the amount of moral evil wrought in girls . . . whose prurient desires have been increased by Indian hemp and partially gratified by medical manipulations, can deny that remedy is worse than disease. I have . . . seen young unmarried women, of the middle class of society, reduced by the constant use of the speculum to the mental and moral condition of prostitutes; seeking to give themselves the same indulgence by the practice of solitary vice; and asking every medical practitioner . . . to institute an examination of the sexual organs.[45]

But if the uterus and ovaries could not be counted on to suppress all sexual strivings, they were still sufficiently in control to be blamed for all possible female disorders, from headaches to sore throats and indigestion. Dr. M. E. Dirix wrote in 1869:

> Thus, women are treated for diseases of the stomach, liver, kidneys, heart, lungs, etc.; yet, in most instances, these diseases will be found on due investigation, to be, in reality, no diseases at all, but merely the sympathetic reactions or the symptoms of one disease, namely, a disease of the womb.[46]

Even tuberculosis could be traced to the capricious ovaries. When men were consumptive, doctors sought some environmental factor, such as overexposure, to explain the disease. But for women it was a result of reproductive malfunction. Dr. Azell Ames wrote in 1875:

> It being beyond doubt that consumption . . . is itself produced by the failure of the [menstrual] function in the forming girls . . . one has been the parent of the other with interchangeable priority. [Actually, as we know today, it is true that consumption may *result* in suspension of the menses.][47]

Since the reproductive organs were the source of disease, they were the obvious target in the treatment of disease. Any symptom—backaches, irritability, indigestion, etc.—could provoke a medical assault on the sexual organs. Historian

Ann Douglas Wood describes the "local treatments" used in the mid-nineteenth century for almost any female complaint:

> This [local] treatment had four stages, although not every case went through all four: a manual investigation, "leeching," "injections," and "cauterization." Dewees [an American medical professor] and Bennet, a famous English gynecologist widely read in America, both advocated placing the leeches right on the vulva or the neck of the uterus, although Bennet cautioned the doctor to count them as they dropped off when satiated, lest he "lose" some. Bennet had known adventurous leeches to advance into the cervical cavity of the uterus itself, and he noted, "I think I have scarcely ever seen more acute pain than that experienced by several of my patients under these circumstances." Less distressing to a 20th century mind, but perhaps even more senseless, were the "injections" into the uterus advocated by these doctors. The uterus became a kind of catch-all, or what one exasperated doctor referred to as a "Chinese toy shop": Water, milk and water, linseed tea, and "decoction of marshmellow . . . tepid or cold" found their way inside nervous women patients. The final step, performed at this time, one must remember, with no anesthetic but a little opium or alcohol, was cauterization, either through the application of nitrate of silver, or, in cases of more severe infection, through the use of much stronger hydrate of potassa, or even the "actual cautery," a "white-hot iron" instrument.[48]

In the second half of the century, these fumbling experiments with the female interior gave way to the more decisive technique of surgery—aimed increasingly at the control of female personality disorders. There had been a brief fad of clitoridectomy (removal of the clitoris) in the sixties, following the introduction of the operation by the English physician Isaac Baker Brown. Although most doctors frowned on the practice of removing the clitoris, they tended to agree that it might be necessary in cases of nymphomania, intractable masturbation, or "unnatural growth" of that organ. (The last clitoridectomy we know of in the United States was performed in 1948 on a child of five, as a cure for masturbation.)

The most common form of surgical intervention in the female personality was ovariotomy, removal of the ovaries—or "female castration." In 1906 a leading gynecological surgeon estimated that there were 150,000 women in the United States who had lost their ovaries under the knife. Some doctors boasted that they had removed from fifteen hundred to two thousand ovaries apiece.[49] According to historian G. J. Barker-Benfield:

> Among the indications were troublesomeness, eating like a ploughman, masturbation, attempted suicide, erotic tendencies, persecution mania, simple "cussedness," and dysmenorrhea [painful menstruation]. Most apparent in the enormous variety of symptoms doctors took to indicate castration was a strong current of sexual appetitiveness on the part of women.[50]

The rationale for the operation flowed directly from the theory of the "psychology of the ovary": since the ovaries controlled the personality, they must be responsible for any psychological disorders; conversely, psychological disorders were a sure sign of ovarian disease. Ergo, the organs must be removed.

One might think, given the all-powerful role of the ovaries, that an ovaryless women would be like a rudderless ship—desexed and directionless. But on the contrary, the proponents of ovariotomy argued, a woman who was relieved of a diseased ovary would be a *better* woman. One 1893 advocate of the operation claimed that "patients are improved, some of them cured; . . . the moral sense of the patient is elevated . . . she becomes tractable, orderly, industrious, and cleanly."[51] Patients were often brought in by their husbands, who complained of their unruly behavior. Doctors also claimed that women—troublesome but still sane enough to recognize their problem—often "came to us pleading to have their ovaries removed."[52] The operation was judged successful if the woman was restored to a placid contentment with her domestic functions.

The overwhelming majority of women who had leeches or hot steel applied to their cervices, or who had their clitorises or ovaries removed, were women of the middle to upper classes, for after all, these procedures cost money. But it should not be imagined that poor women were spared the gynecologist's exotic catalog of tor-

tures simply because they couldn't pay. The pioneering work in gynecological surgery had been performed by Marion Sims on black female slaves he kept for the sole purpose of surgical experimentation. He operated on one of them thirty times in four years, being foiled over and over by postoperative infections.[53] After moving to New York, Sims continued his experimentation on indigent Irish women in the wards of New York Women's Hospital. So, though middle-class women suffered most from the doctors' actual practice, it was poor and black women who had suffered through the brutal period of experimentation.

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Subverting the Sick Role: Hysteria

The romance of the doctor and the female invalid comes to full bloom (and almost to consummation) in the practice of S. Weir Mitchell. But . . . there is a nastier side to this affair. An angry, punitive tone has come into his voice; the possibility of physical force has been raised. As time goes on and the invalids pile up in the boudoirs of American cities and recirculate through the health spas and consulting rooms, the punitive tone grows louder. Medicine is caught in a contradiction of its own making, and begins to turn against the patient.

Doctors had established that women are sick, that this sickness is innate, and stems from the very possession of a uterus and ovaries. They had thus eliminated the duality of "sickness" and "health" for the female sex; there was only a drawn-out half-life, tossed steadily by the "storms" of reproductivity toward a more total kind of rest. But at the same time, doctors *were* expected to cure. The development of commercial medicine, with its aggressive, instrumental approach to healing, required some public faith that doctors could *do something*, that they could fix things. Certainly Charlotte Perkins Gilman had expected to be cured. The husbands, fathers, sisters, etc. of thousands of female invalids expected doctors to provide cures. A medical strategy of disease by decree, followed by "cures" which either mimicked the symptoms or caused new ones, might be successful for a few decades. But it had no long-term commercial viability.

The problem went deeper, though, than the issue of the doctors' commercial credibility. There was a contradiction in the romantic ideal of femininity which medicine had worked so hard to construct. Medicine had insisted that woman was sick *and* that her life centered on the reproductive function. But these are contradictory propositions. If you are sick enough, you cannot reproduce. The female role in reproduction requires stamina, and if you count in all the activities of child raising and running a house, it requires full-blown, energetic *health*. Sickness and reproductivity, the twin pillars of nineteenth-century femininity, could not stand together.

In fact, toward the end of the century, it seemed that sickness had been winning out over reproductivity. The birth rate for whites shrank by a half between 1800 and 1900, and the drop was most precipitous among white Anglo-Saxon Protestants—the "better" class of people. Meanwhile blacks and European immigrants appeared to be breeding prolifically, and despite their much higher death rates, the fear arose that they might actually replace the "native stock." Professor Edwin Conklin of Princeton wrote:

> The cause for alarm is the declining birth rate among the best elements of a population, while it continues to increase among the poorer elements. The descendants of the Puritans and the Cavaliers . . . are already disappearing, and in a few centuries at most, will have given place to more fertile races. . . .[54]

And in 1903 President Theodore Roosevelt thundered to the nation the danger of "race suicide":

> Among human beings, as among all other living creatures, if the best specimens do not, and the poorer specimens do, propagate, the type [race] will go down. If Americans of the old stock lead lives of celibate selfishness . . . or if the married are afflicted by that base fear of living which, whether for the sake of themselves or of their children, forbids them to have more than one or two children, disaster awaits the nation.[55]

G. Stanley Hall and other expert observers easily connected the falling WASP birth rate to the epidemic of female invalidism:

> In the United States as a whole from 1860–'90 the birth-rate declined from 25.61 to 19.22. Many women are so exhausted before marriage that after bearing one or two children they become wrecks, and while there is perhaps a growing dread of parturition or of the bother of children, many of the best women feel they have not stamina enough. . . .[56]

He went on to suggest that "if women do not improve," men would have to "have recourse to emigrant wives" or perhaps there would have to be a "new rape of the Sabines."

The genetic challenge posed by the "poorer elements" cast an unflattering light on the female invalid. No matter whether she was "really" suffering, she was clearly not doing her duty. Sympathy begins to give way to the suspicion that she might be deliberately *malingering*. S. Weir Mitchell revealed his private judgment of his patients in his novels, which dwelt on the grasping, selfish invalid, who uses her illness to gain power over others. In *Roland Blake* (1886) the evil invalid "Octapia" tries to squeeze the life out of her gentle cousin Olivia. In *Constance Trescot* (1905) the heroine is a domineering, driven woman, who ruins her husband's life and then relapses into invalidism in an attempt to hold on to her patient sister Susan:

> By degrees Susan also learned that Constance relied on her misfortune and her long illness to insure to her an excess of sympathetic affection and unremitting service. The discoveries thus made troubled the less selfish sister. . . .[57]

The story ends in a stinging rejection for Constance, as Susan leaves her to get married and assume the more womanly role of serving a man. Little did Dr. Mitchell's patients suspect that his ideal woman was not the delicate lady on the bed, but the motherly figure of the nurse in the background! (In fact, Mitchell's rest cure was implicitly based on the idea that his patients were malingerers.) As he explained it, the idea was to provide the patient with a drawn-out experience of invalidism, but without any of the pleasures and perquisites which usually went with that condition.

> To lie abed half the day, and sew a little and read a little, and be interesting and excite sympathy, is all very well, but when they are bidden to stay in bed a month and neither to read, write, nor sew, and to have one nurse,—who is not a relative,—then rest becomes for some women a rather bitter medicine, and they are glad enough to accept the order to rise and go about when the doctor issues a mandate . . .[58]

Many women probably *were* using the sick role as a way to escape their reproductive and domestic duties. For the woman to whom sex really was repugnant, and yet a "duty," or for any woman who wanted to avoid pregnancy, sickness was a way out—and there were few others. The available methods of contraception were unreliable, and not always that available either.[59] Abortion was illegal and risky. So female invalidism may be a direct ancestor of the nocturnal "headache" which so plagued husbands in the mid-twentieth century.

The suspicion of malingering—whether to avoid pregnancy or gain attention—cast a pall over the doctor-patient relationship. If a woman was really sick (as the doctors said she ought to be), then the doctor's efforts, however ineffective, must be construed as appropriate, justifiable, and of course reimbursable. But if she was *not* sick, then the doctor was being made a fool of. His manly, professional attempts at treatment were simply part of a charade directed by and starring the female patient. But how could you tell the real invalids from the frauds? And what did you do when no amount of drugging, cutting, resting, or sheer bullying seemed to make the woman well?

Doctors had wanted women to be sick, but now they found themselves locked in a power struggle with the not-so-feeble patient: Was the illness a construction of the medical imagination, a figment of the patient's imagination, or something "real" which nevertheless eluded the mightiest efforts of medical science? What, after all, was behind "neurasthenia," "hyperesthesia," or the dozens of other labels attached to female invalidism?

But it took a specific syndrome to make the

ambiguities in the doctor-patient relationship unbearable, and to finally break the gynecologists' monopoly of the female psyche. This syndrome was hysteria. In many ways, hysteria epitomized the cult of female invalidism. It affected middle- and upper-class women almost exclusively; it had no discernible organic basis; and it was totally resistant to medical treatment. But unlike the more common pattern of invalidism, hysteria was episodic. It came and went in unpredictable, and frequently violent, fits.

According to contemporary descriptions, the victim of hysteria might either faint or throw her limbs about uncontrollably. Her back might arch, with her entire body becoming rigid, or she might beat her chest, tear her hair or attempt to bite herself and others. Aside from fits and fainting, the disease took a variety of forms: hysterical loss of voice, loss of appetite, hysterical coughing or sneezing, and, of course, hysterical screaming, laughing, and crying. The disease spread wildly, not only in the United States, but in England and throughout Europe.

Doctors became obsessed with this "most confusing, mysterious and rebellious of diseases." In some ways, it was the ideal disease for the doctors: it was never fatal, and it required an almost endless amount of medical attention. But it was not an ideal disease from the point of view of the husband and family of the afflicted woman. Gentle invalidism had been one thing; violent fits were quite another. So hysteria put the doctors on the spot. It was essential to their professional self-esteem either to find an organic basis for the disease, and cure it, or to expose it as a clever charade.

There was plenty of evidence for the latter point of view. With mounting suspicion, the medical literature began to observe that hysterics never had fits when alone, and only when there was something soft to fall on. One doctor accused them of pinning their hair in such a way that it would fall luxuriantly when they fainted. The hysterical "type" began to be characterized as a "petty tyrant" with a "taste for power" over her husband, servants, and children, and, if possible, her doctor.

In historian Carroll Smith-Rosenberg's interpretation, the doctor's accusations had some truth to them: the hysterical fit, for many women, must have been the only acceptable outburst—of rage, of despair, or simply of *energy*—possible.[60] Alice James, whose lifelong illness began with a bout of hysteria in adolescence, described her condition as a struggle against uncontrollable physical energy:

> Conceive of never being without the sense that if you let yourself go for a moment . . . you must abandon it all, let the dykes break and the flood sweep in, acknowledging yourself abjectly impotent before the immutable laws. When all one's moral and natural stock-in-trade is a temperament forbidding the abandonment of an inch or the relaxation of a muscle, 'tis a never-ending fight. When the fancy took me of a morning at school to *study* my lessons by way of variety instead of shrieking or wiggling through the most impossible sensations of upheaval, violent revolt in my head overtook me, so that I had to "abandon" my brain as it were.[61]

On the whole, however, doctors did continue to insist that hysteria was a real disease—a disease of the uterus, in fact. (Hysteria comes from the Greek word for uterus.) They remained unshaken in their conviction that their own house calls and high physician's fees were absolutely necessary; yet at the same time, in their treatment and in their writing, doctors assumed an increasingly angry and threatening attitude. One doctor wrote, "It will sometimes be advisable to speak in a decided tone, in the presence of the patient, of the necessity of shaving the head, or of giving her a cold shower bath, should she not be soon relieved." He then gave a "scientific" rationalization for this treatment by saying, "The sedative influence of fear may allay, as I have known it to do, the excitement of the nervous centers. . . ."[62]

Carroll Smith-Rosenberg writes that doctors recommended suffocating hysterical women until their fits stopped, beating them across the face and body with wet towels, and embarrassing them in front of family and friends. She quotes Dr. F. C. Skey: "Ridicule to a woman of sensitive mind, is a powerful weapon . . . but there is not an emotion equal to fear and the threat of personal chastisement. . . . They will listen to the voice of authority." The more women became hysterical, the more doctors became punitive toward the disease; and at the same time, they

began to see the disease everywhere themselves until they were diagnosing every independent act by a woman, especially a women's rights action, as "hysterical."

With hysteria, the cult of female invalidism was carried to its logical conclusion. Society had assigned affluent women to a life of confinement and inactivity, and medicine had justified this assignment by describing women as innately sick. In the epidemic of hysteria, women were both accepting their inherent "sickness" *and* finding a way to rebel against an intolerable social role. Sickness, having become a way of life, became a way of rebellion, and medical treatment, which had always had strong overtones of coercion, revealed itself as frankly and brutally repressive.

But the deadlock over hysteria was to usher in a new era in the experts' relationship to women. While the conflict between hysterical women and their doctors was escalating in America, Sigmund Freud, in Vienna, was beginning to work on a treatment that would remove the disease altogether from the arena of gynecology.

Freud's cure eliminated the confounding question of whether or not the woman was faking: in either case it was a mental disorder. Psychoanalysis, as Thomas Szasz has pointed out, insists that "malingering *is* an illness—in fact, an illness 'more serious' than hysteria."[63] Freud banished the traumatic "cures" and legitimized a doctor-patient relationship based solely on talking. His therapy urged the patient to confess her resentments and rebelliousness, and then at last to accept her role as a woman. Freud's insight into hysteria at once marked off a new medical speciality: "Psychoanalysis," in the words of feminist historian Carroll Smith-Rosenberg, "is the child of the hysterical woman." In the course of the twentieth century psychologists and psychiatrists would replace doctors as the dominant experts in the lives of women.

For decades into the twentieth century doctors would continue to view menstruation, pregnancy, and menopause as physical diseases and intellectual liabilities. Adolescent girls would still be advised to study less, and mature women would be treated indiscriminately to hysterectomies, the modern substitute for ovariotomies. The female reproductive organs would continue to be viewed as a kind of frontier for chemical and surgical expansionism, untested drugs, and reckless experimentation. But the debate over the Woman Question would never again be phrased in such crudely materialistic terms as those set forth by nineteenth-century medical theory—with brains "battling" uteruses for control of woman's nature. The psychological interpretation of hysteria, and eventually of "neurasthenia" and the other vague syndromes of female invalidism, established once and for all that the brain was in command. The experts of the twentieth century would accept woman's intelligence and energy: the question would no longer be what a woman *could* do, but, rather, what a woman *ought* to do.

REFERENCES

1. Anna Robeson Burr, *Weir Mitchell: His Life and Letters* (New York: Duffield and Co., 1929), p. 289.
2. Charlotte Perkins Gilman, *The Living of Charlotte Perkins Gilman: An Autobiography* (New York: Harper Colophon Books, 1975), p. 96.
3. Gilman, loc. cit.
4. Charlotte Perkins Gilman, *The Yellow Wallpaper* (Old Westbury, New York: The Feminist Press, 1973).
5. Gilman, *Autobiography*, p. 121.
6. Catherine Beecher, "Statistics of Female Health," in Gail Parker (ed.), *The Oven Birds: American Women on Womanhood 1820–1920* (Garden City, New York: Doubleday/Anchor, 1972), p. 165.
7. Ilza Veith, *Hysteria: The History of a Disease* (Chicago and London: The University of Chicago Press, 1965), p. 216.
8. Quoted in F. O. Matthiessen, *The James Family* (New York: Alfred A. Knopf, 1961), p. 272.
9. Quoted in Irving H. Bartlett, *Wendell Phillips: Brahmin Radical* (Boston: Beacon Press, 1961), p. 78.
10. Quoted in Leon Edel (Ed.), *The Diary of Alice James* (New York: Dodd, Mead, 1964), p. 14.
11. We thank medical historian Rick Brown for sharing this story with us.
12. Thorstein Veblen, *Theory of the Leisure Class* (New York: Modern Library, 1934).
13. Burr, op. cit., p. 176.
14. Olive Schreiner, *Woman and Labor* (New York: Frederick A. Stokes, 1911), p. 98.
15. John C. Gunn, M.D., *Gunn's New Family Physi-*

cian (New York: Saalfield Publishing, 1924), p. 120.
16. New York Public Library Picture Collection, no source given.
17. Dr. Mary Putnam Jacobi, "On Female Invalidism," in Nancy F. Cott (ed.), *Root of Bitterness: Documents of the Social History of American Women* (New York: E. P. Dutton, 1972), p. 307.
18. John S. Haller, Jr., and Robin M. Haller, *The Physician and Sexuality in Victorian America* (Urbana, Illinois: University of Illinois Press, 1974), pp. 143–44.
19. Ibid., p. 168.
20. Ibid., p. 31.
21. Ibid., p. 28.
22. Gilman, *The Yellow Wallpaper*, pp. 9–10.
23. Quoted in G. Stanley Hall, *Adolescence, Vol. II* (New York: D. Appleton, 1905), p. 588.
24. Gunn, op. cit., p. 421.
25. W. C. Taylor, M.D., *A Physician's Counsels to Woman in Health and Disease* (Springfield: W. J. Holland and Co., 1871), pp. 284–85.
26. Winfield Scott Hall, Ph.D., M.D., *Sexual Knowledge* (Philadelphia: John C. Winston, 1916), pp. 202–3.
27. U.S. Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1957*, Washington, D.C., 1960, p. 25.
28. Rachel Gillett Fruchter, "Women's Weakness: Consumption and Women in the 19th Century," Columbia University of Public Health, unpublished paper, 1973.
29. Haller and Haller, op. cit., p. 59.
30. Emma Goldman, *Living My Life*, Vol. I (New York: Dover Publications, Inc., 1970, first published 1931), pp. 185–86.
31. Carroll D. Wright, *The Working Girls of Boston* (Boston: Wright and Potter Printing, State Printers, 1889), p. 71.
32. Ibid., pp. 117–18.
33. Lucien C. Warner, M.D., *A Popular Treatise on the Functions of Diseases of Woman* (New York: Manhattan Publishing, 1874), p. 109.
34. Quoted in Dr. Alice Moqué, "The Mistakes of Mothers," *Proceedings of the National Congress of Mothers Second Annual Convention*, Washington, D.C., May 1898, p. 43.
35. Goldman, op. cit., p. 187.
36. Quoted in G. J. Barker-Benfield, *The Horrors of the Half-Known Life: Male Attitudes Toward Women and Sexuality in Nineteenth-Century America* (New York: Harper & Row, 1976), p. 128.
37. Quoted in Elaine and English Showalter, "Victorian Women and Menstruation," in Martha Vicinus (ed.), *Suffer and Be Still: Women in the Victorian Age* (Bloomington: Indiana University Press, 1972), p. 43.
38. "Mary Livermore's Recommendatory Letter," in Cott, op. cit., p. 292.
39. Mary Putnam Jacobi, M.D., in Cott, op. cit., p. 307.
40. Frederick Hollick, M.D., *The Diseases of Women, Their Cause and Cure Familiarly Explained* (New York: T. W. Strong, 1849).
41. Quoted in Ann Douglas Wood, "The 'Fashionable Diseases': Women's Complaints and their Treatment in Nineteenth-Century America," *Journal of Interdisciplinary History* 4, Summer 1973, p. 29.
42. Quoted in Rita Arditti, "Women as Objects: Science and Sexual Politics," *Science for the People*, September 1974, p. 8.
43. W. W. Bliss, *Woman and Her Thirty-Years' Pilgrimage* (Boston: B. B. Russell, 1870), p. 96.
44. Quoted in Haller and Haller, op. cit., p. 101.
45. Quoted in Veith, op. cit., p. 205.
46. M. E. Dirix, M.D., *Woman's Complete Guide to Health* (New York: W. A. Townsend and Adams, 1869), pp. 23–24.
47. Quoted in Fruchter, op. cit.
48. Wood, op. cit., p. 30.
49. Barker-Benfield, op. cit., pp. 121–24.
50. Ben Barker-Benfield, "The Spermatic Economy: A Nineteenth Century View of Sexuality," *Feminist Studies* 1, Summer 1972, pp. 45–74.
It is unlikely that the operation had this effect on a woman's personality. It would have produced the symptoms of menopause, which do not include any established personality changes. Barker-Benfield, *Horrors of the Half-Known Life*, p. 122.
52. Ibid., p. 30.
53. Ibid., pp. 96–102.
54. Quoted in Theodore Roosevelt, "Birth Reform, From the Positive, Not the Negative Side," in *Complete Works of Theodore Roosevelt*, Vol. XIX (New York: Scribner, 1926), p. 163.
55. Roosevelt, op. cit., p. 161.
56. Hall, op. cit., p. 579.
57. S. Weir Mitchell, *Constance Trescot* (New York: The Century Co., 1905), p. 382.
58. Quoted in Veith, op. cit., p. 217.
59. See Linda Gordon, *Woman's Body, Woman's Right: A Social History of Birth Control in America* (New York: Grossman, 1977).
60. Carroll Smith-Rosenberg, "The Hysterical Woman: Sex Roles in Nineteenth Century America," *Social Research*, 39, Winter 1972, pp. 652–78.
61. Quoted in Matthiessen, op. cit., p. 276.
62. Dirix, op. cit., p. 60.
63. Thomas S. Szasz, *The Myth of Mental Illness* (New York: Dell, 1961), p. 48.